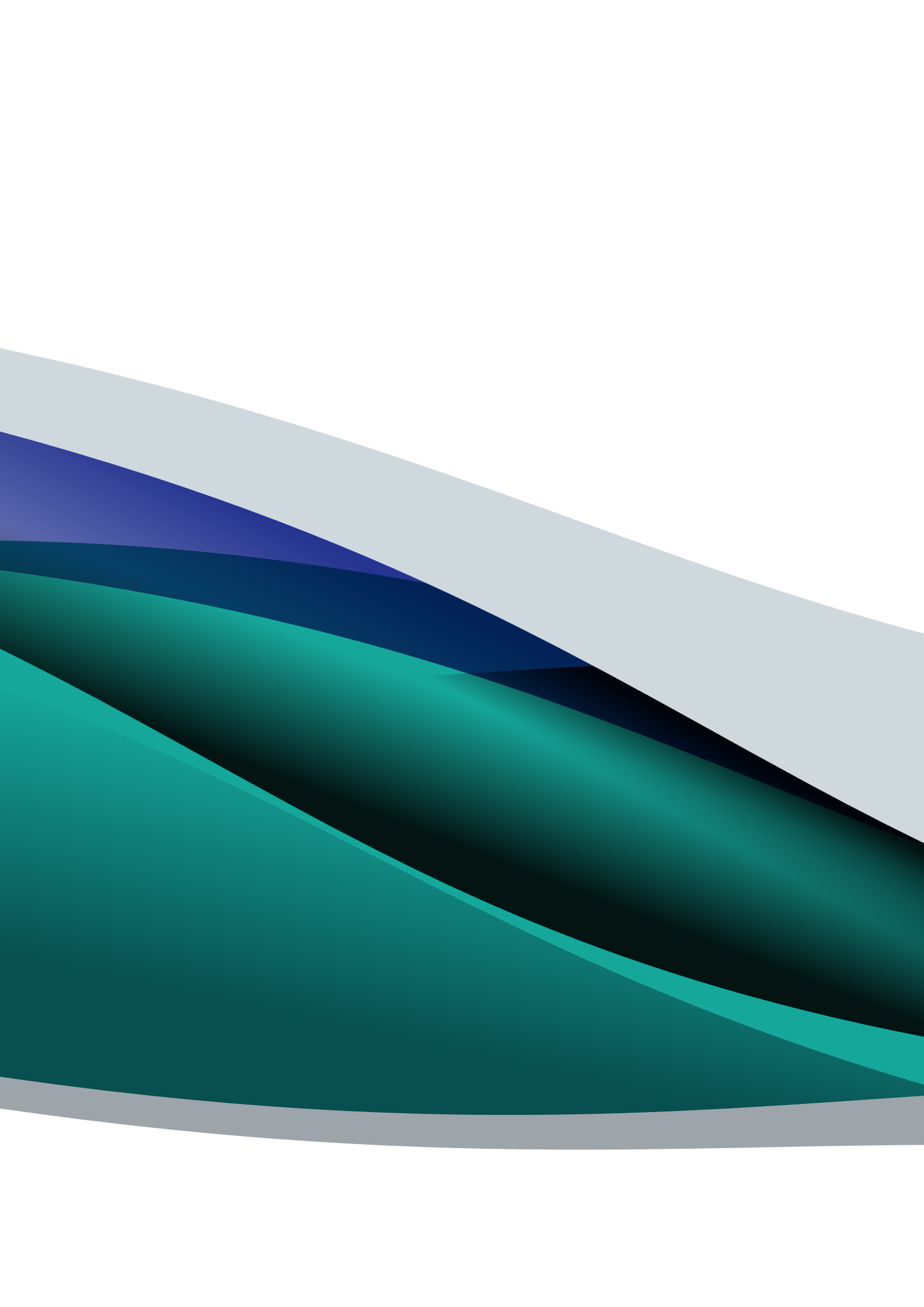
NHS Providers

COLLABORATIVE WORKING

Tackling governance challenges in practice

NOVEMBER 2018



COLLABORATIVE WORKING
Tackling governance challenges in practice

CONTENTS

FOREWORD

In recent years there has been a wholesale shift in the national policy focus, from promoting competition between provider organisations within a purchaser/provider split, to a clear expectation that local health and care organisations collaborate to make best use of public funding and accelerate the integration of services for patients.

There is no doubt that constructive relationships between partner organisations are fundamental to delivering the aspirations of system working. This publication seeks to support provider boards and their partners in identifying what the most important considerations are when developing new governance mechanisms to underpin those relationships. It sets out some of the factors for provider boards to consider as they progress on this journey of collaboration and captures a range of emerging practice from the frontline.

We don't pretend that this publication holds all the answers, but we hope it will make a valuable contribution to discussions on how best to develop robust mechanisms in support of system working.

This is a fast-paced environment, however the case studies were correct at the time of writing. I would particularly like to thank our contributors:

- Daniel Scheffer, joint company secretary, Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust, and colleagues from the North Cumbria Health and Care System
- Julie Pearce, chief operating officer, Dorset County Hospital Foundation Trust, and colleagues from the Dorset Integrated Care System
- Rob Webster, chief executive lead for West Yorkshire and Harrogate Health and Care Partnership
- Karen Coleman, communication and engagement manager, West Yorkshire and Harrogate Health and Care Partnership
- Alan Foster, Cumbria and North East STP lead, accountable officer, North Tees and Hartlepool NHS Foundation Trust
- Kathryn Stuart, associate researcher and trainer.

Saffron Cordery
Deputy Chief Executive
NHS Providers

1 INTRODUCTION

With the impetus towards collaboration and integration from the national bodies, driven by sustainability and transformation partnerships (STPs) and integrated care systems (ICSs), system working is presenting providers and the wider health and care sector with new and challenging questions around how to effectively build relationships and work together at a local level to deliver joined up, higher-quality care for local communities.

The policy drive for integration is progressing at pace and in the absence of a legal basis for STPs and ICSs, providers and other organisations in the health sector face a number of operational, financial and governance challenges when choosing how to develop a local health and care system that works for the populations they serve. From navigating the revision of the purchaser/provider split in the context of system working, to working with multiple organisations across a footprint to develop a common vision for a shared population, the challenges and opportunities of cross-system working are significant.

The world of board-led governance and the emergence of collaborative ways of working in the context of STPs and ICSs may at first seem incompatible. It is certainly true that within a legislative and regulatory system set up for individual, competitive organisations, the prospect of system working raises a different set of organisational risks for provider boards and their partners, to identify, consider and manage.

However, establishing strong working relationships between leaders across local systems is key to progressing. This endeavour needs to be underpinned by strong corporate governance within individual organisations to ensure boards continue to identify and manage risk in the new world of integration.

This publication, sets out a series of case studies. From bringing together shared leadership teams across traditional organisational boundaries in Dorset, taking new approaches to streamlining governance in North Cumbria and investing in a clear, system-wide engagement strategy in West Yorkshire and Harrogate Health and Care Partnership. It is clear that there are a range of answers to a complex question. We hope this publication is helpful in showcasing emerging practice.

1

Risk and corporate governance in the context of collaboration

The combination of system-wide stress and radical change currently being experienced within the NHS is likely to give rise to new risks, some of which may be much more difficult to identify, manage and mitigate than usual. Traditionally, the prudent response from boards of directors to periods of exceptional risk would be to review its appetite for risk, to keep a close eye on the exercise of delegations by executives and perhaps increase the number and scope of decisions that the board reserves to itself. However, given the need for new partnership arrangements to facilitate system working and more integrated care, the trend in the NHS is in the opposite direction, with the use of delegation becoming more common.

A central question for boards of directors is therefore, how do we facilitate streamlined decision making, while exercising proper oversight of the executives who will be making decisions at system level? Most good executives will make good decisions most of the time. However, things do not always go well. While we accept that collaboration can only be based on constructive working relationships, we also know that there is a tendency of individuals from similar backgrounds, with similar life experiences to think the same way and act accordingly. Regardless of individuals' intentions, this level of 'group think' can lead to decisions being made without adequate challenge or identification of risk.

Since risk is by definition uncertainty of outcome and since boards will be held to account if things go wrong, they will wish to exercise a prudent degree of control and continue to seek proper assurance that risk is being properly managed. There is a continued need for boards to exercise good corporate governance, including within the wider context of system working and in relation to system decisions.

Corporate governance can be equated with bureaucracy or seen as an excuse for not making progress on local, collaborative arrangements, but good corporate governance should be neither of those things. It is the process by which boards of directors direct and control their organisations so that risk is managed successfully, including with regard to collaborative ventures, how strategy is delivered and renewed and how corporate culture is shaped. A key element of good corporate governance is boardroom challenge. Linked to this is the need for boards to seek assurance - solid evidence that risk is being properly identified and managed. In short, while corporate governance is not a guarantor of corporate success, its absence is a key feature of corporate failure.

Were it possible to deliver corporate governance at system-level, it is likely that it would be very high on the national agenda because it is a proven method of exercising prudent and effective control. However, corporate governance requires the existence of boards made up of executive and non-executive directors with legal powers to make decisions. The partnerships currently being formed to provide system leadership derive their legitimacy from their component organisations, cannot be board-led and have no formal decision-making powers in law. They are typically groups of executive directors. They depend on

pre- and post-authorisation from their constituent organisations to make decisions, on delegations given to executive directors and on committees in common. Each of these brings with it areas of risk which are made more difficult to manage by the absence of system-level corporate governance. It is in this context that systems have been developing their own governance infrastructures and ways of working.

Principles for system working

There are some common principles that boards could adopt to ensure that the risk inherent in system-wide working are identified and managed for the benefit of their populations. Some suggested principles are set out below:

- **Directors and boards need to prioritise the best interests of patients and the public across the system's catchment area,** rather than thinking about the interests of the system infrastructure or the narrower interests of their trust.
- **The envelope for delegations needs to be carefully defined.** It should include the right to make decisions that accord with trust strategy, policy and culture, accord with the agreed system strategy, will not destabilise the trust financially and will not bring the trust into disrepute.
- **Boards need to consider what classes of decision they will continue to reserve for themselves.** If boards across the system can reach an agreement on decisions they choose not to delegate, but reserve to themselves, all the better, but it is not essential.
- **Boards need to work within the system with colleagues to reconcile top-down decision making with staff engagement programmes from the frontline.** This is particularly important in managing change involving job and organisation design. It should not be an insurmountable process since strategy development needs to be simultaneously top down and bottom up so the staff are brought along with strategy as it emerges, can shape its development, and own and deliver any change.
- **Boards should be clear with one another that while they will endeavour not to overturn decisions made under delegation at system levels, they reserve the right to do so.** However, they will inform partner organisations at the earliest opportunity if this seems likely to happen.
- **Boards should extend their risk management systems to incorporate system-wide risk.** The system itself should also develop a risk management system that allows individual boards to escalate and de-escalate risk within the system.
- **Boards should re-examine how they will obtain assurance on system-wide risk** and decide what actions they will take in the absence of such assurance or if there are concerns about the quality of assurance.
- **Boards should introduce a process of informal call overs (meetings on an informal basis) between non-executive directors/chairs and executives** so that potential decisions can be challenged on an ad hoc basis prior to being taken.
- **Boards should consider retrospectively decisions taken under delegation, examine the risk and look for assurance that it is being mitigated,** and if necessary take steps

to amend their decisions.

- **The guiding principle for everyone should be: doubt is your friend, if in doubt, don't suppress it, act on it for the good of the trust, patients and the wider system.**

Points to remember

When making decisions at system-level there are a number of issues that participants need to be aware of to ensure that decisions have actually been taken and that they are lawful.

- **System boards.** These are typically groups of chief executives or executive directors operating under delegated authority. Many such groups operate a majority voting system, but care must be taken if the minority wish to accept the decision of the majority. When voting as such a group, the participant is using their delegation to either agree or not agree to something. The fact that a majority may have voted for something different does not alter the delegated decision. For example, the majority in a group vote to consolidate a service on a single site. If you have voted against, your organisation remains committed not to consolidate on a single site and the views of the majority have no effect on that decision. If you wish to go along with the majority you must change your vote and the exercise of your delegation.

  If the legality of a decision is challenged or in the event something goes badly wrong, it should not make much difference to the general discourse at meetings or alter circumstances where decisions are reached through consensus, but it should mean that care is taken to both reach a decision and to record it as such.
- **Abstention.** Anyone acting under delegation that abstains or does not cast a vote has decided not to make a decision and, notwithstanding the views of the majority, that decision holds unless the individual chooses to change it as described above.
- **Delegation to non-executive directors (NEDs):** NHS foundation trusts may only delegate to executive directors and to committees consisting of directors. This means that legally, individual foundation trust NEDs operating at system-level are doing so as individuals and have no powers to bind their organisation. This problem may be overcome by two or more NEDs representing a foundation trust as a committee with delegations from the board.
- **Committees in common.** Committees in common are individual committees of the constituent organisations acting under delegation that happen to be meeting to discuss the same agenda in the same room at the same time. Each separate committee will make its own decision. Once again, the vote of the majority does not alter the decision made by any individual committee unless that committee decides to change its decision.

  The law stipulates that NHS foundation trusts can delegate only to executive directors or committees consisting of directors would seem to imply that foundation trusts cannot have committees consisting of one person.

COLLABORATION ACROSS TRADITIONAL BOUNDARIES

2

Emerging systems are bringing together organisations that have traditionally worked separately. A culture of transparency can help to bring together partners in a system to begin working across historical boundaries and commit to finding collaborative solutions to system-wide problems.

Collaboration across traditional boundaries in Dorset integrated care system

> ***Together, we have a successful track record and strong commitment to collaborative working across our organisations, so that we act as one integrated system. This has been fundamental to our ability to build a plan of this scale and ambition – and puts us in an excellent position to deliver it.***
>
> Our Dorset STP

Area covered	Dorset
Population	Approximately 800,000
NHS budget (or system control total)	£1.175.5m (2018/19)
Key partners	• 1 CCG
	• 1 ambulance trust
	• 1 mental health and community trust
	• 3 acute trusts (2 of which are on a path to merger)
	• 5 GP Federations
	• 1 county council
	• 2 unitary authorities

Context

Dorset ICS was one of the eight first wave ICSs. The origins of the draft operational plan for 2018/19 lie in the Dorset CCG clinical services review which began in 2014 and concluded

with a major public consultation. That review provided the backdrop to system-working and helped to reinforce a growing, collective acknowledgement of the need for partners to work more closely together. It also initiated a culture aimed at seeking systemic problem fixes across organisations and moving away from siloed working. A blueprint and subsequent plans were developed as a result of the review which evolved into the STP for Dorset, formulated under the branding of *Our Dorset*.

The current operational plan acknowledges the growth and development of the system and the partners' track record of collaborative working, and, crucially, acts as an umbrella for individual providers' operational plans and for the CCG's operational plan and commissioning intentions.

A memorandum of understanding (MoU), commenced in 2017, setting out how the partnership of local healthcare and local authority organisations would work together for two years, providing joint leadership to help integrate services and funding to transform care. The MoU is now (2018/19) in its second year underpinned by a block contract agreement between commissioners and providers. Governance arrangements are in place via the senior leadership team to monitor the MoU (see diagram).

Collaborative working is also underpinned by a shared understanding that the financial settlement for health and social care in the area is challenging. Committing to getting best value from collective resource sits at the heart of the MoU and the longer-term financial strategy for the system is dependent on key partners across commissioning and provision working together.

The system is working towards an open-book approach which means that organisations in the partnership now better understand, and are more willing to address system-wide issues for the benefit of the local population.

A great achievement for the last financial year (2017/18) was that Dorset met its system control total, a challenge given its sustainability fund allocation and the challenges inherent in moving finances around the different providers. There have been changes in the behaviours of the organisations within the system which have allowed this to happen. Much of this change has been facilitated by the operations and finance reference group (see diagram) which has been able to optimise finances and consequently performance for the whole system.

A more collaborative culture has also opened up shared access for partners to IT and business intelligence teams. The Dorset care record is an essential part of the system's forward plan and will be a key enabler for system-working.

Governance

The system governance arrangements are illustrated in the diagram below and recognise that each organisation has its own direct part to play in the delivery of our system-wide plan, within its own existing governance structures.

This structure has evolved from the Better Together programme and was taken forward by

the system leadership team (SLT) made up of senior responsible officers from constituent organisations, both health and local authority with terms of reference setting out responsibilities. Representatives from NHS England and NHS Improvement are also invited attendees of the SLT. The partners have set up a system partnership board made up of chairs and local authority elected members, alongside the senior responsible officers, to support the SLT in delivering the sustainability and transformation plan.

This new framework of governance at a system-level is not without its challenges. The legal framework created by the Care Act 2012 still focuses on individual organisational sovereignty and accountability. This backdrop at times brings challenges when trying to make system orientated decisions that may have an adverse impact on a single organisation.

Importantly a clinical reference group examines the quality impact of any proposed service changes or financial decisions agreed at the system-level. The operations and finance reference group has proven important in supporting the system to optimise its finances and consequently performance.

Monitoring performance

Plans are drawn up and ongoing for the following programmes of work:

- prevention at scale including self-care and prevention, mental health and implementing right care
- integrated community and primary care services including integrated hubs, transforming general practice, mental health and learning disability services
- one acute network of services including acute reconfiguration, cancer services, maternity and paediatrics, urgent care, collaborative elective care pathway design and clinical networks
- enabling delivery including leading and working differently and the deveopment of a digitally-enabled Dorset (shared records).

Dorset ICS has a robust approach to performance management across the system as follows:

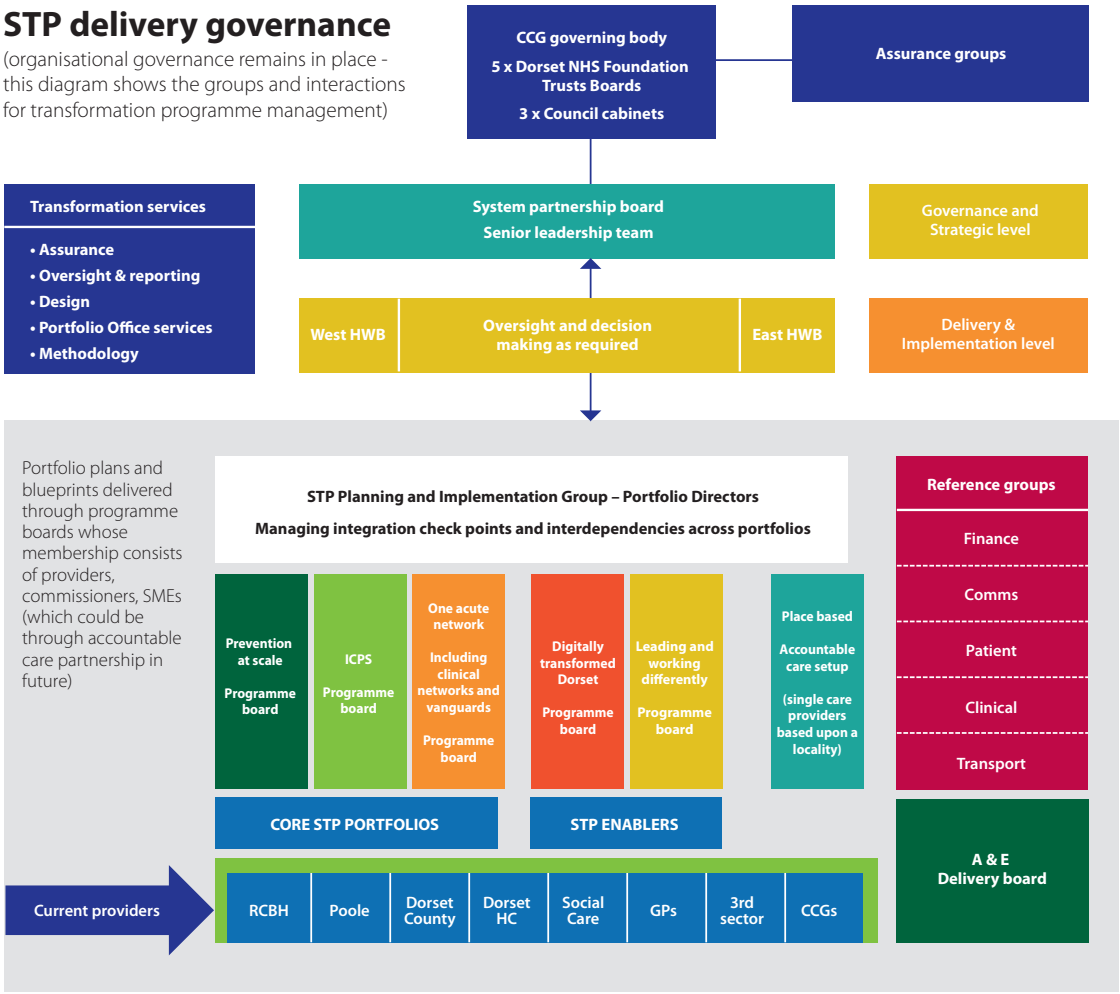
- monthly performance reports on delivery of the joint collaborative agreement to operations and finance reference group
- monthly performance reports to SLT
- joint quality and performance contract meetings in place with providers.

Each organisation continues to manage and monitor performance within their existing structures in line with regulatory requirements.

2

STP delivery governance

(organisational governance remains in place - this diagram shows the groups and interactions for transformation programme management)



How does the system work together to transform and improve services?

Commissioning staff and those working within provider units are now working much more closely together to give rise to change. The roles of all staff involved in the transformation process have become more blurred.

Collaboration involving the commissioner, current providers and other stakeholders will take place using a collaborative problem-solving model. The model assists the partners around the table in working out what is best for patients, most efficient and of sufficient quality for the area. This work involves pooling information, health intelligence and the scoping of the needs of services going forward, and ensuring all partners with relevant expertise contribute directly to producing service specifications. While quality of care is top of mind, part of the strength of the partnership is the open-book approach which provides transparency and a shared realism about what is affordable.

Any services being commissioned by the CCG will still go out to tender as normal with all interested parties having access to the same level of information as local partners.

Further information on the vision for Dorset is available at: ***www.dorsetsvision.nhs.uk***

It is not all plain sailing…

One of Dorset's strengths is a sense of self awareness across the partnership. Colleagues from the ICS summarised their learning as follows:

- Opportunities to improve the health and wellbeing of the Dorset population must 'trump' the interests of individual organisations.
- Behaviours speak louder than words. Partners should keep asking the question, am I part of the problem?
- Making change happen means prioritising staff engagement and facilitating teams to work together.
- The balance of power across the system depends on the willingness of everyone to let go and to compromise at times which is a difficult thing to do. There is a need to trust people, be open and take some risks.
- The languages of health and care are different and it is important to get to a shared understanding of what the system is trying to achieve across key partners, particularly local government and social care.
- Gaining a better understanding of each other's pressures and challenges is an essential start to building relationships of trust and working together effectively.
- Primary care is seen as key to collaborative working.
- Learning and evaluation has been vital in ensuring there is always quality improvement for patients.

3 PROVIDER COLLABORATION

Simplicity of organisational form often leads providers to conclude that either a merger or acquisition is the best way to streamline governance arrangements within a system under a single board. However, such arrangements do not have to happen as a 'big bang', nor do improvements to services for the public need to be put on hold pending organisational change. In North Cumbria there has been an evolutionary approach to change.

Provider collaboration in North Cumbria Health and Care system

> ***One of the most rapidly improving systems in England.***
>
> Matthew Swindells, national director of operations and information, NHS England

Area covered	**West, north and east Cumbria (divided into 8 communities (ICCs), which will work as a team to support local people**
Population	**Approximately 327,000**
NHS budget (or System Control Total)	**Approximately £420m**
Key partners	• **1 coterminous CCG**
	• **GP federations**
	• **GP out-of-hours providers**
	• **Primary care**
	• **1 County Council**
	• **1 acute NHS trust working collaboratively with 1 community and mental health foundation trust**
	• **Other community providers**
	• **1 ambulance trust**
	• **Third sector and community groups**

3

The context

Following a prolonged period with the acute organisation in special measures, and the area under national intervention from the 'success regime,' health and care leaders in North Cumbria celebrated an impressive step forwards when the area became a second wave ICS in May 2018.

Since coming together, the North Cumbria health and care system (the partnership) has been firmly focused on adopting a more preventative approach to support the health and wellbeing of its population. The partnership has benefited from the stable yet dynamic leadership of a chief executive in public service. The partnership leadership specialises in turnaround reconfiguration, and partnership working has been crucial to this. The system-wide partnership has also, interestingly, been underpinned by the development of a close collaboration between the two trusts who have agreed to formally join together in April 2019.

A slow journey to merger

In order to improve and integrate care for patients, and make best use of collective resources the two trusts, Cumbria Partnership NHS Foundation Trust (CPFT) and North Cumbria University Hospitals NHS Trust (NCUHT) decided early on to develop an evolving collaboration, rather than to seek a formal merger as their starting point. They developed a joint executive team while retaining the sovereignty of both organisations.

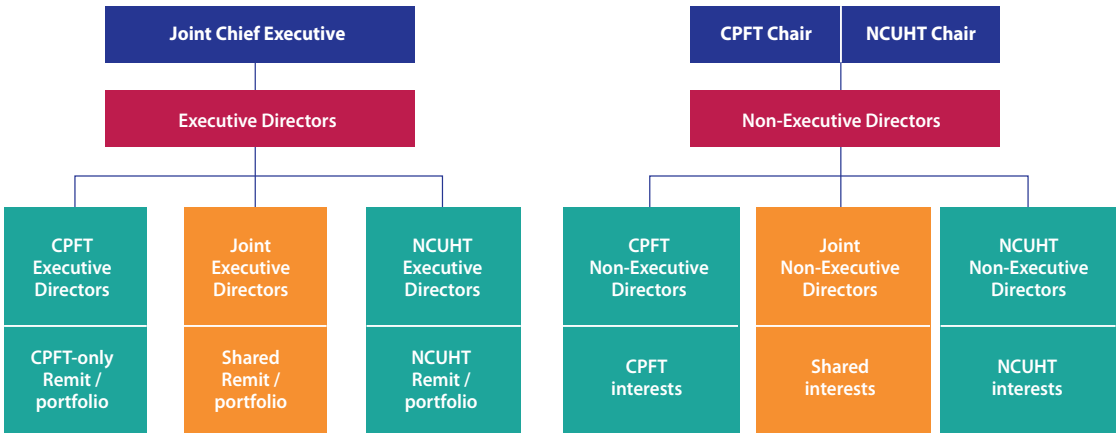
The main opportunities driving the trusts' collaboration are to:

- align and focus decision-making on a population health management approach
- agree priorities for the system balancing a focus on the highest priority needs across local communities, with ensuring appropriate care is available for all
- develop person-centred health and care services on the basis of clinical input and evidence
- use board members' expertise and capacity more effectively
- consolidate processes, share back-office services and support a system-wide workforce plan
- drive greater efficiency and cost reduction.

The governance arrangements between the two trusts have developed as follows, starting over a year and a half ago:

Date	Action and proposals taken to the two boards
January 2017	The boards agreed in principle to integrated leadership, accountability and governance, including shared system leadership roles
March 2017	The boards approve an MoU which provided the basis of working together and governance structure to enable group and common decision-making structures
June 2017	Following discussions with the council of governors, the boards approved the appointment of a joint chief executive
September 2017	The boards approved the establishment of a joint executive management team and transitional executive management arrangements with the aim of supporting closer collaboration and joint working
November 2017	Joint board development session is held to consider governance proposals
December 2017	Discussion paper on governance and leadership arrangements is taken to the boards
January 2018	A board paper asks the boards of directors to consider moving to a single joint board model and single board meetings from 1 April 2018. In addition: • establishment of committees in common across the two trusts • support the recruitment of joint executive and non-executive directors between the two trusts • agreement about the remuneration for joint NEDs
March 2018	The revised MoU is approved and the boards agree to: • an aligned decision-making model in which board meetings of each trust are held at the same time and in the same location, with common agenda items where appropriate • establish arrangements whereby board-level committees across the two trusts are held at the same time and in the same location, with common agendas where appropriate • the exception is the audit and risk committees which have remained separate • a team of three joint administrators has enabled all documentation and minutes to be produced professionally and with regards to the reporting needs of both trusts
March 2018	Board governance and leadership – common chairing protocol established

CPFT and NCUHT Current board structure (to March 2019):



What has changed?

A six-month evaluation of the collaboration between the trusts concluded the following points:

- The changes within the two organisations have helped facilitate a feeling of an equal partnership which within a short period of time, had broken down barriers that had existed in the system for a number of years. The trusts now need to develop a shared sense of identity underpinned by culture and values, as they approach merger.
- Foundations have been put in place for corporate governance arrangements which are enabling aligned decision making. The move to a single executive management team has been positive in breaking down barriers and creating a sense of purpose especially within integrated support services areas.
- The implementation of integrated care communities (ICC) was recognised as fundamental to the delivery of a population health model. There is a sense of board members in both trusts being more outward looking and improving their collective understanding of a fuller range of health and care services across physical and mental health.
- The appointment of a health partnerships officer funded by the NHS and hosted by Council for Voluntary Services Cumbria to build stronger relationships and sustainable connections between health and the third sector at all levels, with an emphasis on strategic developments and at an ICC level.
- The establishment of the system risk share agreement is evidence that partners are working collaboratively to resolve long-standing issues. While recognising the national and local financial position, leaders felt that there was a real opportunity to release funds and transform the activity flow between acute and community services.

- There is a real sense of immediate improvement in the development of workforce planning. This follows the joining together of recruitment arrangements between the trusts and includes successful international campaigns, joined up approach to partnership arrangements with universities and a reduction in agency costs. There have also been improvements in the staff survey results.
- Improving the quality, safety and outcomes of care provided by the trusts remains central. Joint working has resulted in the development of joint pathways of care which will deliver benefits to patients in the near future.

Key governance considerations

- Board/committee members are accountable and responsible for the discharge of their duties and powers as board/committee members. They are, however, acting on behalf of their organisation and therefore would not be personally liable for any decision taken as long as there was no bad faith, illegal conduct etc. Such liability would rest with their organisation.
- As CPFT and NCUHT are two separate organisations and have, to date, opted for an aligned structure, each organisation or committee needs to be free to make its own decisions.
- The respective audit and risk committees at the two trusts have not been brought together as yet. This is partly because the two trusts use different auditors but it has also ensured that each committee can provide scrutiny on how joint arrangements are working.
- Not everything will work immediately so it is important to have a mechanism to quickly agree how to resolve conflicts and 'fix things'.
- Non-board/committee members need to be noted 'in attendance' at the other board/committee meeting in the minutes. Minutes should reflect the debate and discussion leading up to a decision (and therefore can refer to any issue/comment raised by non-committee members in that discussion in the usual way), followed by the final decision taken by the board/committee members.
- There is no issue if a board/committee decides to take on board views expressed by non-board/committee members in making its decision – as above, that was the reason that we sought to hold aligned committees. However, as part of the corporate governance administration audit trail, board/committee members are clear as to the reasons for their decisions (and document that as part of the minutes).
- Non-board/committee members are not accountable for or responsible for board/committees of which they are not a member, although in the interests of good administration and in line with the collaborative relationship to be established between the organisations, non-board/committee members would still be expected to discharge their roles properly.

4 INVESTING IN ENGAGEMENT

Change is often very difficult to accept, even when the reasons for change are evident. For the NHS, change is particularly difficult given strong public affection for existing institutions. ICSs need to work with their populations and this is reflected in the significant investment that many have made in engagement. In West Yorkshire and Harrogate, engagement has been at the centre of their approach to change.

We are committed to meaningful conversations with people, on the right issues at the right time. We believe that this approach informs the ambitions of our partnership - to work in an open and transparent way with communities.

Ian Holmes, director, West Yorkshire and Harrogate Health and Care Partnership

ICS area	West Yorkshire and Harrogate
Population	2.6m
NHS budget (or system control total)	Around £5bn of health and social care funding
Key partners	• 9 clinical commissioning grous (CCGs)
	• GP federations
	• GP out-of-hours providers
	• 8 acute trusts
	• 4 mental health and community trusts and other providers
	• 1 ambulance trust
	• 8 councils
	• Healthwatch
	• Voluntary and community sector (VCS) partners
	• Representatives from national bodies including Health Education England, Public Health England, NHS England, NHS Improvement

4

Context

West Yorkshire and Harrogate Health and Care Partnership (the partnership) came together following the publication of its sustainability and transformation plan in November 2016 and joined the integrated care system (ICS) development programme in May 2018. The partnership is led by the chief executive of South West Yorkshire Partnership NHS Foundation Trust who takes a values-based approach to leadership with a proven commitment to system leadership.

The partnership covers six local places which build on existing collaborations and plans through health and wellbeing board footprints in Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield. These six places serve a diverse range of communities and they recognise that different population groups within their wide ranging geography, have different needs which require different approaches and services. There are therefore nine priority programmes for West Yorkshire and Harrogate, reflecting both national (N) and local (WY&H) priorities.

Primary and community care (N)	Preventing ill health (WY&H)
Mental health (N)	Stroke (WY&H)
Cancer (N)	Hospital working together (WY&H)
Urgent and emergency care (N)	Planned care and reducing variation (WY&H)
Maternity (N)	

Each priority is led by one of the chief executives or CCG officers from within the partnership and benefits from a robust governance structure and a programme management approach. Each priority programme also has mechanisms to capture input from clinicians and key stakeholders such as councils, the voluntary sector and the public in each of the six 'local places'.

Prioritising communication and engagement

The partnership prioritised the development of a common communication and engagement strategy published in September 2017 with the partner organisations, including Healthwatch and the joint committee public, patient involvement assurance group. The strategy sets out the partnership's strong intention for communication and engagement to become an enhancing and productive component of each of the nine programmes. The communication and engagement plan was updated in September 2018 and there is also an easy read version.

Local engagement and communication leads have access to a communications toolkit developed collectively with communications and engagement leads at the partnership level. Place-based engagement and consultation plans are also produced on a locality basis giving rise to multiple streams of engagement relevant to that population and that place. These include consultation and reporting on a broad range of topics, from supporting unpaid carers, to involving communities in #Changetheconversation, the work of the voluntary and community sector (VCS), progressing the digital agenda and mapping support across WY&H for young people. More recently the partnership as a whole has been working to support social cohesion through the Jo Cox Foundation. It's important to note that from the very start of our partnership, we recognised that we are starting from scratch and that good ownership and engagement happened in the six local places. We published a mapping document of all engagement and consultation work that had taking place across the area and the outcomes for the four years prior to our initial plan.

Everything is accessible, and we have worked with specialist organisations to ensure our information is accessible and to a high standard. This includes the Good Things Foundation, Change People and Bradford Talking Media to name a few.

How are different voices heard in the partnership?

- The CCG joint committee wanted to ensure that public and patient voices are at the centre of open and transparent decision making. It therefore has a lay chair, independent of any CCG. In addition, the committee includes two further lay members on the committee who are representative of the CCGs and bring a wealth of expertise and knowledge from health, social care, charitable sector and public and patient involvement.
- The partnership has established a public and patient involvement lay member assurance group which meets every two to three months and comprises lay members from the nine CCGs within the system. This group provides support to system wide communication and engagement activity, in accordance with the joint committee's work plan.
- Approximately 60 members of the public panels from all sectors of the partnership came together in April 2018, to develop and co-produce a robust governance structure which can offer assurance on all engagement and consultation work of the partnership priorities across all sectors, i.e. hospitals, Local Authorities, CCGs. These chairs will also act as advocates and constructively challenge the partnership and ensure that public involvement is at the heart of all decision making. This will inform public representation on the partnership board being developed.
- The partnership actively recruits members of the public, including carers, as patient representatives on to its nine priority programmes. There is an application form and a role description on the partnership's website. Facilitated training is provided to successful applicants to assist their orientation in understanding the workings of the programme boards. There are engagement groups in place for the VCS, carers and public voices aligned to the nine priority areas which are particularly strong for cancer, maternity and stroke.

- A partnership communication and engagement network (approximately 70 members) meets every three months attended by representatives of the health service, council and voluntary/charity group communication and engagement leads.
- The partnership welcomed over 30 trust governors to a special workshop in March 2018 in Leeds to find out more about the work taking place across the area.
- The partnership produces information in alternative formats, including easy read and BSL. Find out more at www.wyhpartnership.co.uk

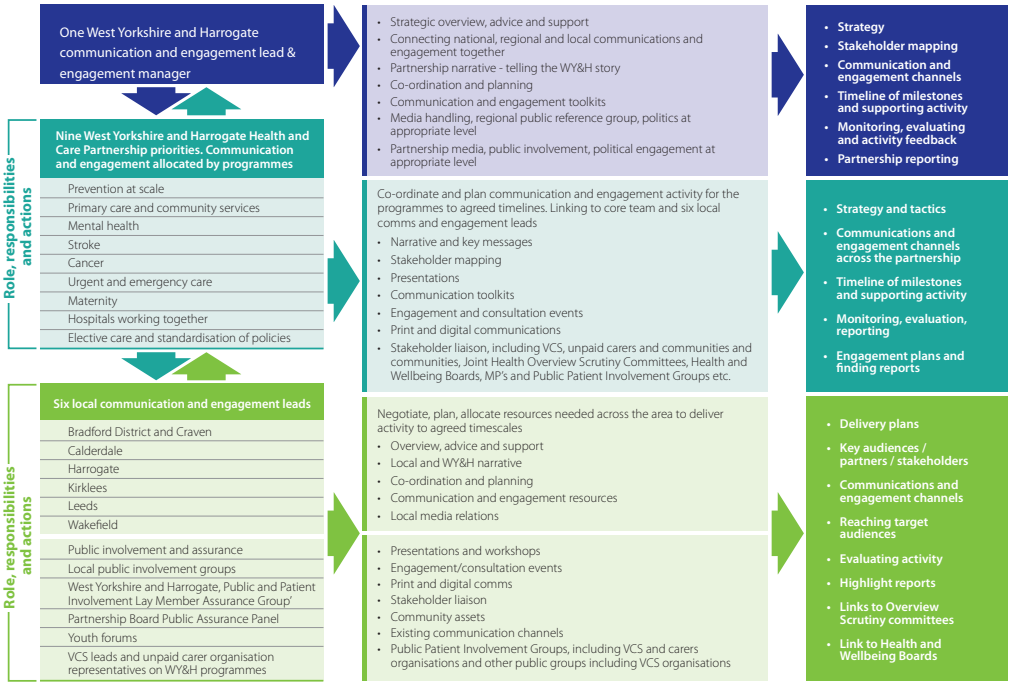
What works?

In developing its communications and engagement strategy, the partnership has learned to base its work around the following key principles, locally and at system levels:

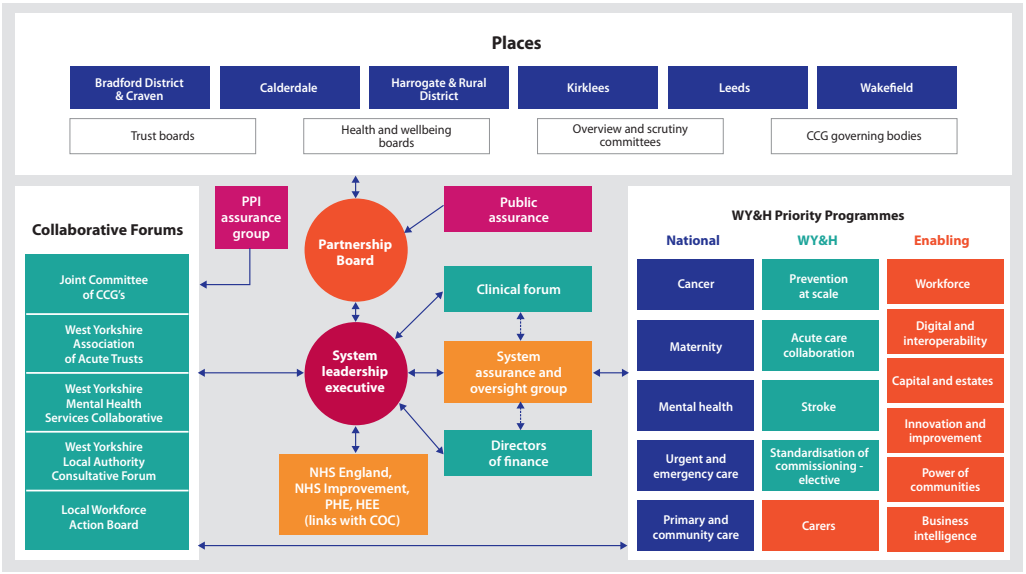
- **Accessible and inclusive** – to all our audiences including patients, the public, stakeholders, clinicians and staff.
- **Based on data and evidence** – data about inequalities in access, experience and outcomes is used to target engagement work. The information gathered from engagement activity is used to inform how the partnership proceeds to develop its priorities.
- **Clear and concise** – allowing messages to be easily understood by all.
- **Consistent and accountable** – in line with our vision, messages and purpose.
- **Flexible** – ensuring communications and engagement activity follows a variety of formats, tailored to and appropriate for each audience.
- **Open, honest and transparent** – being clear from the start of the conversations what the plans are, the reasons why and ultimately, how decisions will be made.
- **Targeted** – making sure messages get to the right people and in the right way using the communication and engagement communication channels.
- **Timely** – making sure people have enough time to respond and are kept updated on a regular basis.
- **Two-way** – listening and responding accordingly, letting people know the outcome of all conversations.

Communications and engagement strategy April 2018

West Yorkshire and Harrogate, Health and Care Partnership – making communication and engagement work together



We are developing collaborative governance and accountability arrangements



(please note: this is a draft and work in progress)

APPROACHES TO DEVELOPING LARGE SYSTEMS

5

Large systems covering wide geographical areas with large populations and multiple stakeholders present a particular governance and organisational challenge. Cumbria and the North East integrated care system (ICS) and Greater Manchester Health and Social Care Partnership have taken contrasting, but equally valid approaches to developing large systems.

> ***There is a need for there to be a system-first attitude and this is bound to cause some ripples…but partners within Cumbria and the north east are committed to developing our new STP footprint into a fully integrated care system – it will serve our communities better and make sure we get best value from our collective pound.***
>
> Alan Foster, lead, Cumbria and North East STP

Area covered	Northumberland, Cumbria, County Durham, North Yorkshire and Tyne and Wear
Population	3.2m
Key partners	• 12 CCGs
	• GP network organisations and GP practices
	• 6 acute trusts
	• 3 community and mental health trusts
	• 1 ambulance trust
	• Tertiary providers in the north east
	• 14 councils
	• Healthwatch
	• Health Education England
	• NHS England; NHS Improvement

The context

Health and care organisations across Cumbria and the north east are leading the first merger of STPs under one shared STP lead. Partners within the three original STPs have a history

of collaborative working and having shared respective plans, decided to create a larger geographical footprint to support collaborative working, improve pathways for patients and make better use of collective resources. This is the first time STPs have come together in this way and will prove an important 'test bed' for the rest of the country. Cumbria and north east STP is now the largest STP area by geography with a population of three million.

Why make the change?

The creation of a larger collaborative system partnership across Cumbria and the north east provides an opportunity to develop a population health management approach with a more strategic commissioning function, to support service reconfiguration and to collectively address key challenges such as workforce planning and development.

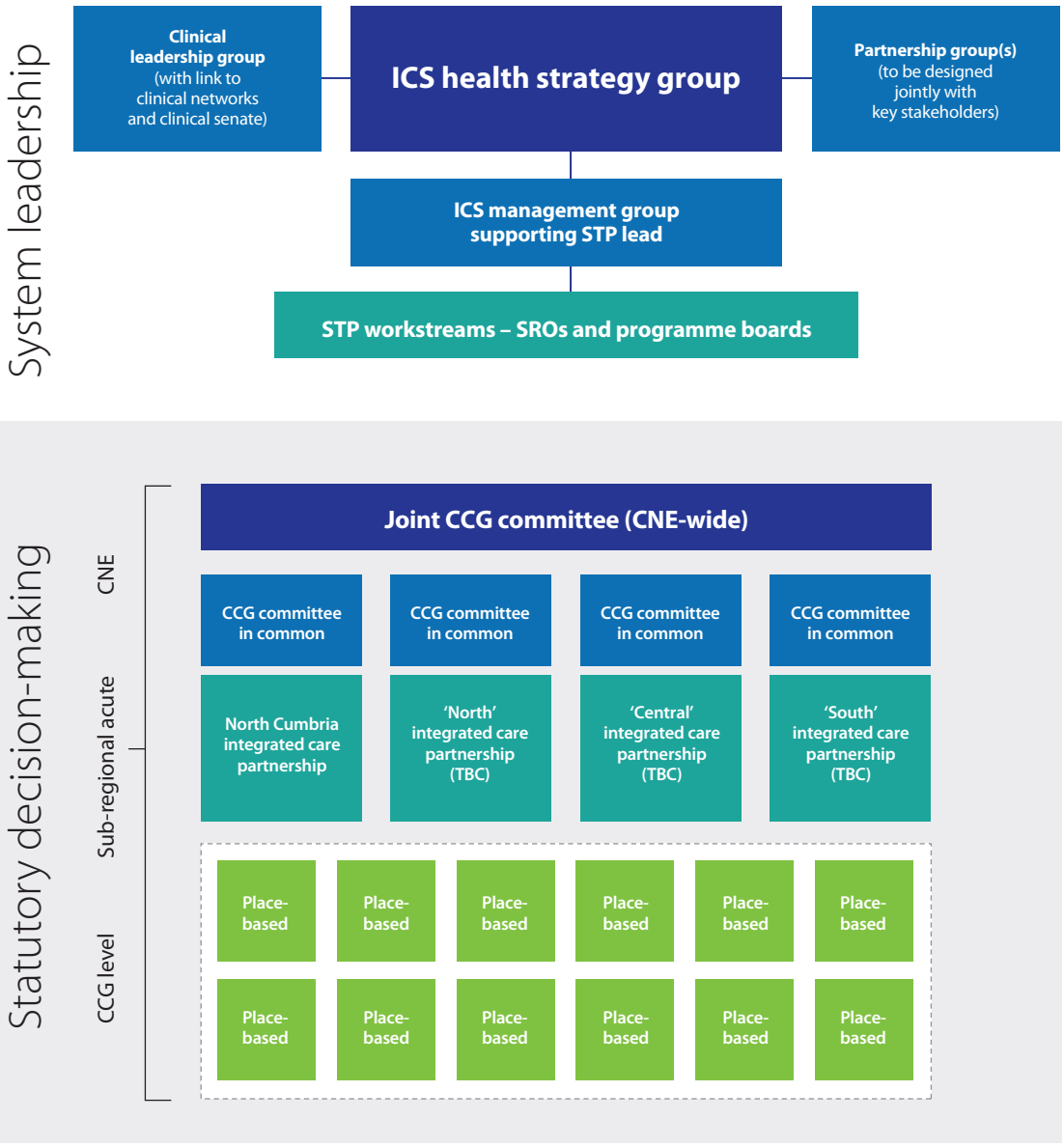
The ability to concentrate specialties such as cancer care into centres of excellence and to do outreach from a speciality hub also influenced the decision, particularly given how much of the geography of the three original STPs is rural. This new partnership will provide greater flexibilities to share specialised workforce (particularly in areas where they struggle to recruit) and to support acute care reconfigurations which create greater scale for diagnostics and specialised care delivery.

The new system-wide partnership will be supported by the development of four integrated care partnerships (ICPs) more able to commission, convene and coordinate care delivery for populations at the appropriate scale. The ICPs would complement strategic commissioning for outcomes, and some specialised services (such as cancer, haematology and digital networks) at the STP-wide level. The ICPs will also encourage vertically-integrated partnerships where services are joined up for patients, led and supported by clinicians working together. Each local area will break down the ICPs into smaller localities and neighbourhoods to deliver truly integrated care. The intention is to avoid being prescriptive about how the ICPs and their delivery units develop, and to allow that to be locally led.

What does the emerging governance look like?

The governance system is evolving and faces inevitable challenges due to the lack of coterminosity, but there is strong support from the leaders of the main partners across commissioning and provision.

1 The three STPs now collaborating as 'Cumbria and north east STP' are: Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP; Northumberland, Tyne and Wear and north Durham STP; and west, north and east Cumbria STP



Key features of the governance mechanisms at system-level are set out below:

- The three original STPs now come together under Alan Foster who acts as the STP lead for the newly created, enlarged system. Alan is currently working four days a week at the partnership and one day per week at North Tees and Hartlepool NHS Foundation Trust, where he remains employed and retains accountable officer status.
- The main STP board provides the leadership forum to bring together the key partners, notably CCGs, trusts and local authorities. All of the chief officers from the CCGs and trusts hold monthly meetings at a leadership forum and this is where decisions around system working, including aspirations to become one large ICS are discussed. Organisationally focused regulation and monetary control are the major impediments slowing progress towards greater integration at the moment.

- The 12 CCGs in the system have formed a joint commissioning committee with delegated decision-making powers. This committee met for the first time at the end of 2017. In parallel, some of the CCGs are seeking to merge to create larger commissioning footprints. The trusts in the system are in the process of forming committees in common. The aim of the CCG joint committees and the provider committees in common is:
  - to create a larger population footprint for strategic commissioning
  - to create the structures to allow providers to collaborate and take operational commissioning (such as developing service specifications and taking responsibility for more performance management).
- A lay and NED reference group comprising CCG lay members, trust NEDs and councillors is being considered to engage non executives and put more scrutiny and challenge into the development and delivery of system planning.

Looking ahead

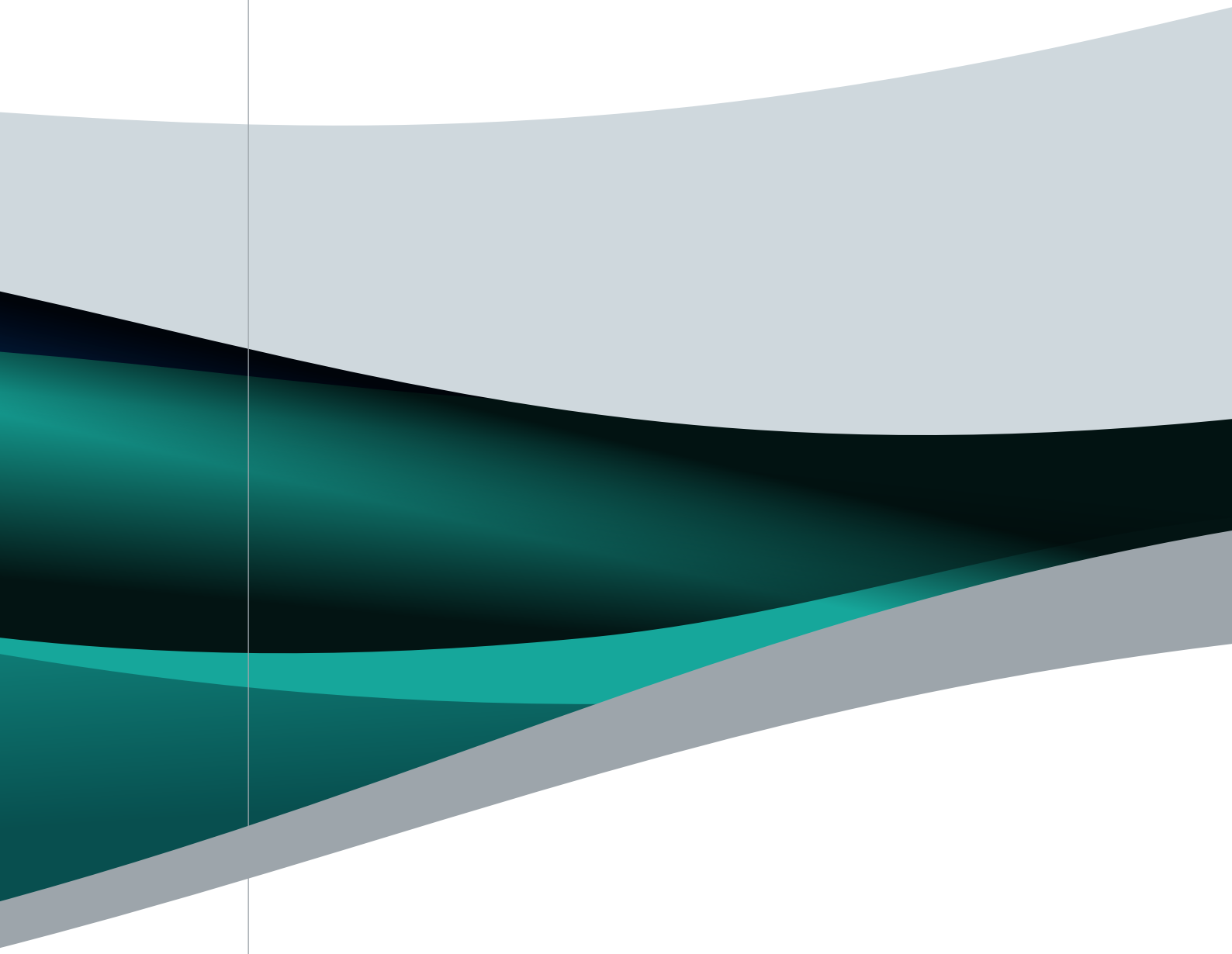
It is early days and the STP concept has not yet been tested as a national policy. In Cumbria and the north east, as elsewhere, it relies on individuals to champion the approach and implement what is agreed at system meetings. There is a need for there to be a system-first attitude and this is bound to cause some ripples and waves given the legislative framework we are working within, which was set up for a different time, and a competitive, rather than collaborative, approach. However, partners within Cumbria and the north east are committed to developing their new STP footprint into an integrated care system.

There is a need for national policy makers to support systems to move towards managing their finances collectively as a system – and to ensure regulation keeps pace with changes at the frontline. The development of NHS England and NHS Improvement's new regional structures will also be pivotal for the success of STPs and ICSs. In Cumbria and the north east there is a hope that NHS England and NHS Improvement may be able to release or second individuals to support the work of the system. This would be a significant shift of resources but an important one if we are to provide system-working with sufficient resource, capacity and functions.

6 CONCLUSION

System working presents a number of fundamental governance challenges given the existing legislative framework. These challenges can be met to effect change, but that does not mean that the legal rights, responsibilities and liabilities of provider directors and boards can be sidelined. Rather, they need to be harnessed to ensure that robust and lawful decisions are made, referred back and challenged on their merits.

The case studies included in this publication show some interesting and contrasting approaches to meeting the governance challenge of integration. Many rely heavily on existing good interpersonal relationships, which is a very workable short to medium-term approach. In the longer term either consolidation into single organisations or legislative change or both will be necessary to ensure the stability of systems. We look forward to continuing to support providers and their partners on this journey.



NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

One Birdcage Walk, London SW1H 9JJ
020 7304 6977
enquiries@nhsproviders.org
www.nhsproviders.org
@NHSProviders