West Yorkshire and Harrogate Health and Care Partnership

WY&H Health and Care Partnership Board

7 September 2021

Summary report	
Item No:	32/21
Item:	**The Health and Care Bill: Developing our governance arrangements**
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Executive summary

This paper updates the WY&H Partnership Board on work to develop our governance arrangements in readiness for the establishment of the statutory Integrated Care System (ICS) from April 2022.

The Health and Care Bill, published on 6 July 2021, reflects much of how we work in WY&H. It recognises that collaborative working produces better health and wellbeing outcomes and a more effective approach to reducing health inequalities. We have demonstrated the value of collaboration in our response to COVID and a wide range of other initiatives that are making a positive difference for local people. We believe that the legislation is 'catching up' with how we work and will help us to further improve the health and wellbeing of everyone across our area.

We have a mature partnership, in which Health and Wellbeing Boards and the Partnership Board set strategic direction. We have strong place arrangements, mature provider collaboratives and inclusive and transparent system leadership. We start from the basis that our existing arrangements, as set out in our Partnership Memorandum of Understanding, are fundamentally sound and are helping us to achieve better outcomes for local people. We will align with what the legislation and statutory guidance requires, rather than be driven by it.

A Governance Working Group, Chaired by Tim Ryley, the Accountable Officer for Leeds CCG, includes partners from across our system and is working to align our place and system governance arrangements. The Group reports regularly to the Future Design and Transition Group and the Chairs and Leaders Reference Group. We have shared our developing thinking with Health and Wellbeing Boards, place partnership forums, CCG Governing bodies and health overview and scrutiny committees. At system level, we have engaged with the West Yorkshire Health Overview and Scrutiny Committee.

Development work to date has focused on:

- establishing clear, outcome-focused governance standards on transparency, independent challenge and accountability;
- models for delegating ICS functions and resources to place
- place leadership and accountability arrangements; and
- system governance arrangements.

Whilst the Bill signals a welcome degree of permissiveness, much of the national guidance which will accompany it, including the ICS functions and governance guidance and the ICS model constitution, had only just been published at the time of writing this report. Initial review of the guidance shows that it supports our direction of travel and we will now be able to progress further work on the detail of our

arrangements in the light of these documents. In particular, we will be able to align our constitution with the national model. CCGs are legally responsible for the development of ICB constitutions, but the process will be led by the designate ICS chair and CEO, with system partners engaged throughout in its development. We are awaiting further guidance on how this will need to work and the implications for the Partnership.

Now that the national guidance has been published, our intention is to share a draft constitution and other governance documents as soon as we are able. We have adjusted other timelines in anticipation of publication. In particular, we will soon be in a position to 'stress test' our proposed arrangements in partner workshops, using case studies. We are planning these for September and October 2021.

We remain confident that we are well placed to transition to 'shadow' operation in November 201, in preparation for new statutory arrangements from April 2022.

Recommendations and next steps

The WY&H Partnership Board is recommended to:

- comment on progress to date in developing our governance arrangements; and
- request a further update to the WY&H Partnership Board meeting in December 2021.

WY&H Partnership Board

7 September 2021

The Health and Care Bill: Developing our governance arrangements

Purpose

1. This report summarises progress in developing our governance arrangements in readiness for the establishment of the Integrated Care System (ICS) as a statutory body from 1 April 2022.

Background and context

2. At its meeting on 1 June 2021, the WY&H Partnership Board considered a report on the development of partnership governance arrangements in response to the White Paper *"Integration and Innovation: Working together to improve integration and innovation for all"* . Subsequently, the Health and Care Bill was laid before Parliament on 6 July 2021. The key elements of the Bill are as follows:

3. **A statutory ICS** will be made up of a statutory NHS body – the **Integrated Care Board (ICB)** and a statutory joint committee - the **Integrated Care Partnership (ICP) -** bringing together the NHS, Local Government and partners. ICSs will be able to **delegate significantly to place level** and to **provider collaboratives**.

4. The ICB will be directly **accountable for NHS spend and performance** within the system. As a minimum, the ICB board must include a chair and 2 non executives, the ICB Chief Executive and clinical and professional leaders, and representatives from NHS trusts, primary care and local authorities. Others may be determined locally. A summary of ICB functions is attached at Annex A.

5. The ICP will be a wider group than the ICB and will develop an **integrated care strategy** to address the health, social care and public health needs of their system. The membership and detailed functions of the ICP will be up to local areas to decide.

6. **Place-based arrangements** between local authorities, the NHS and providers of health and care will be left to local areas to arrange. The statutory ICB will work to support places to integrate services and improve outcomes. **Health and Wellbeing Boards** will continue to have an important role in local places. **NHS provider organisations** will remain separate statutory bodies and retain their current structures and governance, but will be expected to work collaboratively with partners.

7. A **duty to co-operate will** be introduced to promote collaboration across the healthcare, public health and social care system. ICSs, NHS England and NHS providers will be required to have regard to the '**Triple Aim**' of better health and wellbeing for everyone, better care for all people, and sustainable use of NHS resources.

8. Our Governance Working Group, Chaired by Tim Ryley, Accountable Officer for Leeds CCG, has representation from across our places, providers and sectors including NHS commissioners, provider collaboratives, local authorities, voluntary, community AND

social enterprise (VCSE) sector, Healthwatch and our Race Equality Network. The Group is sharing learning from across our places and system, advising on where consistency is required and on the linkages between place, ICB and ICP arrangements.

9. On 19 August 2021, NHS England and Improvement published a model ICS constitution and Interim ICS functions and governance guide. We anticipate further guidance from NHS England over the rest of this calendar year, which we reflect as our work develops.

Key governance issues

10. **Values and behaviours** – strong and effective governance is as much about living our values as about arrangements and structures. It will be critical that our new arrangements reflect and strengthen our principles and behaviours and support the culture that we have established as a genuine partnership over the last 5 years. In particular, we will ensure that the arrangements support our commitment to diversity and equality. We are eager to make progress in ensuring that our leadership and involvement in decision-making reflects the diversity of our communities and are exploring how we can take this forward. Equality impact assessments will play an important role in our new arrangements.

11. **Governance standards** – our principles of subsidiarity mean that places are developing arrangements that meet their local circumstances, within a common framework of good governance. The Governance Working Group has drafted the governance section of our place development framework and has also developed a set of draft standards which we will apply across our system. The standards cover outcomes, values, transparency, citizen involvement, diversity, independent challenge and probity and are attached at Annex B.

12. **Subsidiarity and delegation** – under statutory arrangements, the vast majority of ICS capacity and resources will remain in our places. To enable this delegation, places are developing governance models and committee structures to fit local circumstances, within the context of our core governance standards and our place development framework. Common to each of them are:

- Health and Wellbeing boards continuing to play a key role in bringing partners together and setting strategy.
- building on existing strong place arrangements to enable effective collaborative decision making
- involving statutory and non-statutory partners and ensuring that the citizen voice is heard
- ensuring that providers working across footprints are effectively represented without duplication and overlap.

13. Places are focusing largely on two models of delegation - a place-based **Committee of the ICB** and a **Joint Committee** between statutory partners. Both of these models enable transparent, accountable collaborative decision making within the context of our governance standards. The detail of these arrangements will need to be aligned with national guidance and reflected in our constitution**.** Places have also been exploring leadership models designed to both support distributed leadership and ensure clear accountability.

14. **System arrangements** – the **Integrated Care Partnership** will be a statutory joint committee between partners. Our existing Partnership Board is already a key part of our leadership and governance arrangements. Through our five year plan, it has set out our strategic direction and how we will work together as partners to improve health and wellbeing and reduce health inequalities. The Partnership Board focuses on the wider connections between health and wider issues including socio-economic development, housing, employment and environment. It takes a collective approach to decision-making and supports mutual accountability across our system. Our current arrangements mean that we are well placed to transition to a statutory joint committee and we will be reviewing the membership and terms of reference of the Partnership Board in line with the national guidance on Integrated Care Partnerships, once published.

15. Our Integrated Care Partnership will set the overall strategy for our ICS, it will be built from the five place-based strategies which in turn will have been signed off by Health and Wellbeing Boards and delivered through place based partnership arrangements. This will ensure that the specific needs of all our populations will be met. The decision making framework which supports the setting and delivery of the ICS strategy is much broader than the ICB Board and ICP and includes place which is where we expect most decisions to be made under the principles of subsidiarity.

16. We are carrying out initial design work on the membership and working arrangements for the **ICB board.** We want our board to look, feel and function differently from traditional boards and to align with the legislation, rather than be driven by it. Our collaborative culture and behaviours will be paramount, and nomenclature is important in setting the tone. We propose to use our system language of places and providers, supported by system executive, clinical and professional leadership and overseen by independent lay members. The board will be built on principles of inclusivity, independent challenge and effectiveness and will reflect the scale and complexity of a diverse system which serves a population of 2.7 million. It will be part of a complex, mature and inclusive decision making framework, focused on delivery of our shared outcomes and with independent challenge built in at all levels. Annex C sets out an initial proposition on the proposed membership and way of working Annex D is a draft schematic of wider partnership governance arrangements.

17. National guidance setting out the functions of the ICB Board is set out in Annex A however, it is important to note that these are the technical description of the responsibilities as set out in guidance and West Yorkshire will look to discharge these in a way that aligns much more with our approach through Places and with support.

18. The ICB will be required to establish 2 statutory committees – **audit** and **remuneration**. We will also need to establish other committees to focus on oversight and assurance and provide the board with assurance on the delivery of key functions including system quality and finance. The Partnership already has a number of effective collaborative forums such as the System Leadership Executive, System Oversight and Assurance Group, Quality Surveillance Group, Clinical Forum and Finance Forum. Development work is focusing on how the role, membership and ways of working of these groups may need to be adapted in line with new statutory arrangements.

19. As part of the changes, we are proposing a name change for our ICS from April 2022 to West Yorkshire Health and Care Partnership. It's important to note that whilst Harrogate place will be part of the Humber, Coast and Vale Health and Care Partnership (ICS), our work with Harrogate and District NHS Foundation Trust will continue as part of our West Yorkshire provider collaborative (West Yorkshire Association of Acute Trusts) and clinical networks. Existing patient flows will be unaffected by this change.

Next steps and outline timeline

20. **ICS constitution –** the Governance Working Group is leading the co-production of the ICS constitution in which we will set out our governance arrangements. We will align our ICS constitution with the national model, now that it has been published. The national model is largely permissive and initial gap analysis against its requirements suggests that we will have the flexibility to base our approach and much of the content on our existing MoU. We will need to accompany this with detail on key issues such as our delegation arrangements and ICB board arrangements.

21. **Case studies –** a key element of our plan to take an inclusive and iterative approach is through the use of partner workshops to 'stress test' our emerging arrangements, using case studies. Now that the national guidance has been published we will be able to progress the detail of our arrangements and we are planning to arrange these workshops for late September-October. Engagement with partners has suggested a range of scenarios including:

- serious quality and financial performance issues
- major hospital reconfiguration
- reducing health inequalities

22. **Engagement** --The Governance Working Group reports regularly to the Future Design and Transition Group and the Chairs and Leaders Reference Group. We have shared developing thinking with Health and Wellbeing Boards, place partnership forums, CCG Governing bodies and health overview and scrutiny committees. At system level, we have engaged with the West Yorkshire Health Overview and Scrutiny Committee. We will continue this engagement as we further refine our arrangements over the next six months.

23. The Health and Care Bill requires CCGs to both formally propose the ICS constitution and carry out consultation on it, but the process will be led by the designate ICS chair and CEO, with system partners engaged throughout in its development. We are awaiting guidance on how this will need to work in practice and the implications for our Partnership. It should be noted that the consultation will be on the content of the constitution, not on whether ICSs should be established. In anticipation of the guidance, we are developing our thinking on the approach to consultation including local authorities, Healthwatch and other stakeholders such as VCSE partners and overview and scrutiny committees. To ensure transparency and reduce the risk of challenge, we will publish our draft constitution to enable all interested parties to contribute. Our consultation process will be 'designed once and delivered five times' across our places. Our intention remains that we will share the draft constitution as soon as we are able.

24. **Shadow arrangements -** given the maturity of our Partnership and the strong leadership and governance arrangements that are already in place, in many respects, we are already operating in shadow form. The move towards statutory arrangements from April 2022 will largely be a gradual transition rather than a 'step change'. Groups such as the System Leadership Executive will continue to have a key role, recognising the importance of distributed leadership and retaining the 'us and us' culture. Groups like the Clinical Forum, Finance Forum, System Oversight and Assurance group and Provider collaborative committees in common will also continue to play a key role in supporting collaborative working and mutual accountability.

25. Some new groups will need to be established, including the board of the Integrated Care Board and place-based decision making forums. We envisage that these will start to operate in 'shadow' form and hold their first meetings in November. Some parts of our shadow governance machinery will need to operate in a more formal way before April. For example, a Remuneration Committee will be required to oversee senior remuneration in relation to appointments to the ICB. We are currently working through the practical implications of this. In addition once guidance around the Integrated Care Partnership is published, details setting out the broader decision making framework that sits around the ICB (including the ICP) and the Place Based Decision making arrangements will be brought back for consideration.

26. A key element for operating in shadow form will be agreeing the future leadership arrangements for the ICS including the ICS Chair and Chief Executive, place leads, members of the Board of the Integrated Care Board and WY&H director level appointments. The timelines we are operating to are partially determined by the national recruitment process. The Chair recruitment process is underway and we hope to have the chair designate identified by mid-September. Our expectation at the time of writing is that the Chief Executive post will be advertised at the beginning of September, and identified by the end of October, with other mandated Director posts advertised shortly afterwards.

Conclusion and recommendation

27. Now that the national guidance has been published, we are confident that we are well placed to transition to 'shadow' operation in November 2021 in preparation for new statutory arrangements from April 2022. A revised timeline is attached at Annex E.

28. The WY&H Partnership Board is recommended to:

- comment on the work to develop our governance arrangements; and
- request a further update to the WY&H Partnership Board at its December 2021 meeting.

Stephen Gregg
Governance Lead, WY&H Health and Care Partnership

The integrated care board

ICBs will bring partner organisations together in a new collaborative way with common purpose. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.

Table 3: Functions of the integrated care board

1	Developing a plan to meet the health and healthcare needs of the population (all ages) within their area, having regard to the Partnership's strategy.
2	Allocating resources to deliver the plan across the system, determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.
3	Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
4	Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.
5	Arranging for the provision of health services in line with the allocated resources across the ICS through a range of activities including: a) putting contracts and agreements in place to secure delivery of its plan by providers b) convening and supporting providers (working both at scale and at place) to lead[6] major service transformation programmes to achieve agreed outcomes c) support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships,

[6] It is expected that the ICB will be able to delegate functions to statutory providers to enable this.

	including through investment in PCN management support, data and digital capabilities, workforce development and estates d) working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care.
6	Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers.
7	Leading system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
8	Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes.
9	Through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability.
10	Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.
11	Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
12	Functions to be delegated by NHS England and NHS Improvement include commissioning of primary care and appropriate specialised services.

Statutory CCG functions to be conferred on ICBs

Statutory functions, like those currently exercised by CCGs, will be conferred on ICBs from 1 April 2022, along with the transfer of all CCG staff, assets and liabilities (including commissioning responsibilities and contracts). Relevant duties of CCGs include those regarding health inequalities, quality, safeguarding, children in care and children and young people with special educational needs and (SEN) or disability.[7].

The full expected list of CCG functions to be conferred will be made available to NHS organisations via the NHS England and NHS Improvement ICS implementation hub.

Delegating direct commissioning functions to ICBs

It is the intention to delegate some of the direct commissioning functions of NHS England and NHS Improvement to ICBs as soon as operationally feasible from April 2022.

Our expectation is that from April 2022 ICBs will:

- assume delegated responsibility for Primary Medical Services (currently delegated to all CCGs, and continuing to exclude Section 7A Public Health functions)
- be able to take on delegated responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services (including dispensing doctors and dispensing appliance contractors)
- establish mechanisms to strengthen joint working between NHS England and NHS Improvement and ICSs, including through joint committees, across all areas of direct commissioning (in systems where they are not already delegated).

By April 2023, all ICBs will have:

- taken on delegated responsibility for dental (primary, secondary and community), general ophthalmic services, and pharmaceutical services
- taken on delegated commissioning responsibility for a proportion of specialised services (subject to system and service readiness) with national standards and access policies remaining at a national level
- worked collaboratively with our organisation to determine whether some Section 7A Public Health services, and Health and Justice, Sexual Assault and Abuse

[7] Further guidance will be developed to support the transition of functions to ensure ICSs deliver for babies, children and young people.

Service commissioning functions will be delegated, with decisions on the appropriate model and timescale.

Commissioning healthcare for serving members of the Armed Forces and their families registered with defence medical services, veterans' mental health and prosthetic services will remain with NHS England and Improvement.

DRAFT ICS Governance standards

(Applicable to: the ICP and ICB, joint committees, committees and sub committees with delegated authority from the ICB.)

Principles	Standards
Outcome-focus Our arrangements focus on reducing health inequalities, better health and wellbeing, better quality of care and efficient use of resources.	• Agenda items set out how they contribute to the delivery of the outcomes in Health and Wellbeing strategy/ICB plan/ICP integrated care strategy. • Where relevant, papers are supported by quality and equality impact assessments. • Annual report focuses on delivery of outcomes.
Values Our arrangements reflect our values and ways of working - equal partnership, subsidiarity, collaboration, mutual accountability.	• The agreed principles, values and behaviours of the ICS are set out in the Terms of Reference
Involving citizens and stakeholders We have an inclusive approach, involving citizens and partners from across the system. We are committed to improving diversity in leadership and decision-making.	• Citizens are involved in all relevant decisions. • Decision making involves partners from across our system, including statutory and non-statutory partners.
Transparency We are committed to transparency. We make our decisions in public and publish key policies and registers.	• Decision-taking meetings held in public (unless not in the public interest). • Agenda papers are published at least 5 working days before each meeting. • Key documents are published e.g. minutes, register of procurement decisions.
Probity and independent challenge Our decisions meet high standards of probity and are subject to robust independent challenge.	• Decision-making groups include members independent of any statutory partner. • ICB policy for managing conflicts of interest adopted and implemented.
Accountability and assurance Our arrangements support clear accountability.	• Accountability set out in scheme of delegation or delegation agreement. • Terms of reference agreed and reviewed annually. • Minutes reported in line with agreed reporting mechanisms • Annual report and annual review of performance.

ICB Board – outline proposition on membership and working arrangements

1. This report presents for discussion an outline proposition for the membership and working arrangements of the board of the Integrated Care Board (ICB). In line with our 'form follows function' approach, the proposition is designed to ensure that our board arrangements contribute to better health and wellbeing and reduced health inequalities for our population. The proposition supports our values and principles - we want our board to look, feel and function differently from traditional boards and to align with legislation, rather than be driven by it.

2. Our principles of subsidiarity mean that the ICB will primarily discharge its duties through delegation to place, alongside work that is delivered at WY&H level. We expect that most decisions will be made at place level, in support of local Health and Wellbeing Board priorities. At system level, the ICB board will have a key role in executing the strategy set by the Integrated Care Partnership; its delivery in place and through provider collaboratives; and through engagement with partners at WY&H level. This will include overseeing the delivery of and being accountable for all ICB functions, including those delegated to place. To do this, it will need to have a wide-ranging perspective on the business of the ICB, shape proposals on strategy and priorities, enable constructive challenge and champion the partnership's principles and values, including the expression of different views.

3. The membership of the ICB board will be important, and equally so will be the tone the leadership sets to create an environment in which it operates, including our culture of networking and collaboration. In designing our arrangements, we need to balance the following principles:

   - **Inclusivity -** our well-established partnership approach demonstrates the value of inclusivity and diversity in decision making. Through a combination of its membership, and the ways in which members engage with partners, the board will need to take into account the perspectives and expertise of our places, providers, citizens, clinical and professional leaders, sectors and functions. It will also need to progress our ambition for our leadership to reflect the diversity of our communities.
   - **Independent challenge –** this is essential to robust decision making and we will need to ensure that it is built into both our board membership and ways of working.
   - **Effectiveness -** the ICB Board will need to be of an appropriate size to allow for effective decision making. Accountability will need to be set out clearly.

4. There are tensions between these principles, for example maximising inclusiveness is likely to lead to a larger than optimum board. It is therefore important that we consider the board not in isolation, but as one component of our collaborative decision-making arrangements, such as those in place, programmes and the system leadership executive.

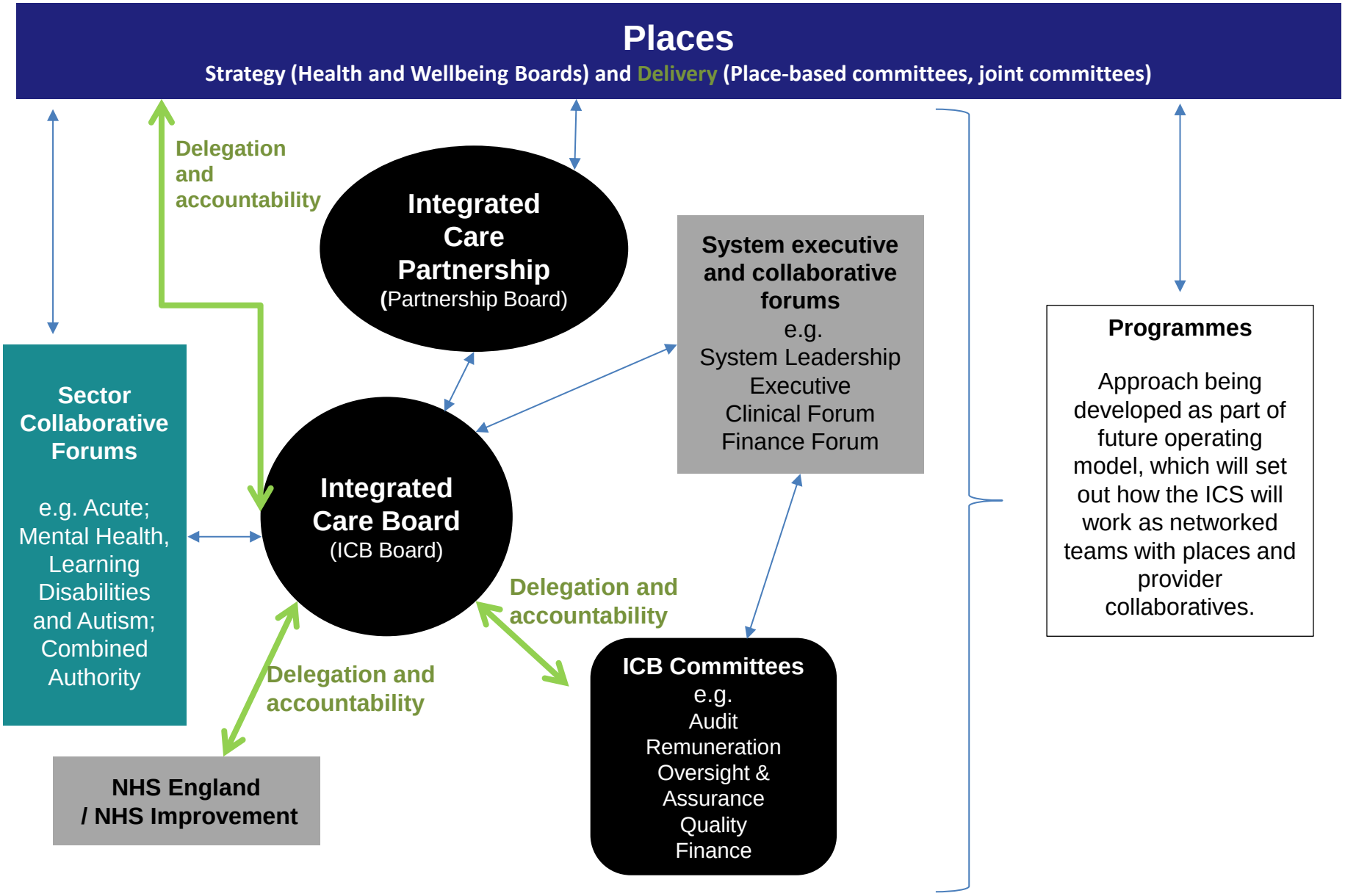
5. We want our board to reflect our partnership ethos. Our collaborative culture and behaviours will be paramount, and nomenclature is important in setting the tone. We propose to use our system language of places and providers, supported by system executive, clinical and professional leadership and overseen by independent lay members.

Proposition

6. Taking into account our partnership ethos and the principles of inclusivity, independent challenge and effectiveness, a proposed board membership is attached which balances independent lay members, place, providers, statutory and non-statutory partners and executive, clinical and professional roles. This is larger than optimum but is intended to reflect the scale and complexity of a diverse system which serves a population of 2.7 million. The board will be part of a complex, mature and inclusive decision making framework, focused on delivery of our shared outcomes and with independent challenge built in at all levels.

WY&H proposition	**Minimum national requirement**
Independent Lay perspective Chair Lay members x2	 Chair Non- Executive directors x2
Healthwatch perspective • Healthwatch	 No minimum requirement.
Place perspective • Place representative x5 • Local authority	 • No minimum place requirement • One local authority member
Provider perspectives • Acute provider • Mental health, learning disability and autism provider • Voluntary, community and social enterprise sector • Primary medical services	One member drawn from • NHS trusts and foundation trusts • primary medical services (general practice) providers
System executive, clinical and professional • Chief Executive • Director of Finance • Director of Nursing • Medical Director • Director of Public Health	 • Chief Executive • Director of Finance • Director of Nursing • Medical Director
Subject matter experts • Invited to be in attendance permanently or as required, e.g. workforce, digital.	No minimum requirements.
Total board size: 19	**10**

DRAFT Our Integrated Care System - a partnership of places, programmes and sectors



Governance timeline (as at 19 August 2021)

National planning timelines – as amended by ICS Design Framework	Outline WY&H timeline	WY&H reporting
By end Q1 (30 June 2021) Update System Development Plans and confirm proposed boundaries, constituent partner organisations and place-based arrangements.	**April – June 2021** Develop the governance arrangements for the ICS: • Map out proposed place, provider and system arrangements. • Map out delegation arrangements and how decisions will be taken. • Co-produce draft proposed structure for ICS constitution.. • Wider engagement with partners and stakeholders on emerging thinking.	**31.03.21 Future Design and Transition Group** • Approach to governance arrangements. **28.04.21** • Place leadership arrangements. **30.04.21 Chairs and Leaders** • Approach to governance arrangements. **01.06.21 Partnership Board** • Approach, emerging thinking and timeline. **09.06.21 FD&TG** • Update **25.06.21 Chairs & Leaders** • Update
By end Q2 (30 September 2021) Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive. Draft proposed ICS operating model and governance arrangements, in line with the NHS England and NHS Improvement model constitution and guidance. Begin due diligence planning.	**July – September 2021** Timings to be refined in line with key national dependencies including: • **Functions and governance guidance** • **ICS model constitution.** • **ICP guidance** Further iteration of governance development process: • Refine and adapt proposed arrangements in the light of legislation and national guidance. • Co-produce with partners a draft ICS constitution. • Test emerging arrangements through partner workshops • Start recruitment to key roles, including Chair and Chief Executive of the Integrated Care Board.	**7.07.21 FD&TG** • ICS design framework • delegation to place • ICP development framework **30.07.21 Chairs & Leaders** • Place leadership arrangements. **27.08.21 Chairs & Leaders** • Update, including ICB board proposition. **01.09.21 FD&TG** • Update, including ICB board proposition. **07.09.21 Partnership Board** • Update. including ICB board proposition

National planning timelines	Outline WY&H timeline	WY&H reporting
By end Q3 (31 December 2021) Confirm designate appointments to ICS NHS body finance director, medical director and director of nursing roles and other board and senior level roles ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form. Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.	**October – December 2021** Further iteration of governance development process outlined above. • Refine and adapt proposed arrangements. • Co-produce with partners revised draft ICS constitution • Complete testing of arrangements through partner workshops • Complete appointments for leadership roles. • Put in place 'Shadow' arrangements and ways of working.	**FD&TG, Chairs and Leaders** • Draft constitution and governance arrangements • Timings in line with dependencies. **07.12.21 Partnership Board** • Draft constitution and governance arrangements
By end Q4 (31 March 2022) Confirm designate appointments to any remaining senior ICS roles. Complete due diligence and preparations for staff and property (assets and liabilities, including contracts). Submit the ICS constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement.	**January – March 2022** Further iteration of governance development process outlined above. • Finalise proposed arrangements. • Submit final draft ICS constitution to NHS England for approval • Complete appointments processes, due diligence as outlined in the planning guidance.	**FD&TG and Chairs and Leaders** • Updates in line with dependencies. **01.03.22 Partnership Board** • Final draft constitution and governance arrangements.
1 April 2022 Establish new ICS NHS body, with staff and property (assets and liabilities) transferred and boards in place.		**April 2022** • ICS formally established. • First formal meetings of ICB Board, ICP and place-based committees.