Good Governance Institute

Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

Surrey Heartlands Health and Care Partnership

Supporting next steps in governance development

A report from the Good Governance Institute

January 2020

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Supporting next steps in governance development

Final Report

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1. Executive summary and recommendations

In September 2020 the Good Governance Institute (GGI) was appointed by Surrey Heartlands Health and Care Partnership (SHHCP) to undertake a governance review programme. The purpose of this programme was twofold. Firstly, to review the extant governance arrangements and to assess whether these are fit for purpose in delivering the aims of the Integrated Care System (ICS), and secondly, to provide guidance and recommendations in relation to governance arrangements as the system seeks to mature further in line with local ambition, national policy and NHS legislative change relating to ICSs.

The review was undertaken and report prepared between September and December 2020, using a well-established review technique that has as its basis the triangulation of evidence. This included a review of governance and assurance documents, interviews with a range of stakeholders from constituent organisations within the system, meeting observations, and benchmarking against governance best practice and the experience of health and care integration initiatives elsewhere. The review team comprised experienced GGI consultants.

During this period the goalposts shifted significantly, with various statements from the Centre on ICS development, and in the final days of the review the important policy paper 'Integrating care. Next steps to building strong and effective integrated care systems across England' was published. Also, the review has a definite 'Hawthorne Effect' which, in combination with the knowledge of impending policy changes, definitely started to accelerate the pace of collaborative working and at the same time made some of the initial thinking redundant, as legislation within the year seems inevitable.

This said, the headline findings of the governance review are:

i. Much progress has been made to date with a positive culture of working together between system partners. This was one of the early ICSs. There are, however, areas of discomfort and disagreement between some of the system actors that need working through to resolve

ii. The last 12-15 months, particularly during the first phase of the pandemic, have been characterized to us as being some of the best in terms of collaboration and cooperation, but it is important to embed more formalised governance so as not to rely on informal decision-making and decision-taking processes

iii. There is sometimes a lack of understanding or different views with regards to what the overall objectives of the ICS are, and how these are agreed and delivered. Not all the partners agreed that the ICS had been the catalyst to improved working between partners

iv. Current system governance has evolved organically over time and now is seen as repetitive, overly complex and burdensome. There is a clear need to design this out and reduce duplication. Clarity around the up-and-coming legal form to ICSs will help this as it is released but there are immediate opportunities to move forward. Much of what is termed 'governance' is clearly managerial or representative groups with no 'governance' purpose

v. There are some key areas of tension and uncertainty which need to be navigated, including governance between place-based working and provider representation at system level, and between current statutory responsibilities of Board members and the delivery of shared accountability across the system. Greater involvement of non-statutory partners, who may have no formal role in the governance itself, needs also to be advanced

vi. There is broad recognition that market mechanisms are being replaced by a culture of collaborative working and prioritising system, patient and taxpayer benefit

vii. There is an appetite for this phase of system development to be a single stepping-stone to the future organisational forms and governance that legislation or guidance will establish, which will be achieved through an ICS strategy refresh in early 2021

The review makes the following recommendations to strengthen the governance of the ICS. These are expanded on and explained within the main body of this report.

Recommendations

The following recommendations will give the ICS this ability to take binding decisions on behalf of all constituent members without resorting to individual board decisions. This will move the ICS governance forward in a number of ways, and provides the NHS and local authorities within Surrey Heartlands the opportunity to anticipate the future creation of the ICS as a legal entity, in which all current players can shape the culture, ethos and operating model. It will allow sound decisions, and support any decisions taken prior to legislation being enacted against any potential future judicial reviews.

Governance

1. Consider establishing competently governed process with formalised arrangements through a **Committees in Common** arrangement for the Surrey Heartlands ICS System Board with the benefit of non-executive oversight[1]. The scope of the work of this should be established but within the principle of subsidiarity where the ICS takes responsibility of those decisions and developments which can uniquely be carried out at ICS level.

    a) This should meet in public. Its mindset and working arrangements should be system focused and it should not act as a forum of representatives
    b) In common with all others across the country, provider boards, in governing their own organisations, will need to develop a new mindset, together with some different reporting arrangements to their own boards. To maintain being competent controlling minds in this scenario they will need to be systematically sighted on systems risks and system performance and to understand the impact this will have on their own responsibilities. This scenario was, in any case, to be anticipated by the 'system by default' approach of NHS England/Improvement (e.g. the system control total). There are good examples across the country where this work is being done with initiatives such as systems-wide risk systems between providers
    c) Membership of the Committees in Common is ideally skills and roles based, rather than representative of each individual organisation and committee members are 'accountable for the whole system'. It will be a sign of system maturity if member organisations are able to feel comfortable not always sending Chairs and Chief Executives, but rather thinking what the matrix of skills needs are necessary for effective working at the systems level
    d) An organisation being represented holds one vote regardless of the number of people representing them. All organisations must agree to form a binding decision

To note, the strength of this recommendation has changed with the new paper on ICS development. We remain convinced that a Committee in Common for ICS functions would be helpful and be better governance. It is for you to judge the ease with which you could persuade all the organisations that comprise the ICS of our view. We feel it would also be a helpful rehearsal of the inevitable legal form for the ICS – the one 'stepping-stone' between now and the ultimate ICS arriving on 1st April 2022. However, with just 16 months to go it is important that if you are to proceed as we recommend this can be done smoothly and not eat into time when there is so much to be achieved. The potential downside of maintaining the status quo is not insignificant, however, and with very important decisions to be taken it might become a regret in due course that these were not done within the comfort of a tightly governed system when there was the opportunity to do so.

To emphasise, all individual organisations, including the group of CCGs, will maintain their individual boards and Governing Bodies. For the group of CCGs, this means their current Committees in Common. Other groups currently meeting within the current governance system can be stood down, for example SOAG and the finance and quality groups. The System Board, through the executive, would subsume these responsibilities as, for example, all the finance directors would not need to all gather together to thrash out the funding etc. The system board may wish to set up sub-committees and the executive would doubtless want to convene forums where they could work through issues with colleagues from the various parts of the overall system, either collectively or within sub-systems.

As the CCG wind-down process is agreed and the transfer or ending of some current functions agreed, we would expect CCG Governing Bodies to meet less frequently.

To note, the Health and Well-Being Board is a Sub-Committee of the Local Authority and a statutory requirement, and though a critical part of the ICS' working, it is not part of its governance.

2. Provider Boards, CCG Governing Body and Local Authority agree to delegate the agreed scope of authority to the Committees in Common:

   a) Clear terms of reference with prescribed level of decision taking
   b) We particularly recommend when developing the overall governance model the adoption of the principle of subsidiarity – to push down responsibility and decision making to the sub-systems' boards and away from the ICS board as much as possible
   c) Committees in Common members take decisions, within this scope only, on behalf of the system and its constituent organisations without resort to each constituent board for proper governance ratification
   d) All members hold an effective veto, until this is potentially changed by legislation
   e) Changes will be required to individual organisations' schemes of delegation to enable this, the aim being that decisions best taken at system level are decisions that do not need subsequent ratification by individual organisations i.e. the decision is taken only once
   f) For the CCG group, we would foresee that the scope of delegation to the ICS would be incremental. As CCGs pass on responsibilities to both other system partners and, ultimately, as they are dissolved of their responsibilities, will either have disappeared, go to the ICS or to other statutory organisations
   g) The scope delegated by NHS provider boards we would see as minimal in quantity but significant in nature, and to do with strategy, the outcomes framework, reporting to the Centre and high-level decisions around finance and other resources
   h) Local Authorities are limited in terms of what decisions they can delegate away from themselves which may mean some of their decision-making may need to double-run
   i) The System Board should be developed and work in the spirit of this move, being as close as possible to the final form of the ICS once legislation is enacted
   j) The boards and governing bodies of ICS members should work to adopt the mindset of the ICS being 'theirs' – the new ICS legal entity, the sub-systems and the collaboratives all as one system, but with a different segmentation of decision-making between the new actors to the market model of commissioners and providers

3. Establish formal reporting into the Committees in Common from:

   a) ICS Executive
   b) The four sub-systems
   c) System enabling programmes
   d) Joint strategic commissioning with Local Authority

4. Build on work to date to develop a system risk register, assurance framework and risk appetite of the System Board. This should have two dimensions, being both to govern the process of system development and for the system itself. To emphasise, from our experience, the resulting products will not be simply a summation of the existing risk tools of the constituent members. but the process of developing these will have real value in terms of bringing the 'dynamics' of system governance together. The system risk register and assurance framework is not the same as the CCG governance tools of the same names – indeed these will significantly change in nature as the process of wind-down leads to transfer of responsibilities and all the specific risks of an organisational wind-up are managed.

5. As part of ensuring that the expectation of sub-systems is clear, the ICS should adopt the ICS governance principles for sub-systems. These can be applied in a way that caters for local variation but this should not be done so flexibly to allow additional complexity or variability in assurance. There does need to be some rigour used as beliefs around what constitutes good governance was variable between and within the sub-systems.

6. Establish a dedicated governance team for the ICS, tasked with administering and servicing the System Board/whole-systems tasks (e.g. the systems assurance framework) and establishing governance mechanisms to meet operational and strategic planning requirements. An informal forum of governance leads was being established during the period of the review, and this should be supported as a forum to aid communication and knowledge-sharing in the interest of effective system governance. This should be staffed from existing governance personnel, rather than through additional recruitment. Almost certainly, better focus could be achieved by this and the aim should be to release resources from governance functions to other system needs. This should be done carefully though, with a proper needs and skills analysis for the ultimate governance team/unit. GGI notes the national commitment to transferring current CCG staff to the ICS in April 2022.

Strategy, planning and organsiational development

7. Partners to restate the strategic objectives of the ICS and restate what uniquely the ICS can do, and the expected added-value the ICS should be bringing to the Surrey Heartlands system. This will help support the development of the Board Assurance Framework for the Surrey Heartlands ICS System Board.

8. Agree an effective system development plan that is achievable in next nine months to support effective system change and performance. This should implement the recommendations of this report, and support Board development activities for the reframed System Board, and any 'shadow form' arrangements.

9. Work on building the commonly-held vision sub-systems, as described in the draft Surrey Heartlands ICP framework, that is strong, inclusive and enables input into ICS thinking and strategy. Establish a standard assurance framework to enable effective assurance reporting between sub-systems and the System Board.

2. Introduction and context

Introduction

At the heart of any governed system is a board that is accountable for decision-taking. In the case of the ICS this is the System Board. The management of the system is undertaken by an executive, and in parallel with our review a revised System Executive was being developed and consulted on. A board is the identifiable controlling mind that has the authority and competence to be accountable for an enterprise.

An ICS is not a legal entity, but the aspiration of the ICS is that on 1st April 2022 there will be such a legal entity. Between now and then significant system reform, steered by a System or Partnership Board has to put in place a function whole system, realigning how the NHS across each ICS works. This work will be intense, with come current ICS footprints likely to be merged, Clinical Commissioning Groups (CCGs) defenestrated of their GP memberships and each current NHS provider brought with a provider collaborative of one sort or other. All this at a time of a global pandemic, a world-wide recession and the next stage of Brexit.

A governed solution for the ICS is important as it will enable the System Board to take binding decisions on behalf of all ICS partners, within an agreed scope, and under a series of delegations from the various individual entities that make up the ICS. We have focused our findings on making that a workable solution. Much of what is considered by majority of individuals we spoke to be 'ICS governance' is not governance, but groups and structures set up as part of managing the system, undertake joint/partnership working and generally communicate. Other elements of the 'governance' are actually elements of the governance or working of individual organisations, relevant to the work of the system but not part of the governance. This has been part of a general confusion about governance and much probably developed from a genesis of each part of the system wanting to feel involved in everything. Once the system has a board that can make binding decisions within whatever the agreed scope is, and the various actors can settle into the roles they will have going forward within the system, we would expect the need for many of these groups to dissipate. Working as a system post-April 2022 we anticipate as being very different to operating within the market ethos that has dominated the NHS for the last 30 years.

Local context

SHHCP was part of the first wave of ICSs established in England during 2017. The system covers 85% of the population of Surrey and has a combined health revenue allocation of over £1.5bn with a combined social care and public health budget of £350m.

The system partners are:

- Ashford and St Peter's Hospitals NHS Foundation Trust
- CSH Surrey
- Epsom and St Helier University Hospitals NHS Trust
- First Community Health and Care
- General practice (represented as a provider)
- Local Medical Committee
- NHS England and NHS Improvement (NHSE/I)
- Royal Surrey NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- Surrey County Council
- Surrey and Sussex Healthcare NHS Trust
- Surrey Heartlands CCG
- South East Coast Ambulance Service NHS Foundation Trust.

Surrey Heartlands includes four sub-systems:

- Crawley, East Surrey and Horsham (CRESH)
- Guildford & Waverley ICP
- North West Surrey ICP
- Surrey Downs ICP

A number of system governance forums and groups have been established:

Strategy

- Surrey Health and Wellbeing Board - acts as the overall strategy supporting forum for Surrey, it sets the long-term vision and strategy looking across all public services. It's work takes into account the wider determinants of health and wellbeing.

- Surrey Heartlands System Board - oversees the implementation and delivery of the Surrey Heartlands strategy in the context of the overall Surrey Health and Wellbeing Strategy. System Board membership:

- Senior Responsible Officer and CCG Accountable Officer, Surrey Heartlands ICS and CCG
- Leader, Surrey County Council
- Chief Executive, Surrey County Council
- Chief Executive and Clinical Lead, Epsom and St Helier University Hospitals
- Chief Executive and Clinical Lead, Royal Surrey County Hospital NHS Foundation Trust
- Chief Executive and Clinical Lead, Ashford & St Peter's Hospitals NHS Foundation Trust
- Chief Executive and Clinical Lead, Surrey and Sussex Healthcare NHS Foundation Trust
- Chief Executive and Clinical Lead, Surrey and Borders Partnership NHS Foundation Trust
- Chief Executive and Clinical Lead ,South East Coast Ambulance Service NHS Foundation Trust
- Chief Executive and Clinical Lead, First Community Health and Care
- Chief Executive and Clinical Lead, CSH Surrey
- Executive Director for Children, Families and Learning, Surrey County Council
- Executive Director for Adult Social Care, Surrey County Council
- Director for Public Health, Surrey County Council
- Representative from NHS England / NHS Improvement – South East region
- Clinical Chair, Surrey Heartlands CCG
- Lead PCN Clinical Director, Surrey Heartlands
- Clinical Director, Surrey Heartlands Academy
- Representative from the Local Medical Committee
- Director of Finance, Surrey Heartlands CCG and ICS

The System Board is Chaired by the Surrey Heartlands ICS Chair.

Strategic decision-making

- Surrey Committees-in-Common – facilitating strategic and streamlined decision-making for jointly commissioned services across Surrey Heartlands Clinical Commissioning Group and Surrey County Council.

Oversight and assurance

- Surrey Heartlands System Oversight and Assurance Group (SOAG) - oversees the performance of the partnership, holding partners to account and seeking assurance that the strategy and outcomes are being delivered and swift executive action is taken to address performance issues. The SOAG oversees finance, quality, performance and delivery of work programmes.

SOAG membership:

- Senior Responsible Officer and CCG Accountable Officer, Surrey Heartlands ICS and CCG
- Director of Finance, Surrey Heartlands ICS
- Chief Executive Officer, South East Coast Ambulance Service
- Chief Executive Officer, First Community Health and Care
- Independent Co-Chair, Strategic Finance and Assurance Board, Surrey Heartlands ICS
- Independent Co-Chair Quality and Performance Board, Surrey Heartlands ICS
- Chief Executive Officer, Surrey and Borders Partnership
- Chief Executive Officer, Epsom and St Helier University Hospitals
- Chief Executive Officer, Central Surrey Health
- BAEM Executive Sponsor, Surrey Heartlands ICS
- Chief Executive Officer, Surrey County Council
- Chief Executive Officer, LMS Julius parker

- Lead Primary Care Network Clinical Director
- Director of Strategy and Transformation, South East, NHS England and NHS Improvement
- Chief Executive Officer, Ashford and St Peter's Hospitals NHS Foundation
- Trust
- Chief Executive Officer, Royal Surrey NHS Foundation Trust
- Chief Executive Officer, Surrey and Sussex Healthcare NHS Trust
- Director of Adult Social Care, Surrey County Council
- Director of Children's Services, Surrey County Council
- COVID Director, Surrey Heartlands CCG
- Director of Recovery, Surrey Heartlands CCG
- Director of Strategic Transformation KSS, NHS England and NHS Improvement
- Deputy Director Performance and Assurance, Surrey Heartlands CCG
- Director Specialist Commissioning & Cancer, Surrey Heartlands ICS
- Director of Children's Services, Surrey Heartlands ICS
- Director of Corporate Affairs and Governance, Surrey Heartlands ICS
- Director of Mental Health, Surrey Heartlands ICS
- Director of Quality, Surrey Heartlands ICS
- Director of Performance and Assurance, Surrey Heartlands ICS
- Governance Manager, Surrey Heartlands ICS
- Head of System Governance, Surrey Heartlands ICS

SOAG is chaired by the Joint Senior Responsible Officer and CCG Accountable Officer.

- Strategic Finance and Assurance Board - oversees the delivery of the overall system financial position including the delivery of the nationally agreed ICS system control total as well as addressing individual place or organisational financial position. The Finance Board also oversees the financial perspective of local system financial recovery plans.

The Strategic Finance and Assurance Board is chaired by the Independent Co-Chairs of Finance.

- Quality and Performance Board - oversees the delivery of the constitutional targets and main national "performance" metrics across health and social care. It also oversees development of integrated quality systems for quality planning, quality improvement and quality assurance, as well as the specific "quality" metrics and workstreams, ensuring action is taken on any quality concerns across the system.

The Quality and Performance Board is chaired by the Independent Co-Chairs of Quality and Performance.

In April 2020, the four Clinical Commissioning Groups (CCGs) serving the area merged to form a single entity from the 'legacy organisations' of East Surrey CCG, Guildford and Waverley CCG, North West Surrey CCG and Surrey Downs CCG. With this final merger and the accompanying governance changes to create a single CCG constitution, now is a crucial time to capitalise on the progress that has been achieved to date at system level.

Partners recognise that system governance has developed somewhat organically to date, presenting the opportunity to streamline decision taking and assurance and reduce duplication. Whilst the statutory legal entities will continue to be the CCG, the providers and the local authority, the ICS needs to operate as a collaborative system in order to achieve its ambitions of improving the health and wellbeing outcomes of local communities. Governance is one important enabler of these aims.

National context

SHHCP is one of a number of ICSs in England working to deliver joined-up and proactive care for communities as part of delivering the NHS Long Term Plan (LTP). These efforts are intended to tackle traditional organisational and service boundaries in order to improve population health and wellbeing. Partners across health, social care, the voluntary and independent sectors and beyond recognise the benefits of collaborating to deliver benefits for the communities they serve.

The success agenda for Integrated Care Systems	-	Population health
	-	Delivering financial plans
	-	Sustainable care system
	-	Economic regeneration
	-	Sustainability and environmental preservation
	-	Public protection
	-	Citizen engagement
	-	Building community assets
	-	Decisions at place
Key Actors	-	Sub-systems
	-	NHS providers
	-	Strategic commissioners
	-	Local Authorities
	-	Primary Care Networks
	-	Private sector providers
	-	Third sector organisations
Citizens and a new social contract	-	Speaking up and involved in choices
	-	Participating in democracy
	-	Knowledgeable guardians of their own healthcare
	-	Enabled to be carers and advocates
What care system re-form needs to deliver	-	Integrated services matching community
	-	Discerning, empowered service users and carers
	-	Financial balance and value for money
	-	Digital by default
	-	Skilled workforce
	-	Fit-for purpose care estate
	-	Development of community-based assets
	-	Rebalancing the value chain
	-	Deliver financial plans and, if relevant deliver their system control total

Broader concept of systems working as an ICS (GGI)

The impact of COVID-19 has not delayed NHSE/I plans for the establishment of ICSs across England by April 2021. NHSE/I have outlined next steps to developing effective Integrated Care Systems across England.[2] This sets the expectation of:

a) Stronger partnerships in local places; a more central role for primary care in providing joined-up care

b) Formal collaborative arrangements that allow providers to operate at scale

c) Development of strategic commissioning through systems with a focus on population health outcomes

d) Digital and data to drive system working, connect providers, improve outcomes and give citizens control of their care

The recent NHSE/I paper identifies two options for securing ICSs in legislation:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations. This option retains individual organisational duties and autonomy and relies upon collective responsibility.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS. This model would deliver a clearer structure for an ICS and avoids the risk of complicated workarounds to deliver the vision of ICSs.

NHSE/I have identified Option 2 is a model that offers greater long-term clarity in terms of system leadership and accountability through a clearer statutory vehicle. Views are sought on the proposed options as part of a consultation process to inform future system design work.

GGI's recommendation is to establish competently governed process with formalised arrangements through a Committee in Common arrangement for the Surrey Heartlands ICS System Board with the benefit of non-executive oversight. This would provide a useful preparatory basis for further system maturity, aligned with the national policy direction, and the ambitions of the ICS.

Within this direction of travel, NHS organisations and Local Government will discharge their statutory functions in three different ways:

- **As an ICS** - agreeing strategy, priorities and outcomes for which the system will be held to account and acting as a unit of reporting nationally.

- **As sub-systems** – NHS bodies and other providers working together on planning, generative and transformation programmes and tackling the wider determinants of inequalities. PCNs included as the unit of delivery for Primary Care. Locus for adoption of local care pathways, local regeneration. Engagement with the independent sector and citizens.

- **As individual statutory organisations** – undertaking business as usual, provider organisations stepping forward in formal collaborative arrangements that allow them to operate at scale, establishing integration arrangements, shared roles, subcontracting. In some systems, larger providers may also choose to use their scale to host functions on behalf of other system partners. All providers will be within some form of provider collaborative.

This implies some 'reshuffling of the pack' in terms of responsibilities, for example, strategy development will become a collaborative process undertaken by the ICS, rather than as an outcome of the 'market' and the actions of commissioners and providers. In this sense, the NHS is moving towards a planned economy or system and away from the internal market.

It is within this context that our findings and recommendations are presented.

We also suggest that our palette of language for the system and it's various components is a more appealing vision for system working than that in the NHS E/I paper, as we maintain focus on collaboration, population health and existing progress. From our many interviews we counsel the 'two-ears-to-one-mouth ratio' approach to developing the system. There is significant talent and public service commitment within the system which offers real synergy as it develops to meet the new legislation.

Purpose of the governance review

GGI's work with Surrey Heartlands began in September 2020 and concluded in December 2020. In summary, the focus of this review is to:

- support governance arrangements for Surrey Heartlands Health and Care Partnership to become fit for purpose, and to be understood by the relevant stakeholders within the local system.
- streamline decision making and assurance.
- aid the ICS in its development of governance architecture and creating 'buy-in' from partners to more effectively fulfil this.
- support governance relationships between the four sub-systems and the ICS.
- assess the extent and effectiveness of devolution to the individual sub-systems.
- identify areas of duplication and opportunities to streamline effective decision making within the ICS
- support the understanding of roles and responsibilities by key individuals.
- identify factors that make a definite positive contribution to system assurance.

To carry out this work GGI adopted the following methodology:

- Interviews with stakeholders from across the Partnership
- Observation of system meetings
- Document review and benchmarking
- Developing options and testing these with the Partnership

3. Key themes and findings

a) Defining governance

It is important to note that much progress to date with systems across the country has been largely built around goodwill, relationships, commitment to collaboration and other informal factors, and that the time has come for more formal arrangements to enable more consistent systemwide decision-making and accountability. This was a strong and consistent theme which emerged from interviews as part of this review with SHHCP stakeholders. The below illustrative diagram outlines some of the formal and informal mechanisms which must be balanced and combined in order to progress with effective ICS governance and assurance.

Formal mechanisms

- In reality none – senior leaders just meeting, taking decisions and reporting back with fait á complis
- Formal meetings of leaders without pre-agreed, formalised inter-organisational/governance arrangements (eg, CEOs meetings)
- Memorandum of understanding (MOU)
- Formal delegations
- Contractual models (eg lead provider)
- Committees in common – can be with limited and defined scope
- Management contracts
- Joint committees - can be with limited and defined scope (not available for NHS FTs)
- Joint ventures, of varying legal forms
- Merger/acquisition

Informal mechanisms

- Joint values and intent
- Common information (open book accounting, whole system quality metrics, etc)
- Principle of subsidiarity (with authentic authority)
- In-common mechanisms (eg, risk systems)
- Place-based joint endeavour (eg, planning, priorities, pathway agreement)
- Relationships
- Regular caucusing of key actors (eg, regular meetings of non-executives and Cabinet members across the system)
- Joint posts (eg, Chairs in common, joint appointment of non-executives)

However, there were real and not inconsequential differences of opinion, and indeed around the ICS' role in catalysing some of the changes that have taken place. We feel the review process, which engaged with all the partners and created a 'Hawthorne Effect', and perhaps more significantly the issuing of the guidance on ICS development, accelerated the process of coming together. Just 'naming' that there were real issues of difference and that the changes are indeed happening within a short timescale appears to have help sharpen focus and resolve to work together to influence the end-state for the development of this ICS.

A key goal of ICS governance now must be to enable partners to agree that certain decisions can be taken in a system forum, rather than having to go to all individual constituent boards to be ratified or wait until 2022 for the legislative changes. Moreover, many systems have established meetings, groups, 'Boards' and other structures which are labelled as governance, but are seen as adding additional layers of bureaucracy and duplication that do not add sufficient value. It is useful to distinguish the difference between decision-making and decision-taking; *taking* is reserved to the competent body usually a board or a committee, while *making* is the process of compiling the evidence and opinions that contribute to informed decision taking. Much of what is referred to as system governance is actually management meetings, and useful or not, any decision taking within these forums is not as 'safe' as decisions taken within a 'governed' system.

GGI suggest the following governance design principles, which SHHCP could adopt and agree to support future governance development efforts.

1. Governance, for the purpose of this exercise, is the ability to make a binding decision on behalf of all organisations
2. Governance exists to facilitate the delivery of our strategy and ICS objectives. The ICS is the NHS, Local Government and a broad range of partners working as a system for local citizens
3. Updated governance should reduce duplication across the ICS and both simplify and hasten decision-taking
4. Governance arrangements should embody the principle of subsidiarity focused on our four sub-systems
5. It is important to clarify the difference between forums for participation and engagement, and those tasked with taking decisions
6. The absence of an entirely clear policy landscape should not stop our ICS from making positive progress with integration. We want to be seen as a progressive ICS
7. We are committed to gaining the benefits of non-executive oversight
8. The ICS is committed to achieving shared goals through partnership working

b) ICS strategy and objectives

The majority of interviewees could clearly articulate the broad aims of the ICS and the purpose behind it being established. However, within the interviews, the review team found a distinct absence of an agreed set of clear strategic objectives for the system. Many colleagues spoke enthusiastically of broad ambitions for more joined up care, a greater focus on prevention, and an enthusiasm to improve health and wellbeing outcomes through collective endeavour. Concrete actions necessary to be taken by the system, specific contributions from partner organisations to achieve these aims, and the means by which they would be held accountable were less clear from interview discussions.

Many thought specific actions were either completely absent or confused in the various layers of governance and therefore, struggled to articulate their organisations' specific accountability for the delivery of system objectives. In many respects this reflects interviewees perspectives of the culture of system working in Surrey; although great progress has been made in relation to the will to work collectively, this has largely relied on informal arrangements. Interviewees expressed strong views that the current timing and context provides a crucial opportunity for the system to embed more mature and effective decision making and accountability arrangements. We did feel that some participants over-stated the frustration about the governance arrangements to make a point and because there was a ready-source to absorb their ire.

c) Partner relations

Representatives of NHS providers interviewed expressed some diverging perspectives of the establishment of greater system working. Those who had been involved in the system co-design from the outset seemed to have more positive perspectives on the changes and progress to date than those who felt the arrangements were being imposed upon them without sufficient input or clarity of purpose. There was a mixed level of belief that the Centre were about to embark on a significant reorganisation and the December paper on integrated services from NHS E/I is very useful as it clarifies both the direction and pace of travel. It is important to emphasise that whilst not everyone agreed the ICS programme had been the catalyst for change all agreed that over the last two years things had moved forward. Some partners were more comfortable with the ICS leadership style than others, but this should not be conflated with these colleagues being unhappy about an ambitious agenda for progressing integration, centred around service to the citizens within Surrey Heartlands. Those organisations spanning more than one ICS, and where very different approaches have been taken to important issues such as 'what an ICS is' by the different systems within which they work, were obviously needing to work through how they shaped their partnership working within very different system ethoses.

Some felt that the phasing of system development in some areas was being approached incorrectly, with a need for greater clarity about the required clinical and care models before delivery and financial plans could be developed and agreed, for instance. These feelings stem from the various sub-systems developing organically and, as a result, at different paces and to different approaches, a fact compounded by view held by some that they were fully matured. Concerns that the responsibilities of statutory providers could act as a barrier to collaboration and system progress were also highlighted among the Trust leaders with whom we spoke. All recognised that system governance requires clarification and simplification, and that this was not just a question of a clear structure. Some of the opportunities and tensions underlying this are outlined in the table below.

ICS development – opportunities and tensions to work through

	Now	Likely future
Legal framework	• 2012 Health and Social Care Act • Varied status of current statutory organisations	• New legislation • ICS given legal form, potentially leaving the empty organisational 'shell' of the CCG • CCGs repurposed and defenestrated of their GP memberships, with ICS taking on strategic commission-ing/ planning functions • CCG governing body and GP mem-bership model would be replaced by a board consisting of representa-tives from the system partners.
Providers	• GPs as providers are a collection of individual organisations • GPs currently represented within governance as commissioners • Developing Primary Care Networks • Provider alliances • Development of hospital chains • Some joint appointments and management teams • Cross-subsidisation between place possible	• Delivery focus – with some strategy set at sub-system • Integrated multidisciplinary teams drawing on resources across part-nership • Care networks • Shared services • Mergers and acquisitions • PCN maturity • All providers to be in one form of a collaboration or other

ICS development – opportunities and tensions to work through

There is a risk of distraction here, and clearly the ICS will move at greater pace and be more effective if all providers are aligned with shared intent. Some providers operating in multiple ICSs which also needs to be recognised in terms of focus and clarity of contribution. One option to consider would be host ICS status (similar to current commissioning arrangements for specialist commissioned services such as ambulance trusts and tertiary providers) where the place is held to account by one ICS but acts on behalf of others. However, this brings risk of unbalanced accountability towards one system over the other and potential for diversion between ICSs on strategic intent. This could be overcome with ICSs working together to ensure commonality for the relevant place but this will need further thought.

The integrated care systems document released by NHSE/I aides very little in highlighting what the expected reporting and governance mechanisms will be in place between ICSs and the region. Nonetheless it is safe to assume that the key outcomes expected of ICSs in relation to the Long Term Plan including areas of responsibility on digital, population health outcomes, and finance will be form some part of accountable reporting to the region. The ICS will therefore need to be agile but broad in its ability to supply assurance to the region on its deliverables.

d) Improving governance effectiveness

The perceived burden and duplication within ICS governance was highlighted by many interviewees. This is certainly not a unique factor to Surrey Heartlands. It was felt that much of the system governance structure has developed organically over time ("grown like Topsy") resulting in papers being presented at multiple committees and almost identical conversations being had to multiple variations of more or less the same audience each time. This has created additional burdens and parallel systems of assurance which may limit the effectiveness of decision making as well as exhaust patience at a time when all are busy. Neither does more governance equate to good governance. Interviewees relayed that a number of different workstreams have been established and that it is not always clear how these relate to the various committees and groups, whether they are time-limited 'task and finish' arrangements or intended to be part of long-term governance.

This has led to concerns over the quality of assurance that committee and group chairs can provide, as highlighted in the below table. Those supporting the governance arrangements expressed as much frustration as those sitting through the various governance forums and counted as the strongest advocates for reform and simplification.

Issues	Examples	Impacts
Duplication of responsibilities at committees and groups	Perceived reliance on reassurance rather than robust assurance at Quality and Performance Board	Insufficient assurance against ICS strategic objectives, escalated issues left unresolved
Lack of clarity about organisational and team roles within governance framework	Overburdened SOAG agenda, without consistent alignment to ICS strategic objectives	Hindering effectiveness of managers
Lack of clarity about reporting and access to information	Complicated ICS workstream reporting arrangements	A growing understanding of system finance arrangements, with opportunities to clarify

System governance was described as complex and poorly understood. This is not the same thing as saying that governance was poor – just painful. Some lack of understanding stems from the range of bodies performing governance functions. Interviewees highlighted issues with poor communication across different governance teams within the ICS. While this is an expected element with an ICS maturity journey, improved information sharing and common understanding of roles and responsibilities are central to achieving more effective assurance. More streamlined governance which reduces duplication will mean that partners need to sign up to clear delegated authority so that information does not need to be seen at multiple meetings, and that there is trust and transparency in relation to ICS decision making. It is worth noting that system governance within the context of a legislative framework overtly not intended for system working, but rather for the internal market, inevitably will be complex. Over the last five years, as the appetite for managing the NHS through the internal market has diminished, every part of the country has been trying to make sense through establishing forums, partnership arrangements, aligned reporting etc. Structures and governance rituals have become increasingly burdensome and difficult to navigate through. This explains the sense of relief when the temporary suspension of many of these arrangements became necessary to address the pandemic. The knowledge of up-and-coming legislative changes that provide a fit for purpose legal context to system working helps enormously. Systems are complicated and the recommendations in this report will, we believe, provide some palliation to the burden as well as better, sounder governance for Surrey Heartlands in this last leg of the journey to ICSs established as legal entities. We believe this is worth the effort and rather than trying for 'a coalition of the willing' a sound interim governance solution should be your aspiration. There will be significant decisions being taken over the coming months that some will question, and individual leaders remain exposed and decisions may be overturned if they are taken outside a well-governed framework.

At the heart of addressing all these issues is the need to build on the progress made to date and to capitalise on positive elements of the ICS governance arrangements. Many interviewees commented on the ability of ICS partners to collaborate and make decisions at pace in order to progress system aims and deliver shared objectives. ICS governance should facilitate and channel these contributions to best effect, rather than risk diluting them through complex structures.

This is emphasised within the NHSE/I next steps for ICSs paper, which states:

> *"Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS."*[3]

As noted above and as part of these efforts in Surrey Heartlands, an informal forum of governance leads was being established during the period of the review, and this should be supported to aid communication and knowledge-sharing in the interest of effective ICS governance.

Such support could take the form of a common information source or regular informal meetings, to remove barriers to communication and ensure that all governance leads across the system have a shared understanding of challenges, proposed solutions and common deadlines. GGI also recommends forming a unified governance team for the ICS, tasked with servicing the ICS Board and establishing governance requirements to meet operational and strategic planning needs.

Work is also underway in relation to the ICS approach to risk, which is to be welcomed. The ICS should be focused on receiving assurance against the delivery of its strategic objectives. This is a central guiding principle of effective governance. While relevant cross-cutting system risks can usefully be identified from the objectives of individual ICS partner organisations as a starting point, the ICS assurance framework should add up to more than the sum of its parts. Agreed system strategic goals as articulated within the Surrey Health and Wellbeing Strategy[4] should form the basis for an ICS approach to risk which does more than simply collate risks which are currently shared by multiple partners. The system risk register and assurance framework should in time replace the existing CCG assurance framework to avoid creating another 'level' of governance.

As such, the approach to system risk should be informed by the strategic commissioning approach of the ICS which involves:

- assessing population health needs and planning and modelling demographic, service use and workforce changes over time
- planning and prioritising how to address those needs, improving all residents' health and tackling inequalities
- ensuring that these priorities are reflected in the ICS' financial strategy and operating plans

Building on the efforts underway to build the system-wide assurance framework and risk register also provides the ICS Board, working through a Committee in Common, with a useful developmental opportunity to develop and agree its risk appetite. In GGI's experience, this can provide a powerful development opportunity for Boards in relation to overall effectiveness, as well as being a practical resource for decision making. GGI's risk appetite Board Assurance Prompt is included in Appendix 1.

As addressed earlier, governance, for the purpose of this exercise, is the ability to make a binding decision on behalf of all organisations. This requires a competently governed ICS Board with adequate delegated authority and robust governance arrangements. Outlined below are options for the governance form and composition of a revised ICS Board.

Potential governance form of Surrey Heartlands System Board

Option	Implications
1. Maintain 'as is' arrangements	• Not competently governed (in the sense of 'competence' as a technical governance term) • May slow ambitions for system • Risks falling behind pace of national policy direction • Said to be 'at limit for hard decisions' • Maintains current inefficiencies
2. Develop a Sys-tem Board as Committees in Common	• **Enables competent governance** • **Reduced duplication across the system** • **Committees in Common decisions not in contravention of the ability of individual statutory bodies to govern themselves appropriately** • **Provides a competent vehicle, a governed solution prior to a legislative footing that allows decisions to be taken that not all parties agree with and therefore managing apparent and perceived conflicts of interest**
3. CCG as lead en-tity of ICS	• CCG Governing Body acting as ICS Board would not be able to take decisions on behalf of providers organisations • Lack of appetite from partners • Misses current enthusiasm from partners to shape the 'Sur-rey Heartlands' approach

GGI recommends that the ICS develop a System Board as Committees in Common, as outlined in Option 2 in the above table.

ICS Partners could delegate certain decision-taking capabilities to a committee of their constituent organisation. If this committee meets at the same time, in the same location as other committees (from other partners) it is referred to as **committees in common**[5 6]. It is the place and time that meetings are held that is in common rather than the committees themselves. Effectively this could run as the System Board of the ICS.

For committees in common to run smoothly, each committee needs to have the same agenda. Only one discussion takes place about each agenda item and then each committee makes its own decision. Partner Boards delegate to designated qualifying individuals the function of approving or agreeing decisions on their behalf through the committees in common. The ICS and the sub-system are in any case very used to working as Committees in Common. We are suggesting the extension of an approach you are well-versed in.

Committees in Common is different from, and has governance advantages from, simple delegation to one individual from each organisation. These include:

- By more than one individual attending from each organisation ('a committee') it underlines that decisions taken on behalf of each organisation at the Committees in Common can benefit from oversight. Each individual Committee of the Committees in Common can be said to be 'governed'.
- It allows non-executive membership of the Committees in Common, rather than non-executive presence at the Committees in Common
- For these reasons, it is also more palatable for some boards to accept

NHS Trusts - the Board can delegate its authority to a committee, to an executive director, or an employee of the Trust. Unlike Foundation Trusts, they can also have individuals on a committee that are neither directors nor employees of the Trust.

NHS Foundation Trusts - Board can delegate its authority to a committee of directors or an individual executive director (but not to an employee who is not a director of the FT).

CCGs – can delegate authority to a member of the CCG (a member GP), the Governing Body, to a committee of the CCG, or to an employee of the CCG.

Local Authorities – Cabinet authority implications to be worked through due to their lack of a vote in a committee in common.

Potential Surrey Heartlands System Board composition – revised through a Committees in Common arrangement:

Mindset:	System Board members are not acting as representatives of organisations, but instead are there to lead on behalf of the system. Potential for sub-committees to pick up whole system issues and involve executives and non-executives from within the system that are not on the System Board
Process:	Delegate decision taking away from individual partner Boards for the scope of what is best done at system level (the 'scope' for the Committees in Common)
System Execu-tive:	• ICS Senior Responsible Officer / CCG Interim Accountable Officer • CCG Deputy Accountable Officer / ICS Chief Operating Officer • Chief Finance Officer • Joint Director of Integrated Commissioning / Director of Adult Social Care • Joint Director of Public Service Reform • Director of Workforce and Digital • Director of Multi-Professional Leadership • Chief Medical Officer • Primary Care Network Leader • Sub-system Leaders x 4
Membership of the System Board:	**Option 1** • System Board Chair • System Executive • Chair and Chief Executive from each statutory NHS organisation with delegated decision-taking authority from their respective Boards • Elected member (separate from the system Chair, whilst he remains in that position) and executive officer from the local authority **Option 2** • System Board Chair • System Executive • A Non-Executive Director and an Executive Director from each statutory NHS organisation with delegated decision taking • Elected member (separate from the system Chair, whilst he remains in that position) and executive officer from the local authority **Option 3** • System Board Chair • System Executive • One Executive and one Non-Executive Directors from each NHS statutory organisation, appointed on skills and experience basis and selected with board composition in mind. There is delegated decision making to these • Elected member (separate from the system Chair, whilst he remains in that position) and executive officer from the local authority In each instance the ICS Chair would Chair the System Board. The Chair and members of the System Executive would be full members of the System Board, but not part of the Committees in Common. Votes to make decisions binding on all partners, obvious-ly, could only be undertaken by members of the Committees in Common and could only be valid if there were no dissenters. The ICS Chair should act as an Independent Chair. The number of ICS Chairs nationally who are also in leadership of one of the system partners is diminishing fast. We under-stand that by the time Surrey Heartlands ICS is in its final form an Independent Chair appointment will be made through a formal advertised process, as indeed will the role of ICS Chief Executive. Yet, we recognise the particular progress that has been made, through the existing arrangements, to bring the local authority along with the ICS.

Focus:	Remit of Committees in Common are for partners to discuss and agree. Illustrative headings are presented below. • ICS strategy? • Outcomes Framework? • Strategic quality assurance? • System financial control total? • Allocation of funding to sub-systems? • Oversight of delivery at a system level – e.g. system-wide programmes of work? • Assurance reporting to NHSE/I? • Assurance over sub-systems?

As outlined above, the governance effectiveness of the ICS depends in no small part on the mindset of system leaders in discharging their functions and accountability within a new and evolving context. The so-called 'grey area' between statutory roles and accountabilities of individual constituent organisations and system level ambitions and decision taking clearly presents a risk of confusion and frustration.

Rather than organisations viewing system collaboration as a 'loss of power' to the system, partners should be encouraged to think more about expanding their sphere of influence and their accountability in the interest of delivering improved outcomes for local communities. This mindset shift is in line with the assumed policy direction of travel and is an important element of system maturity; ensuring contributions can be made not as as representatives of organisations, but instead as leaders on behalf of the system to achieve shared ambitions. We rehearsed this approach with partners, including those uncomfortable with the current leadership approach, and found this to be a more appealing way of approaching the task of building the new ICS.

Our one caveat to the creation now of a Committee in Common for ICS functions, and why, as we have finalised this report, the strength of our recommendations for structure and the system board has changed, relates to the new paper on ICS development. We remain convinced that a Committee in Common for ICS functions would be helpful and be better governance. However, it is for you to judge the ease with which you could persuade all the organisations that comprise the ICS of this. We feel it would also be a helpful rehearsal of the inevitable legal form for the ICS – the one 'stepping-stone' between now and the ultimate ICS arriving on 1st April 2022. However, with just 16 months to go it is important that if you are to proceed as we recommend this can be done smoothly and not eat into time when there is so much to be achieved. The potential downside of maintaining the status quo is not insignificant, however, and with very important decisions to be taken it might become a regret in due course that these were not done within the comfort of a tightly governed system when there was the opportunity to do so. We would also proffer that building a system governance structure that all parties have played into will create a much better DNA to the ICS as a new legal entity than taking one off the shelf.

e) Sub-system maturity

The recent paper from NHSE/I on the future of integrated care identifies four roles for sub-systems within ICSs:

1. to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods

2. to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);

3. to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and

4. to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

This offer will be met through providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together with meaningful delegated budgets to join up services. It will also allow important links to be made to other public or voluntary services that have a big impact on residents' day-to- day health, such as by improving local skills and employment or by ensuring high-quality housing.[7] Sub-systems will need to identify their population health needs in the context of the ICS health and wellbeing strategy, and arrange budgets and service delivery accordingly, then give assurance to the ICS that this is being done with appropriate balance between those at risk and the needs of the whole population.

Surrey Heartlands has four emerging sub-systems - Guildford and Waverley, CRESH[8] (Crawley, East Surrey and Horsham), North West Surrey and Surrey Downs. The four Surrey Heartlands sub-systems are recognised to be at different stages of maturity and are constituted differently. Some interviewees expressed that one sub-system is focusing on financial recovery whereas the others are focusing on service strategy and delivery at place level.

There is a fundamental need to clarify escalation and assurance arrangements from sub-system to the ICS in relation to the delivery of ICS objectives at a local level. The stated ambition to develop "a population-based budget approach which delegates budgetary responsibility for the majority of health and care functions to local sub-systems" requires clear accountability. Sub-systems need to have more commonality and work as uniformly as possible across the system in their approach to delivering assurance, whilst still accounting for local differences in relation to population need.

In GGI's view, making sub-systems 'real' requires:

- Ability to take decisions within an agreed strategic framework
- Delegated budget
- Local risk management and assurance systems
- Local delivery of outcomes framework
- Operating as unit of reporting to ICS
- Acceptance by providers that solutions will be local
- Oversight of local delivery programmes

Sub-systems will need to provide assurance on a range of issues, including: delivery of constitutional standards, outcomes from the Joint Health and Wellbeing Strategy and sub-system local outcomes, and ambitions for rebalancing the value chain & community resilience in line with 'anchor institution' type approaches to local and regional development.

To note, it has been put to us that the term 'sub-system' implies these are lower down the pecking-order than the system as a whole and we would suggest considering finding a different term. In other ICSs the 'Place' or ICP element of an ICS is being built up as the most important part of the ICS. One ICS Chair has described this relationship as 'The purpose of the ICS is to fulfil the ambitions of Place'.

A recent draft report jointly developed by the sub-systems[9] outlines potential options for sub-system form and contractual models including an alliance agreement, lead provider model, and a corporate joint venture. A Board or Committees in Common model are explored as options for decision taking at sub-system level, identifying the need to develop and agree a Surrey Heartlands-wide Scheme of Delegation which clearly sets out the decisions which will be within the remit of the ICS, sub-systems and individual partner organisations.

That draft report sets out the following principles to support the governance of sub-systems within Surrey Heartlands ICS:

- Surrey Heartlands recognises that effective place-based governance will be reliant on good interpersonal relationships. Although future legislative change may bring greater stability, it is essential that sub-systems partners have strong working relationships.
- It is for individual sub-systems to design and implement an effective governance structure. This may include provisions for non-board/committee members who can be 'in attendance' at board/committee meetings and express views but decisions must be taken by board/committee members.
- Surrey Heartlands expects the partners of a sub-system to include acute, community, primary care, social care and mental health providers as well as voluntary sector representation.
- Surrey Heartlands recognises the critical importance of primary care to integrated working at place and expects this to be reflected in sub-system governance arrangements. For example, in Surrey Downs, primary care has the casting vote on the sub-system Board.
- Many of the individual sub-system partners have lay members, non-executive directors or councillors within their organisational governance structures. Foundation Trusts also have governors and members. Given the value of independence, sub-systems should consider similar roles within their governance structures. Surrey Heartlands does not expect there to be an increase in total cost for such roles and sub-systems should therefore utilise existing independent individuals (e.g. existing lay members, non-executives or councillors) within their governance structures where possible, whilst ensuring that such individuals are clear they are undertaking a different role and providing independent representation for the place (not the organisation to which they are attached). Streamlined governance should be designed to allow time to be released from roles with individual organisations and utilised in sub-system roles.
- In designing their governance structures, sub-systems will set out how the patient/public voice will be heard. Sub-systems and the ICS will need to work together to ensure the purpose of citizen engagement at each level is clear.
- Sub-systems must consider the role of clinical/professional leadership within their governance structures.

The purpose of developing sub-system governance is to enable decision making and accountability beyond relying only on a 'coalition of the willing'. Many interviewees felt there was a need to define the governance structures needed at sub-system level and that their relatively organic development risked complex and inefficient arrangements. In this respect, sub-system governance needs to balance the needs of the locality while effectively feeding into the broader system. Although this can vary across sub-system as to how it is achieved, there needs to consistency in assurance delivered to the System Board. This can be achieved through the development of the ICP assurance framework, as outlined in the recent 'A Framework for developing Integrated Care Partnerships across Surrey Heartlands' report.

As part of ensuring that the expectation of sub-systems is clear, GGI recommend that the ICS agree a set of common governance principles for sub-systems which allow for local variation but not for additional complexity or variability in assurance. This should enable competent governance and formal non-executive input, provide for community network, citizen and the independent sector engagement in decision-making.

GGI's recommendation is to develop a commonly-held vision for sub-systems that is strong, inclusive and enables input into ICS thinking and strategy, and to establish a standard assurance framework for functions across the four sub-systems.

f) Community networks

The ICS Joint Health and Wellbeing Strategy highlights the importance of prevention and addressing root causes of poor health and wellbeing. It focuses on three interconnected priority areas:

1. Helping people lead healthy lives

2. Supporting the emotional health and wellbeing of our citizens

3. Supporting people in Surrey to fulfil their potential

Alongside COVID-19 recovery efforts which seek to place citizens, patients, communities and staff at the centre, these ICS priorities emphasise the need for collaboration with a broad range of partners. Multidisciplinary teams using shared data and delegated budgets at sub-system level will be tasked with working to achieve improved health and wellbeing outcomes for local communities. This speaks to the suggested principles of governance arrangements embodying subsidiarity focused on the four sub-systems, and ensuring clarity in the difference between forums for participation and engagement, and those tasked with taking decisions.

A number of non-NHS organisations we spoke with expressed concerns that decisions taken at ICS level without their representation could be in conflict with their organisational duties. In this regard, these non-NHS organisations were wary of the ICS agenda being shaped largely by large NHS Trusts, without having their input fully taken into account. They feared, in this scenario, the potentially negative impact on them as a company when decisions are taken onto them that could be conflict with fiduciary duties of their boards. There are also some concerns about the ability of entities such as community interest companies to effectively align with ICS governance, and the need for any governance to ensure that undue burden is not placed on voluntary and independent sector partners, particularly at sub-system level.

These concerns will need to be allayed order to ensure that the benefit of ICS contribution can be unleashed for the benefit of local communities. The work underway in relation to developing Thriving Community Networks is central to this ambition. The ICS should look to build on progress to date an embrace best practice in relation to community engagement and involvement.[10]

There is an opportunity here for Surrey Heartlands ICS to be at the forefront of embracing the role of 'anchor institutions', as identified within the Long Term Plan. A 2019 report by the Health Foundation defines anchor institutions as:

> *"large, public sector organisations that are called such because they are unlikely to relocate and have a significant stake in a geographical area – they are effectively 'anchored' in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development."*[11]

The concept of an anchor institution is tied to the approach that living conditions, access to education and training, employment and working conditions all contribute to health and wellbeing inequalities for communities. Anchors complement the system-working aims to expand the remit of the service beyond acute care models, into the community, and partnering to improve prevention are dynamics which can be aided by the NHS implementing and nurturing anchor approaches. These issues present important challenges and opportunities in relation to how to define an effective healthcare system, and in particular how the power of the ICS can be harnessed to improve community wellbeing and support sustainable healthcare delivery for generations to come. As such anchor institutions act as a facilitator of other organisations within the system that provide a range of services form care to education. This collaboration involves patients and service users, GPs, hospitals, local authorities, educators, and the independent and voluntary sectors, among many others. It requires anchors to act as entrepreneurs and innovators and a different model which bring together stewardship and enterprise.

ICS partners have enormous potential to contribute to community wellbeing and a rebalancing of the value chain through how they structure their procurement and spending power, operate as an employer, and use the estate, for instance. The Joint Health and Wellbeing Strategy recognises that living conditions, access to education and training, employment and working conditions all contribute to health and wellbeing inequalities for communities. These factors cannot be addressed successfully by providers of health and social care services alone. The mindset and priorities of the ICS Board and sub-system teams must engage with themes such as asset-based community development, and holistic integrated reporting beyond traditional measures in order to deliver what the ICS has set out to achieve.[12] [13] Allied to this is the importance of retaining the concepts of clinical and multi-professional leadership in ICS and sub-system leadership, one of the many legacies from the achievement of the CCGs that it will be critical to maintain and build further.

4. Conclusion

2020 has been an unpredictable and challenging year, with significant upheaval and unprecedented burdens experienced across the health and care landscape. System partners are to be commended for the considerable progress made to date in Surrey Heartlands. The ICS is well placed to advance into next stages of maturity, with important decisions ahead.

There is an opportunity for Surrey Heartlands to be an exemplar and a source of learning and leadership for other integration initiatives across the country. However, the challenges of progressing are not to be underestimated within the current climate, with considerable and immediate operational demands in relation to mobilising COVID-19 vaccination and annual winter pressures. The operation of an ICS, and the development of functioning sub-systems are not straightforward things to achieve.

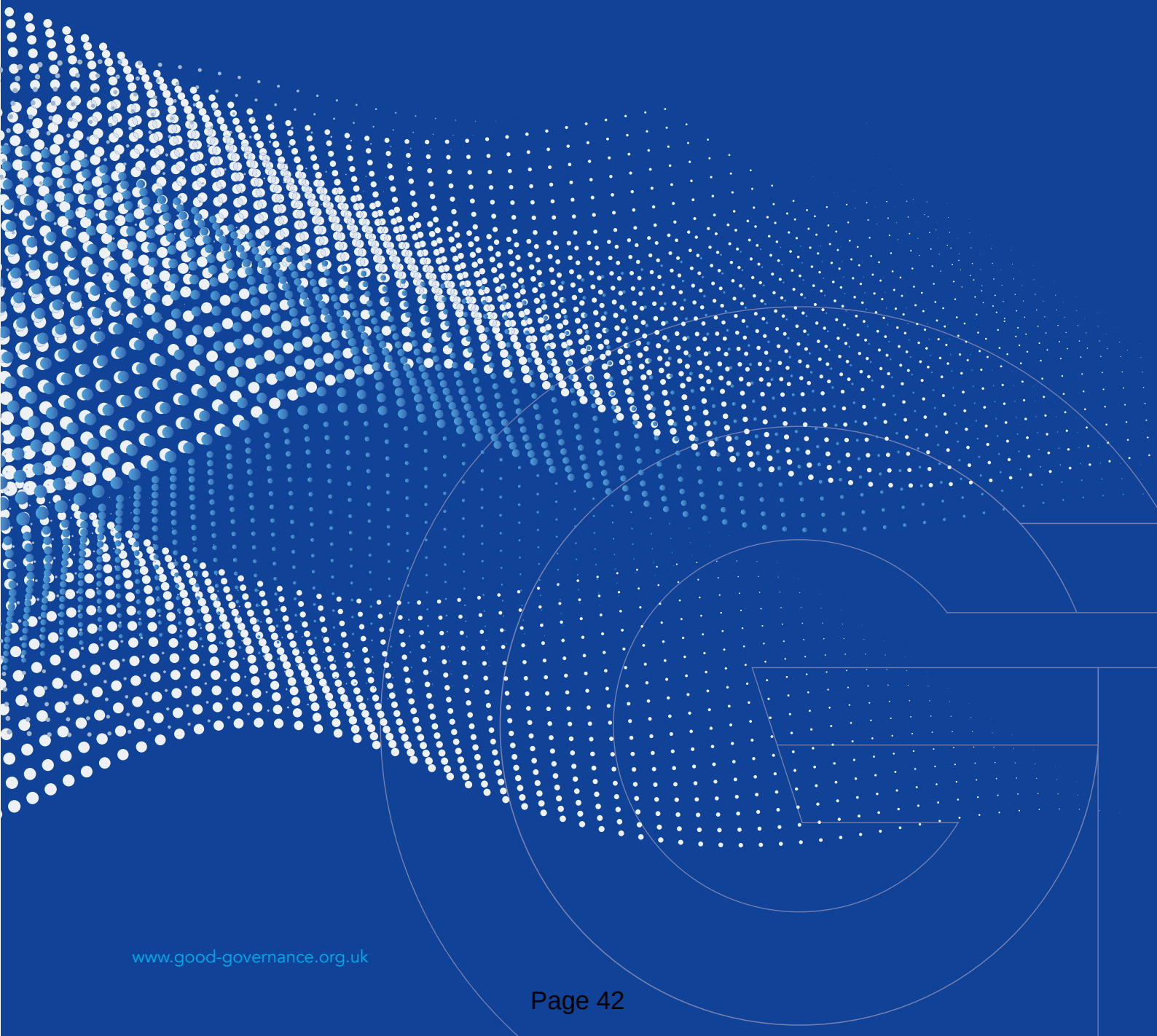
It is GGI's view that the system will reap substantial long-term benefit from embedding more streamlined and formalised governance arrangements. The recommendations set out are designed to enable the ICS to strengthen accountability and transparency in the delivery of agreed objectives. It is crucial that the ICS ensures clarity of vision in this respect, testing governance for 'added value' in the context of the health and wellbeing strategy and the outcomes desired for local communities. The ultimate litmus test for success of the ICS will be the improvement of population health and the shaping of services to be both effective and sustainable. In preparing for the new legal entity of an ICS that will deliver this mission GGI would add as a further success criterion: 'and do all current partners feel they are the ICS, rather than the ICS is something separate?' We believe Surrey Heartlands has the potential to achieve all this and hope our report, and the process of preparing it, has added to the success of your work.

5. Appendix

Board guidance on risk appetite

Good Governance Institute (GGI)

May 2020



Board guidance on risk appetite

Risk appetite, defined as 'the amount and type of risk that an organisation is prepared to pursue, retain or take[1]' in pursuit of its strategic objectives, is key to achieving effective risk management. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings, and therefore should be at the heart of an organisation's risk management strategy – and indeed its overarching strategy.

It is important that boards understand and apply risk appetite because:

- If they do not know what their organisation's collective appetite for risk is and the reasons for it, this may lead to erratic or inopportune risk-taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development
- If they do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient and user outcomes affected
- It can serve as the basis for consistent and explicit communication at different levels, and to different stakeholders. Risk appetite will be influenced by a number of factors including personal experience, political factors and external events among others.

Risk can generate significant opportunities and therefore should be considered in terms of both opportunities and threats:

- When considering threats, the concept of risk appetite embraces the level of exposure which is considered tolerable and justifiable should it be realised
- When considering opportunities, the concept embraces consideration of how much one is prepared to actively put at risk in order to obtain the benefits of the opportunity
- It is important that boards understand that in order to achieve their strategic objectives they may have to adopt a more assertive risk appetite, recognising that risk appetite should be forward-looking.

Risk tolerance is subtly different to risk appetite in that it reflects the boundaries within which the executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the board's strategy and risk appetite. It is the level of residual risk within which the board expects sub-committees to operate and management to manage. Breaching the tolerance requires escalation to the board for consideration of the impact on other objectives, competing resources, and timescales.

At least once a year, the board should set specific limits for the levels of risk the organisation is able to tolerate in the pursuit of its strategic objectives. The board should also review these limits during periods of increased uncertainty or adverse changes in the business environment.

In setting these risk appetite and tolerance levels, the board should consider risk factors in both the external and internal business environments. These levels could be measured quantitatively, qualitatively, or both, and should be specific to each of the relevant core activities and outcomes.

The board may also set limits regarding the enterprise's risk appetite, i.e. the risk limits that the board desires, or is willing to take.

The board should monitor and audit the management of significant risk undertaken by managers and clinical staff and satisfy itself that decisions balance performance within the defined appetite and tolerance limits. The board should ensure that it understands the implications of risks taken by management in pursuit of better outcomes, as well as the potential impact of risk-taking by, and on, local communities, partner organisations, strategic providers and other stakeholders.

This process is dynamic; risk probability and impact as well as risk appetite can change through circumstances and experience. The perception of the public to risk and confidence in the organisation's ability to identify and mitigate risk successfully can shift quickly in the light of publicity and risk failures often outside the direct control of the organisation. As such, risk awareness and communication play an important part in protecting the reputation of the organisation from such instances of outrage.

1. ISO 31000

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GGI believes that it helps to identify different types of risk (including, but not limited to, finance, regulation, quality, reputation, and people) but it is important to always assess these in the round. To support this, we have developed the risk appetite matrix.

The matrix sets five levels of risk appetite for each of the risk types. There are no right answers, but the matrix allows board members to articulate their appetite and tolerances and arrive at a corporate view, considering the risk appetite of others and the capacity for management to communicate and deliver.

Boards should consider each strategic objective against the matrix and agree its level of risk appetite, what it can delegate, and what additional assurance it requires. The matrix can also be used for individual initiatives and emerging problems and should help the board to better manage its agenda and the level of routine reporting required.

Breaches of agreed appetite must be escalated with agility.

Strategic risks and the board assurance framework

A critical role of any board is to focus on the risks that may compromise the achievement of the organisation's strategic objectives. In order to be confident that the systems of internal control are robust, a board must be able to provide evidence that it has systematically identified its strategic objectives and managed the principal risks to achieving them.

A good board assurance framework (BAF) is a live tool that helps boards to undertake this duty by providing a simple yet comprehensive means by which to effectively manage the principal risks to meeting the strategic objectives. The Audit Committee Handbook identifies the BAF as 'the key source of evidence that links strategic objectives to risks and assurances, and the main tool that the board should use in discharging its overall responsibility for internal control'.[2]

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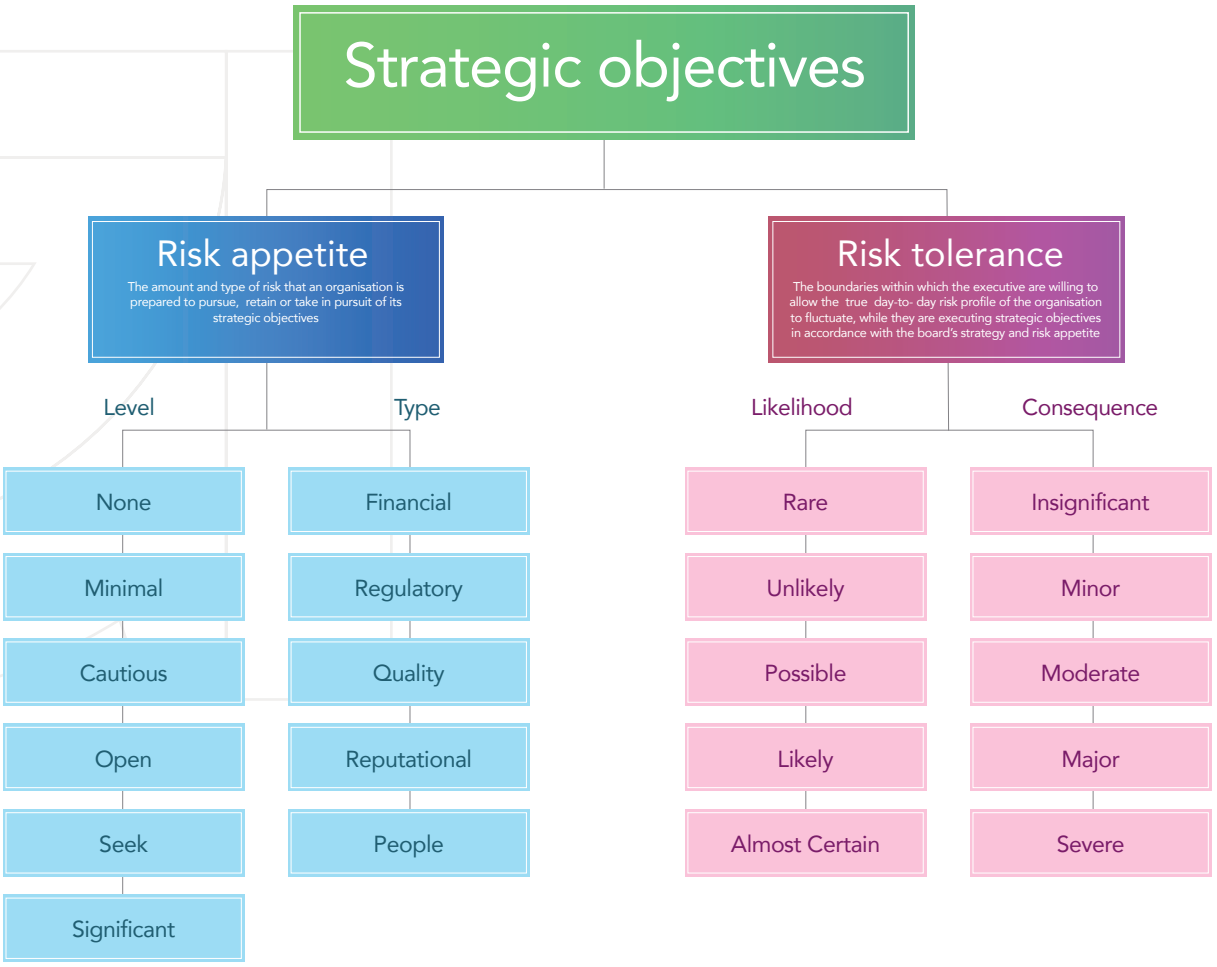
The BAF, therefore, is the key document that should be driving the board and committee agendas. It provides a structure that enables the board to focus on the significant risks, highlights any key controls (management actions to avoid or mitigate risks) that have been put in place to manage the risk, any areas requiring further action, sources of evidence or assurance, and any gaps.

The BAF is, in GGI's view, the original invest-to-save scheme for boards. Time spent on getting the various elements of the BAF right will help boards streamline assurance, locate where and how assurance is tested and develop proportionality in board reporting.

Key to this will be boards taking responsibility for identifying their risk appetite and risk tolerance for each strategic objective and agreeing what is sufficient in terms of controls and the assurances that the controls are operating effectively. The greater the risk appetite, the more controls should be put in place by management to avoid or mitigate the risk.



2. DH/HFMA, 2005, Gateway Ref 5706

Applying risk appetite matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

Notes

1. Non-executive oversight is different from non-executive presence or involvement. A core principle of good governance is independent and constructive challenge, from non-executives, as part of 'testing' the soundness of both decisions, reports, assurances and indeed the governance system itself. The concept of non-executive oversight would include elements of good governance such as audit committee scrutiny of governance process.
2. NHS England & NHS Improvement, 2020, Integrating care - Next steps to building strong and effective integrated care systems across England
3. NHS England & NHS Improvement, 2020, Integrating care - Next steps to building strong and effective integrated care systems across England
4. https://www.healthysurrey.org.uk/__data/assets/pdf_file/0007/197530/Surrey-Health-and-Wellbeing-Strategy-FINAL-19.11.20.pdf
5. Hill Dickinson, GGI, thiNKow - Joint committees and committees in common in CCGs
6. Mills & Reeve - Operating Effective Committees in Common
7. NHS England & NHS Improvement, 2020, Integrating care - Next steps to building strong and effective integrated care systems across England
8. The CRESH footprint spans two ICS/STP geographies – Surrey Heartlands ICS and Sussex ICS
9. A Framework for developing Integrated Care Partnerships across Surrey Heartlands, October 2020
10. NICE, 2016, Community engagement: improving health and wellbeing and reducing health inequalities [NG44], https://www.nice.org.uk/guidance/ng44/chapter/Recommendations#overarching-principles-of-good-practice
11. Health Foundation, 2019, Building healthier communities: the role of the NHS as an anchor institution, https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution
12. NESTA, 2020, Asset based community development for local authorities, https://www.nesta.org.uk/report/asset-based-community-development-local-authorities/
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