Welcome to

Partnership Working

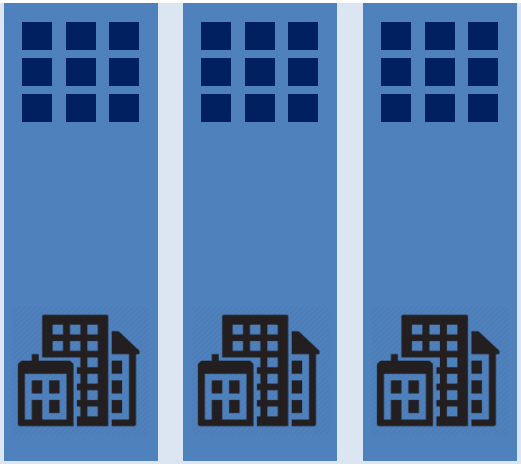
2 March 2020

Principal Hotel, York

Integrated Care Systems – developing system architecture

2 March 2020

Background – the ambition



Integrated care systems (ICSs) are local partnerships with shared responsibility for improving population health within allocated resources.

5 aims:

- Improve the health and well-being of the population
- Enhance experience of care and support
- Reduce per capita cost of care and improve productivity
- Increase the well-being and engagement of the workforce
- Address health and care inequalities

- **All STPs to become ICS by April 2021**
- **Integrated Care Systems will undertake two core roles: system transformation and collective management of system performance.**
- **In 2020/21 NHSEI will start working through ICSs/STPs on a "system by default" basis.**

Functions at System, Place and Neighbourhood

Neighbourhood plans care around the individual

Local services are delivered and partners collaborate with primary care. The neighbourhood should be enabled to be a decision making member of the ICS, particularly at place

Place aggregates neighbourhoods to a scale for agreeing wider service changes

Building on existing arrangements, in particular local authority, the focus of place should be on agreeing delivery of services and transformation

System sets the overall strategy

The system acts as a convener, ensuring that delivery at place and neighbourhood is strategically aligned to meet the needs of the population.

Consistent ICS operating arrangements from 2021/22

- System-wide governance arrangements, including a system partnership board with NHS, Local Government and other partners, to enable a collective model of responsibility and decision-making between system partners.
- Leadership model for the system, including a system leader with sufficient capacity, and a non-executive chair appointed in line with NHSEI guidance.
- System capabilities to fulfil the two core roles of an ICS, such as population health management, service redesign, workforce transformation, and digitisation.
- Agreement on a sustainable model for resourcing these collective functions or activities, NHSEI will contribute part-funding for system infrastructure in 2020/21.
- Ways of working agreed across the system in respect of financial governance and collaboration.
- Streamlining commissioning arrangements, including typically one CCG per system.
- Capital and estates plans at a system level, as the system becomes the main basis for capital planning, including technology.

Key lessons from Integrated Care Systems: Governance Policy

All Integrated Care Systems (ICSs) will have in place governance arrangements, to support partnership working and embed a collective model of decision-making and accountability.

The Long Term Plan stated that all ICSs should develop their system level governance arrangements; stating the importance of multi-professional leadership within it.

It stated that every ICS will:

- Establish a partnership board, drawn from constituent organisations
- Have a non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/governing bodies;
- Have sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes;
- Fully engage with primary care, including through a named accountable Clinical Director of each primary care network;
- Clearly articulate the links between the neighbourhood – place – system, including robust reporting and escalation processes which link all tiers of the system; and
- Build a culture of improvement and development across the governance groups

Using governance to enable system-working

System Vision

Develop a system wide vision focused on improving the health of it's population and reducing health inequalities through wide engagement which is meaningful to the citizens who live in the ICS.

Delivery

Delivery of the vision and plan is overseen by the partnership board, which is made up of a wide range of stakeholders selected for their ability to represent the population and best achieve these outcomes

Collaborative working

There is collaborative working across the system at all levels which allows a flexible approach to wider membership to involve active parties in the system who might influence the wider determinants of health

Planning

The system has effective planning across all partners enabling a focus on achievement of outcomes rather than a retrospective review of targets

Putting it into practice – learning from ICSs

Key lessons from Integrated Care Systems

Key lessons :

(1) Prioritise engagement and partnership working: Working across system partners including local government as equal partners from the start is crucial for a robust and achievable roadmap to integrated system working

(2) Coalesce around a set of key and co-developed design principles: Agreeing together the overall system aims and using these as the starting point for delivery objectives ensures a shared vision and direction of travel

(3) Start with what we know: Identify what is working well and build on it and call out barriers with candour to co-develop solutions ensures pace and mitigates duplicative work

(4) Make system working the end goal: Whilst ICS status is a good measure of system working, ensuring the objectives seek to develop and strengthen ways of working between all system partners within SHCP leads to true system integration

(5) Make it system specific: Develop a local approach to subsidiarity, using the national steer as a guide to, consider where activities and decisions might best be housed within SHCP

(6) Ensure form follows function: Stress test the existing governance arrangements to ensure they support proposed changes.

Example from West Yorkshire and Harrogate, Our leadership aim and principles

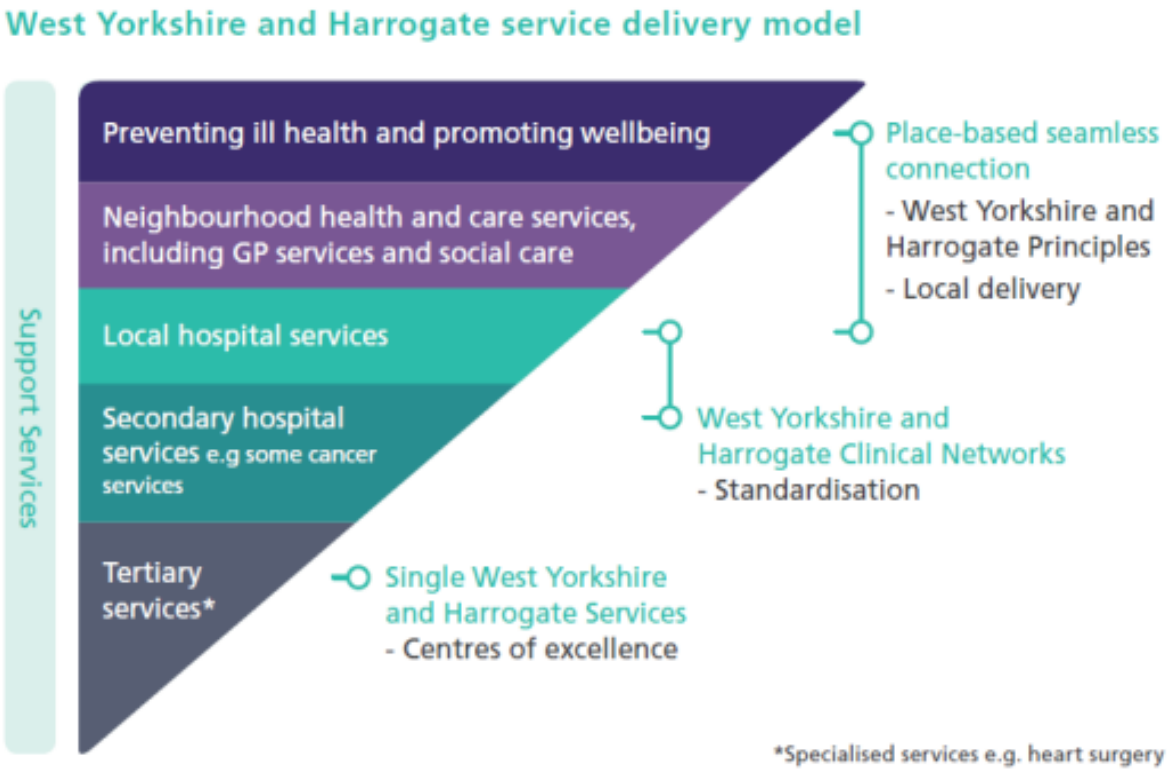
Our collective leadership aim is to achieve the best possible outcomes for the population through delivery of the Five Year Forward View

We have Guiding principles that shape everything we do as we build trust and delivery

- We will be **ambitious** for the populations we serve and the staff we employ
- The WY&H Health and Care Partnership belongs to **commissioners, providers, local government, NHS and communities**
- We will **do the work once** – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
- We will undertake **shared analysis** of problems and issues as the basis of taking action
- We will apply **subsidiarity** principles in all that we do – with work taking place at the appropriate level and as near to local as possible

These are critical common points of agreement that bind us together

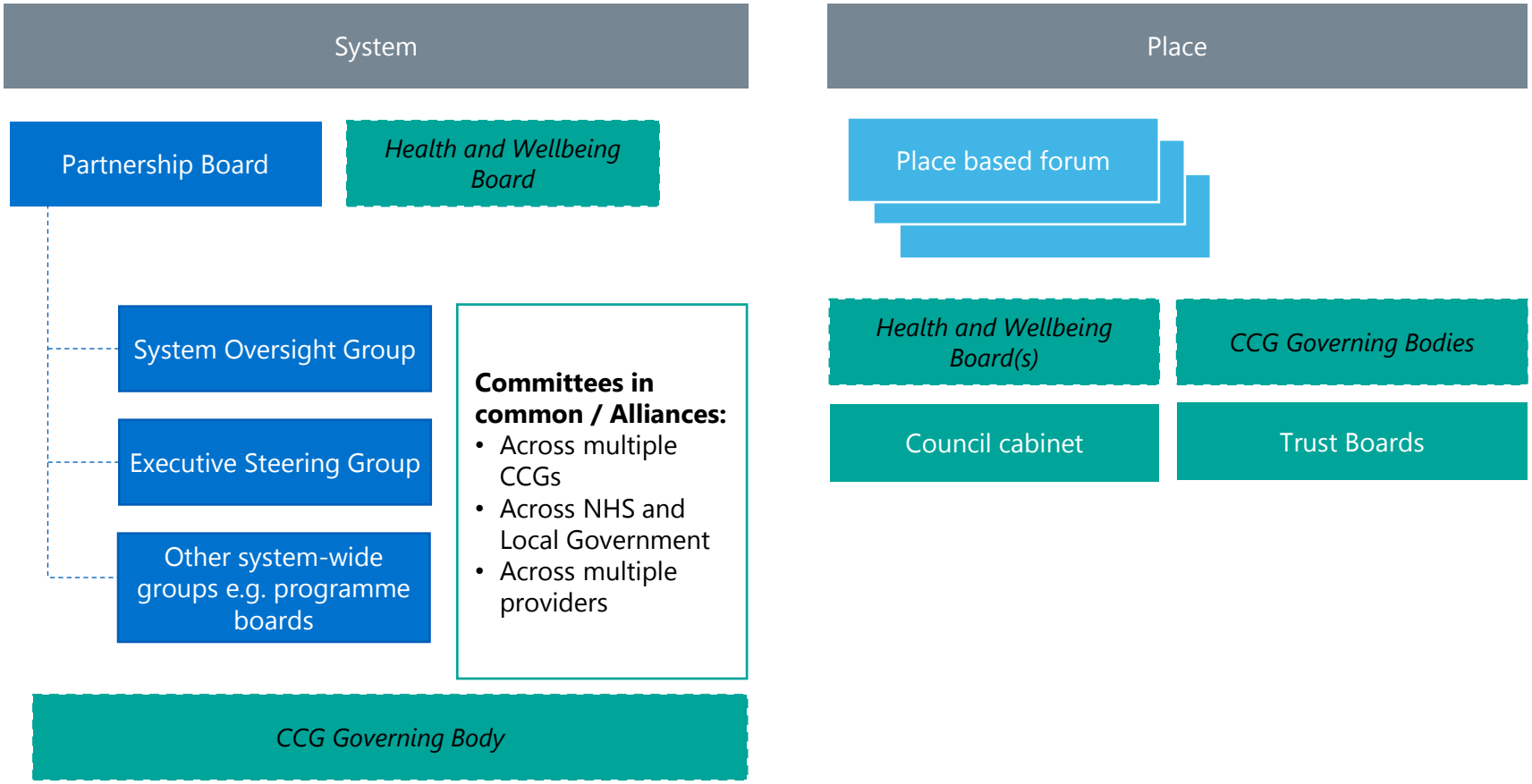
Example from an existing ICS: *West Yorkshire and Harrogate, Our service delivery model*



We work together at WY&H level when local partners agree the need to do so, considering three key tests:

- Do we need a critical mass beyond the local level to achieve the best outcomes?
- Will sharing and learning from best practice and reduce the variation in some outcomes for people across different areas?
- Can we achieve better outcomes for people overall by applying critical thinking and innovation to 'wicked issues'?

Generic approach to System Governance (Simplified)



Next steps – develop a ‘system by default’ approach

Emerging thoughts for discussion

- What do we actually mean by ‘System by Default’ and do we all have the same view?
- How do we continue to develop the enablers to be supportive of the broader ambition to build collaborative systems which address the wider determinants of health?
- How do we maintain the focus on collaboration at place and avoid additional layers of bureaucracy
- Freedoms and flexibilities
- How do we work towards systems which are mutually accountable with regions – without just ‘shifting functions’

Time for Coffee

Partnership working in the NHS

Dr John Bullivant, FCQI

Chairman Advisory Board
Good Governance Institute (GGI)

Overview

- Role of the Audit Committee
- Asking the right questions
  - Have we got the right model?
    - ...of commissioning, ...of delivery
  - Is our decision making effective?
  - How many assurance systems are we operating
    - Extended BAF
    - Single BAF
  - Risk appetite of own and partner organisations
  - Mutual Aid: are we ready, is it legal?

Good Governance Institute

GBO Matrix 2010

- **Continuity of Care**
- **Partnerships & Networks**
- **Mutual Aid & Business continuity**
- **Assurance**

DRAFT Version 4.1 Dec 2010	**Governance Between Organisations Maturity Matrix developed by Dr John Bullivant & Andrew Corbett Nolan** *To use the matrix: identify with a circle the level you believe your organisation has reached and then draw an arrow to the right to the level you intend to reach in the next 12 months.* **O====→**					
	Progress Levels:					
Key Elements:	**NO**	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
Continuity of Care 1. Joint commission outcomes and connectivity of care pathways from primary through acute, diagnostics, tertiary to community & home.	**NO**	Recognition that patients expect continuity of care	Services are jointly commissioned and measured by health and social care on basis of pathway of care	Focus on Outcomes is being achieved through focus on Intelligent Funding/results based approach	Metrics and Audit shows patients are being managed along pathway of care without delay or confusion	Patient Pathways are main currency of commissioning, planning and enabling better outcomes
2. Patient handover, referral or data transfer: Take the extra step - have they arrived: What has not arrived?	**NO**	Providers have protocols for handover within organisation	Providers have protocols for handover between organisations	All patients & their data checked for arrival at next care setting	Audit shows handover is being achieved without delay or confusion	Handover procedures working well and lessons shared
3. Review and apply lessons from investigations elsewhere (NHS and other sectors) Could it happen here?	**NO**	All staff trained and updated in communication skills between professionals and with patients and carers	Failures of communication identified elsewhere in NHS and lessons reviewed	Failures of communication identified elsewhere outside NHS and lessons reviewed	Audit shows decline in communication caused untoward incidents	Lessons from internal and external reviews are learnt and applied
Partnerships & Networks 4. Jointly audit critical processes across the boundary (clinical, financial, information etc) at appropriate depth & frequency respective to risk	**NO**	Protocols agreed for integrated clinical/systems audit	Protocols agreed for joint audit of single provider by two interested (commissioning) organisations	Protocols agreed for interface audit across organisational boundaries	Audit covers boundary conditions	Integrated clinical/system audit plan tracks key whole pathways on regular basis as part of clinical audit spiral of improvement
5. Be consistent in telling patients/carers what they are entitled to and when they or others are holding responsibility for their care	**NO**	Patients are informed of their rights and responsibilities	Commitment to informing patient/carer who is holding responsibility for their care at any time	Staff are actively encouraged/trained in informing patients/carer who is holding responsibility for their care at any time	Audit shows professionals and patient/carer knows who is holding responsibility for the care at any time	Patients and carers are clear of rights and responsibilities and evidence shows improvement in fulfilling these
6. Check our partners/suppliers have the capacity to deliver their obligations to us	**NO**	Needs and joint resources have been identified and deployed	Protocol /etiquette for working together agreed with escalation / failure actions predetermined	Agreement on resource deployment between responsible organisations agreed as part of planning/commissioning cycle	Audit of process shows joint working arrangements and arbitration are working to plan and time	Routine robust check of partners resource and decision making capacity with corrective action plan

Good Governance Institute

Mutual Aid

"Mutual Aid will be an integral part of the role of leaders, both managers and clinicians.

As we move to an NHS which is deeply interconnected, leaders in all parts of the NHS will be encouraged to support one another across and beyond their organisations.

This will be especially the case for thriving, successful organisations which will increasingly be asked to support their neighbours develop capabilities and build resilience.

This will form part of a 'duty to collaborate' for providers and clinical commissioning groups alike."

NHS Long Term Plan (para 7.10) --

Good Governance Institute

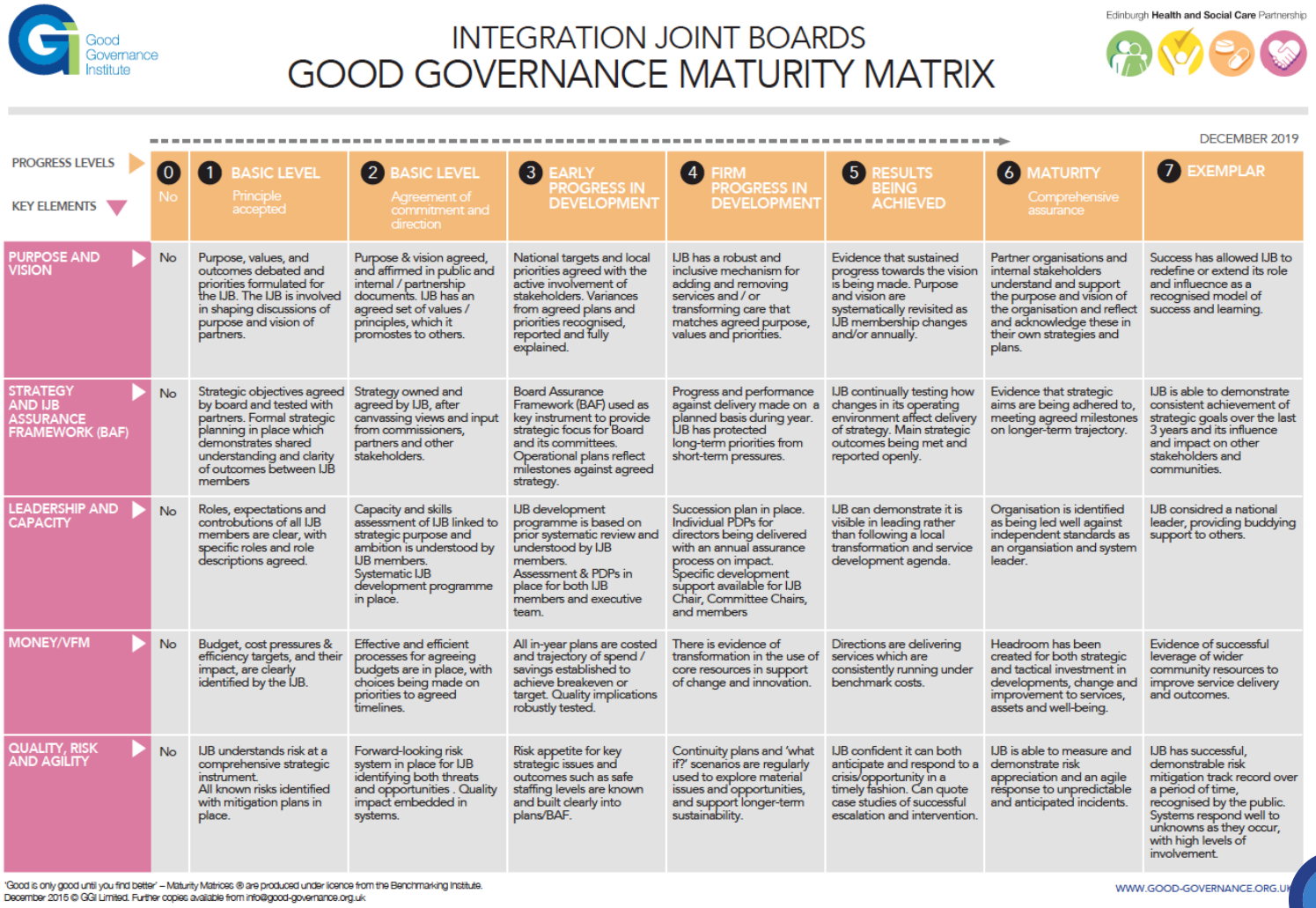
GBO Matrix 2013

1. **Joint and Delegated Decision Taking**
2. **Assurance**.
3. **Continuity of Care**
4. **Partnerships and Networks**
5. **Mutual Aid and & Business Continuity**

Key Elements:	Governance between organisations (GBO) **a Maturity Matrix developed by the Good Governance Institute, 2013** **Progress Levels:**				
	NO	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
1. Joint and Delegated Decision Taking Include reputational risks and potential failure of partners and suppliers.	**NO**	All delegated functions to external organisations are mapped and owned by our managers.	Board has established its risk tolerance for performance by others taking decisions on our behalf.	Board level decision tracking system records decisions taken by others on our behalf.	Audit of decisions taken by others on our behalf reported to Audit Committee, escalated to governing body as appropriate.	Contracts and delegated decision taking improved in light of reviews of joint/delegated decision making.
2. Assurance Independent assurance of partnership and delegated working.	**NO**	Strategic objectives focused governing body assurance framework is established and embedded in organisation.	Potential boundary failures and capacity of partners/suppliers is included in assurance framework with indication of our risk appetite/tolerance.	Independent assurance is available for red flagged risks including partners' systems.	Systems have been tested to demonstrate our own and our partners' ability to respond in timely manner.	Assurance framework includes reputational risk of partners/suppliers and all risks in the framework are checked routinely for potential boundary failure.
3. Continuity of Care Joint commission outcomes and connectivity of care pathways	**NO**	Recognition that patients expect continuity of care	Health and social care services are jointly commissioned and measured on basis of pathway of care where possible	Outcomes are being planned and achieved through focus on Mandate/Intelligent Funding/results based approach	Metrics and Audit shows patients are being managed along pathway of care without delay or confusion	Patient Pathways are main currency of commissioning, planning and enabling better outcomes ,

Good Governance Institute

GBO Matrix Scotland 2020



Good Governance Institute

INTEGRATION JOINT BOARDS
GOOD GOVERNANCE MATURITY MATRIX

Edinburgh Health and Social Care Partnership

DECEMBER 2019

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted	2 BASIC LEVEL Agreement of commitment and direction	3 EARLY PROGRESS IN DEVELOPMENT	4 FIRM PROGRESS IN DEVELOPMENT	5 RESULTS BEING ACHIEVED	6 MATURITY Comprehensive assurance	7 EXEMPLAR
PURPOSE AND VISION	No	Purpose, values, and outcomes debated and priorities formulated for the IJB. The IJB is involved in shaping discussions of purpose and vision of partners.	Purpose & vision agreed, and affirmed in public and internal / partnership documents. IJB has an agreed set of values / principles, which it promostes to others.	National targets and local priorities agreed with the active involvement of stakeholders. Variances from agreed plans and priorities recognised, reported and fully explained.	IJB has a robust and inclusive mechanism for adding and removing services and / or transforming care that matches agreed purpose, values and priorities.	Evidence that sustained progress towards the vision is being made. Purpose and vision are systematically revisited as IJB membership changes and/or annually.	Partner organisations and internal stakeholders understand and support the purpose and vision of the organisation and reflect and acknowledge these in their own strategies and plans.	Success has allowed IJB to redefine or extend its role and influecnce as a recognised model of success and learning.
STRATEGY AND IJB ASSURANCE FRAMEWORK (BAF)	No	Strategic objectives agreed by board and tested with partners. Formal strategic planning in place which demonstrates shared understanding and clarity of outcomes between IJB members	Strategy owned and agreed by IJB, after canvassing views and input from commissioners, partners and other stakeholders.	Board Assurance Framework (BAF) used as key instrument to provide strategic focus for Board and its committees. Operational plans reflect milestones against agreed strategy.	Progress and performance against delivery made on a planned basis during year. IJB has protected long-term priorities from short-term pressures.	IJB continually testing how changes in its operating environment affect delivery of strategy. Main strategic outcomes being met and reported openly.	Evidence that strategic aims are being adhered to, meeting agreed milestones on longer-term trajectory.	IJB is able to demonstrate consistent achievement of strategic goals over the last 3 years and its influence and impact on other stakeholders and communities.
LEADERSHIP AND CAPACITY	No	Roles, expectations and controbutions of all IJB members are clear, with specific roles and role descriptions agreed.	Capacity and skills assessment of IJB linked to strategic purpose and ambition is understood by IJB members. Systematic IJB development programme in place.	IJB development programme is based on prior systematic review and understood by IJB members. Assessment & PDPs in place for both IJB members and executive team.	Succession plan in place. Individual PDPs for directors being delivered with an annual assurance process on impact. Specific development support available for IJB Chair, Committee Chairs, and members	IJB can demonstrate it is visible in leading rather than following a local transformation and service development agenda.	Organisation is identified as being led well against independent standards as an organsiation and system leader.	IJB considred a national leader, providing buddying support to others.
MONEY/VFM	No	Budget, cost pressures & efficiency targets, and their impact, are clearly identified by the IJB.	Effective and efficient processes for agreeing budgets are in place, with choices being made on priorities to agreed timelines.	All in-year plans are costed and trajectory of spend / savings established to achieve breakeven or target. Quality implications robustly tested.	There is evidence of transformation in the use of core resources in support of change and innovation.	Directions are delivering services which are consistently running under benchmark costs.	Headroom has been created for both strategic and tactical investment in developments, change and improvement to services, assets and well-being.	Evidence of successful leverage of wider community resources to improve service delivery and outcomes.
QUALITY, RISK AND AGILITY	No	IJB understands risk at a comprehensive strategic instrument. All known risks identified with mitigation plans in place.	Forward-looking risk system in place for IJB identifying both threats and opportunities . Quality impact embedded in systems.	Risk appetite for key strategic issues and outcomes such as safe staffing levels are known and built clearly into plans/BAF.	Continuity plans and 'what if?' scenarios are regularly used to explore material issues and opportunities, and support longer-term sustainability.	IJB confident it can both anticipate and respond to a crisis/opportunity in a timely fashion. Can quote case studies of successful escalation and intervention.	IJB is able to measure and demonstrate risk appreciation and an agile response to unpredictable and anticipated incidents.	IJB has successful, demonstrable risk mitigation track record over a period of time, recognised by the public. Systems respond well to unknowns as they occur, with high levels of involvement.

WWW.GOOD-GOVERNANCE.ORG.UK

Good Governance Institute

Audit Committee Matrix 2019

AUDIT COMMITTEES MATURITY MATRIX

Produced by John Bullivant, Good Governance Institute and Elaine Dower, 360 Assurance

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 1 - 4

VERSION 2.0 APRIL 2019 - DRAFT

PROGRESS LEVELS / KEY ELEMENTS	PRE-REQUISITES	1 BASIC	2 IMPROVING	3 MATURE	4 NEXT STEPS Fit for future/ independently verified/ best practice shared
1. RELATIONSHIP WITH BOARD	Role and membership of the Board clear and documented	Relationship with Board identified –with Board articulating the assurance required from the AC and the frequency and method of reporting/ escalation.	Requirements established by Board consistently met (inc frequency and method of reporting).	As a result of its work the AC is able to make recommendations to Board on changes to systems of Governance, Risk Management & Control.	AC is proactive in supporting boards ability to handle arising threats and opportunities
2. CLARITY OF PURPOSE/ROLE OF AC	Organisation has clear Strategic Objectives which are consistently interpreted by members of the Board	AC has a ToR with a defined purpose, which identify how the AC supports the organisation achieve its strategic objectives	AC ToR identifies how the AC will fulfil its role through its relationship with other Board Committees.	Programme of work reflects purpose and reorientation away from relying on arms-length regulation and performance management to supporting service improvement and transformation within providers and across systems	Formal annual review and challenge by Board/governors/ stakeholders confirms AC is being effective in supporting board and stakeholders interests
3. RELATIONSHIP WITH OTHER BOARD COMMITTEES	Management and Committees have annually defined purpose and agendas for year	ToR for both AC and other Board Committees identify the other Board Committees	The difference in function is clearly articulated in the ToR (for both AC and other Committees).	Relationship with other Committees is robust, scrutiny/challenge is accepted both to and from others.	Annual review cycle affirms or adjusts purpose of committees for coming year
4. NDEPENDENCE & LEADERSHIP	Independence of Committee referenced in TOR and Induction materials	Roles of AC and other committees formally supported through access to SID	Non-Executive/Lay Member membership with Executive officers in attendance. The Committee sets forward agenda/ work programme to meet its needs and 'commissions'/ requests necessary papers/reports. Established that AC Chair cannot chair another Board Committee.	Committee confident to reject reports/papers if necessary. There is clear evidence of challenge to poor/unreliable sources of assurance. Members can call who they need to the Committee. Chairs of other Board Committees understand the difference in role requirements if they also sit on AC.	AC has begun to challenge wider performance issues such as buying locally, management capacity, green credentials (e.g. supply chain)
5. MEMBERSHIP –SKILLS & KNOWLEDGE	Membership defined and meetings quorate.	Board has identified skills required to reflect holistic approach to all systems within the institution. Any gaps in skills or experience are filled, temporarily if necessary.	Induction and development programme in place for members.	Schedule of observations of other ACs in place and encourage AC members from other organisations to attend AC with clear parameters and methods for providing feedback.	Succession plan in place.
6. ASSURANCE MAPPING	Clear and consistent assurance levels in place across the organisation.	Assurance mapping undertaken at an organisational level (e.g. for BAF purposes). Top down based on assurance required against strategic objectives and underpinning strategies.	Other Board Sub-Committees have completed their own assurance mapping (across all services and facilities to ensure no gaps i.e. bottom up).	The AC has undertaken its own assurance mapping/scrutinised that done by other Sub-Committees.	Independent scrutiny has been commissioned of the assurance mapping.

WWW.GOOD-GOVERNANCE.ORG.UK

Audit Committee Matrix 2019 extras

PROGRESS LEVELS / KEY ELEMENTS		2 BASIC (Principle accepted)	3 EARLY PROGRESS (Agreement of commitment & direction)	4 RESULTS	5 MATURITY	6 EXEMPLAR	7 EXEMPLAR
1. MERGERS, ACQUISITIONS AND DISPOSALS (MAD)		AC has sought and adopted guidance on mergers, acquisitions, disposals and changes in service delivery	AC has shared and imbedded guidance on mergers, acquisitions, disposals and changes in service delivery or setting	MAD are designed to reflect users needs rather than just survival of the organisation i.e. fiduciary duty challenged	Best value is used as model to define who runs what; 5 case model Treasury guidance on investment extended to include sustainable service delivery	Mergers etc successful within agreed timetable. Cultures aligned	Success is shared as better practice with others
2. CONTINUITY OF SUPPLY OF GOODS, SERVICES AND STAFF		Continuity plans sought for critical goods etc	New contracts include continuity clauses and risk sharing in event in supply chain disruption	Alternative sources of supply and storage investigated and secured	Scenarios carried out to test supply disruption	Buying locally is having impact on local economy and strengthening continuity of supply	Continuity system is developed across ICS
3. INTEGRATED SUPPORT AND ASSURANCE PROCESS (ISAP) FOR NOVEL CONTRACTS		AC has defined and identified novel contracts	All parties are aware they are dealing with novel contract status, risks and requirements	Contract procedures are tested and shown as robust enough to avoid challenge and disruption	Risk sharing is evident between commissioners, providers and partners of both	Contracts have been shown to survive challenge and variations in demand and or requirements	ISAP model shared as better practice
4. INTEGRATED CARE SYSTEMS (ICS)		MOU and etiquette in place; expected system benefits defined	Appropriate AC committees in common in place if required	System of scrutiny agreed and joint assurance system in place	Joint Audit process in place with partners for financial, systems and clinical processes	Expected system benefits are being achieved	ICS is making their contribution to critical national improvement programmes, on a comply and explain basis;
5. RESILIENCE TO CYBER THREATS		Information assets and managing the risks to those assets is recognised as a board level responsibility.	Education and awareness training is in place to reinforce staff behaviours that may unintentionally compromise data security	Cyber security focus moving from erecting more barriers to creating greater agility, to provide the capabilities to counter threats as they evolve.	Scenarios are used to test resilience and agility. When defences are breached these are recorded, so that damage is contained	Robust protocols in place to balance data sharing, patient/user confidentiality and system security	Cyber threat agility approach shared as better practice

Good Governance Institute

Audit Committee Matrix 2019 extras: ICS

	BASIC	EARLY PROGRESS	IMPROVING	RESULTS	MATURITY	EXEMPLAR
4. INTEGRATED CARE SYSTEMS (ICS)	MOU and etiquette in place; expected system benefits defined	Appropriate AC committees in common in place if required	System of scrutiny agreed and joint assurance system in place	Joint Audit process in place with partners for financial, systems and clinical processes	Expected system benefits are being achieved	ICS is making their contribution to critical national improvement programmes on a comply and explain basis

Good Governance Institute

HFMA Audit Handbook: ACS Section

1. Focus on processes not operational
2. MOU at least, with scheme of delegation
3. Appropriate challenge
4. Pooled budget arrangements
5. Aligned board meetings and reporting
6. Shared financial control total
7. Shared performance goals
8. Risk share agreements
9. Access to information

Plus

1. opportunity for common ambitious strategic objectives
2. Public reporting such as Integrated Reporting approach

Good Governance Institute

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed with Southwark CCG & BSU v2.2 Nov 2011

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal (ALARP)** (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. Only willing to accept the low cost option. VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Avoid anything which could be challenged, even unsuccessfully. Play safe.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

 ISBN 978-1-907610-12-7

www.good-governance.org.uk

Further information from www.good-governance.org.uk

Key questions

1. With regard to ‘System working’, how can we move this forward at suitable pace, to allow us to demonstrate positive impact for our population?
2. What is the Board’s approach to out of area (STP) contracts? Will we be able to support them or have to novate to providers within home STPs?
3. How are we using Getting it right first time (GIRFT) across the patch? How is it being implemented and successes communicated and how are we measuring and monitoring this programme to deliver better value from our NHS budget?
4. Do we think as a Board that cost improvement initiatives are taken seriously in the NHS? How do we improve this in our Board and our area?

Good Governance Institute

Key questions

1. What do I need to ask my partnership board (or my representative attendees) to provide assurance we can fulfil our duties and strategic objectives?

2. What do I need to ask my own executives to ensure that meeting regional/national mutual aid commitments will not compromise staff and patient safety.

Good Governance Institute

Links

Good Governance Institute https://www.good-governance.org.uk

RCPE Quality Collaborative: https://www.rcpe.ac.uk/careers-training/quality-governance-collaborative

Commission on Governance in Public Services 2030: https://www.nationalcommission.co.uk

Good Governance Ltd / Governance benchmarking: https://governance-benchmarking.org.uk

Integrated Reporting: https://integratedreporting.org

Good Governance Institute

Lunch

brownejacobson LLP

Integrated Care Systems – Partnership Working – Legal requirements and constraints

Gerard Hanratty – Head of Health

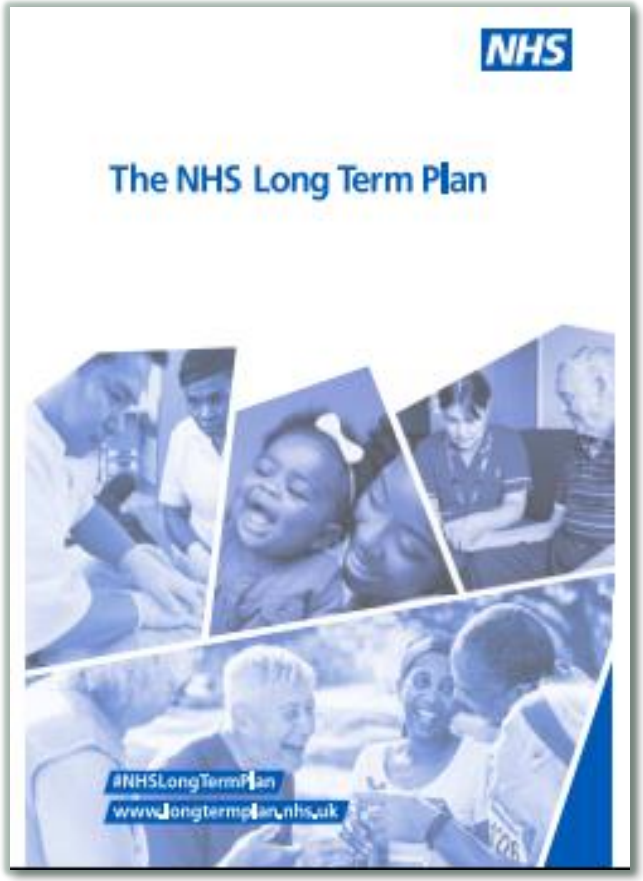
2 March 2020

What is an Integrated Care System?

- Lots of STPs and ICSs have taken time to develop what they think are the aims and ambitions of their system
- This has involved local/regional analysis against central policy expectations and how they fit with statutory functions
- Lack of policy and legislation alignment means that relationships and partnership working are critical to success
- Aim is to integrate the delivery of health and social care in way that works in that STP/ICS area to meet the LTP

NHS Long Term Plan – new service model

- 10 year plan
- Boost out of hospital care and dissolve the divide between primary and community health
- Reduce pressure on emergency hospital services
- More personalised care
- Digitally enabled care
- Move to Integrated Care Systems everywhere



NHS Long Term Plan – full steam ahead?

'Within the first three months of our new term, we will enshrine in law our fully funded, long-term NHS plan.'

What are statutory expectations

- Statutory functions are exercised to enable Business As Usual during STP/ICS development
- For NEDs and Lay Members that relates to some specific expectations around governance, finance, remuneration, patient/public involvement and holding executives to account
- As to liabilities, same test of not acting recklessly and/or criminally
- CCGs – larger role if merged or merging across audit, patient and public involvement and governance

Moving forward

- Still have existing statutory expectations and perhaps some new ones under new legislation and that means application of statutory accountability
- Also have an ICS and its constituent parts of:
  - System – policy [merged/merging CCG may provide statute]
  - Place – statute/policy
  - Neighbourhood – statute/policy
- How will that blend of policy and statute work going forward?

Integrated Care System (1)

- Need relationships/partnership working to enable
- System Level
  - Will need to assure itself
  - Make policy decisions and lead on system strategy
  - Effect of being co-terminus with CCG
  - Role of NEDs and Lay members
  - Role of LA and councillors
- Place Level
  - Statutory organisations and functions
  - Integrated partnership working – how wide?
  - Assurance and challenge

Integrated Care System (2)

- Neighbourhood Level
  - Primary Care Networks and alignment
  - Role of GPs, other health care professionals and social care
  - Lay member PPI role?

- Future
  - Local plans and development
  - Policy and move to system-by-default
  - New legislation

Future - Queen's Speech - Health

- Legislation will enshrine in law the largest cash settlement in the NHS's history [NHS Funding Bill to 2024] and we will deliver the NHS Long Term Plan in England to ensure our health service is fit for the future.
- A Medicines and Medical Devices Bill will ensure that our NHS and patients can have faster access to innovative medicines, while supporting the growth of our domestic sector.
- We will also pursue reforms to make the NHS safer for patients.
- We will provide extra funding for social care and will urgently seek cross-party consensus for much needed long-term reform so that nobody needing care should be forced to sell their home to pay for it.
- We will continue work to modernise and reform the Mental Health Act to ensure people get the support they need, with a much greater say in their care.

NHS recommendations for NHS Bill (1)

- Published 26 September 2019
- 23 recommendations
- ‘An NHS Bill should be introduced in the next session of Parliament. Its purpose should be to free up different parts of the NHS to work together and with partners more easily. Once enacted, it would speed implementation of the 10 year NHS Long Term Plan’

NHS recommendations for an NHS Bill

- Repeal CMA's statutory roles in the NHS as set out in the HSCA 2012 for merger review and licensing or tariff review (R1, R3) – [*effectively position now*]
- Abolish Monitor's specific focus and functions to enforce competition law (R2) [*still CMA*]
- Scrap s75 of the HSCA 2012 (R4) – [*fits with above*]
- Remove commissioning of NHS healthcare services from the jurisdiction of the PCR 2015 (R5)
- New NHS procurement regime (not to be called best value test) (R6) [*cabinet office consultation expected April/May*]

NHS recommendations for an NHS Bill

- New patient choice regulations (R7)
- Specific flexibilities on NHS national tariff formula (R8, R9, R10, R11) [*follows JR challenges*]
- Reverse repeal of Secretary of State's power to establish new NHS trusts, to support the creation of Integrated Care Providers (ICPs) (R12) [*never enacted*]
- Only statutory NHS providers should be permitted to hold NHS ICP contracts [*makes clear focus on NHS delivery*]

NHS recommendations for an NHS Bill

- 'Reserve power' only for NHS E&I to set annual capital spending limits for NHS Foundation Trusts (R13) (but see Health Infrastructure Plan – Oct 2019)
- NHS commissioners and providers should be allowed to form joint decision-making committees on a voluntary basis (R14) [*reduce commissioner/provider split in HSCA*]
- Closer collaboration between NHS commissioners and providers (R15, R16, R18-R22) (and between NHS and local authorities) [*new s.75 NHS Act anticipated*]

NHS recommendations for an NHS Bill

- A new 'triple aim' of better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer (R17) [*fits with overarching function of comprehensive health service*]
- NHS England and NHS Improvement should be permitted to merge fully (R23) [*will some functionality therefore go to ICSs?*]

Potential Future Position

- Focus on integrated delivery across health and social care by public authorities
- Central strategy to direct regional delivery
- Reduction in competition and procurement law constraints
- Potential to create less adversarial mechanism for procurement disputes – tribunal or ombudsman
- Create by statute a Health Service Safety Investigations Body with Medical Examiners to to carry out their functions of scrutiny to identify and deter poor practice; and to ensure that their performance is monitored
- Enable the SoS to create Integrated Care Providers (ICPs) as statutory bodies
- Free up different parts of the NHS to work together and with partners more easily.

Any questions?

Gerard Hanratty

Head of Health

E: gerard.hanratty@brownejacobson.com

T: +44 (0)7921 685815

Humber Coast and Vale Health and Care Partnership

In Pursuit of ICS Status

2 March 2020

Humber Coast and Vale Health and Care Partnership

In Pursuit of ICS Status or Did I Fight in the Punk Wars for This?

2 March 2020

Back to 1948

- National Health Service is established
- Electricity and gas supply industries nationalised
- First new comprehensive schools opened
- HMT Empire Windrush arrives in Britain
- First supermarkets opened

Back to 1948

- National Health Service is established
- Electricity and gas supply industries nationalised
- First new comprehensive schools opened
- HMT Empire Windrush arrives in Britain
- First supermarkets opened

- Lulu, Olivia Newton-John, Chris de Burgh, Rick Parfitt and John Bonham all born

Advances in Medical Care

- Renal dialysis (1945)
- Kidney transplant surgery (1954)
- Linear accelerator (1956)
- Coronary artery bypass grafts (1960)
- CT scanning (1971)
- Coronary angioplasty (1977)
- MRI scanning (1977)
- Gene therapy treatment (1990)

UK Life Expectancy

Gender	1948	2000	2010	2018
Males	66	76	79	80
Females	70	81	83	83

The UK's Ageing Population

	65-75	75-85	85+
2018	6.6m	3.8m	1.6m
2043	7.7m	6.6m	3.0m

The Perils of Old Age

	70	80	90
No difficulty	80%	62%	27%
2 difficulties	4%	8%	10%
5+ difficulties	5%	9%	40%

NHS – Well Organised

The COMMONWEALTH FUND

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**2**	**9**	**10**	**8**	**3**	**4**	**4**	**6**	**6**	**1**	**11**
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11

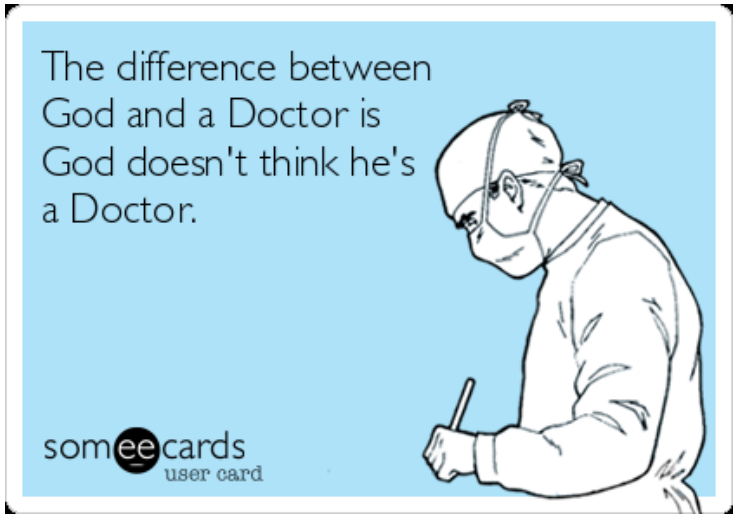
NHS – Effective?

The COMMONWEALTH FUND

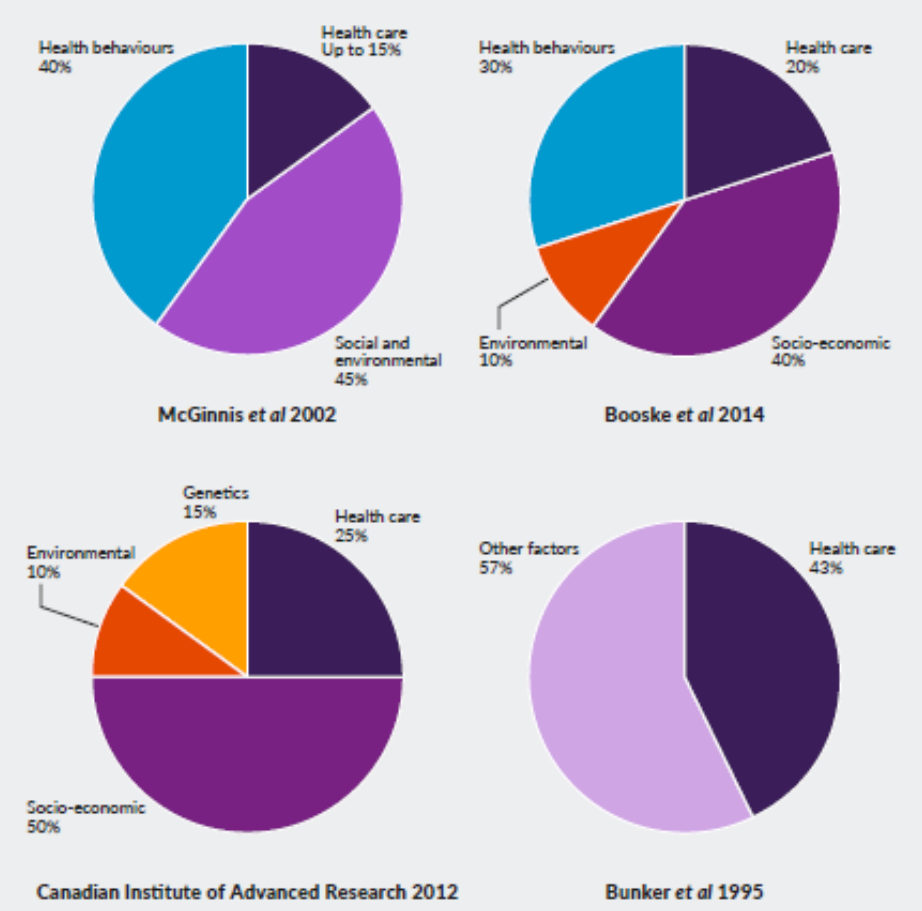
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**2**	**9**	**10**	**8**	**3**	**4**	**4**	**6**	**6**	**1**	**11**
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes	1	9	5	8	6	7	3	2	4	10	11

Inconvenient Truths

- Many illnesses and health conditions can be prevented
- Prevention is more effective (and cheaper) than treatment
- Not all treatments are effective
- Treating people with multiple conditions is difficult and expensive
- Provision of health and care services has a limited impact on health and wellbeing



Determinants of Health



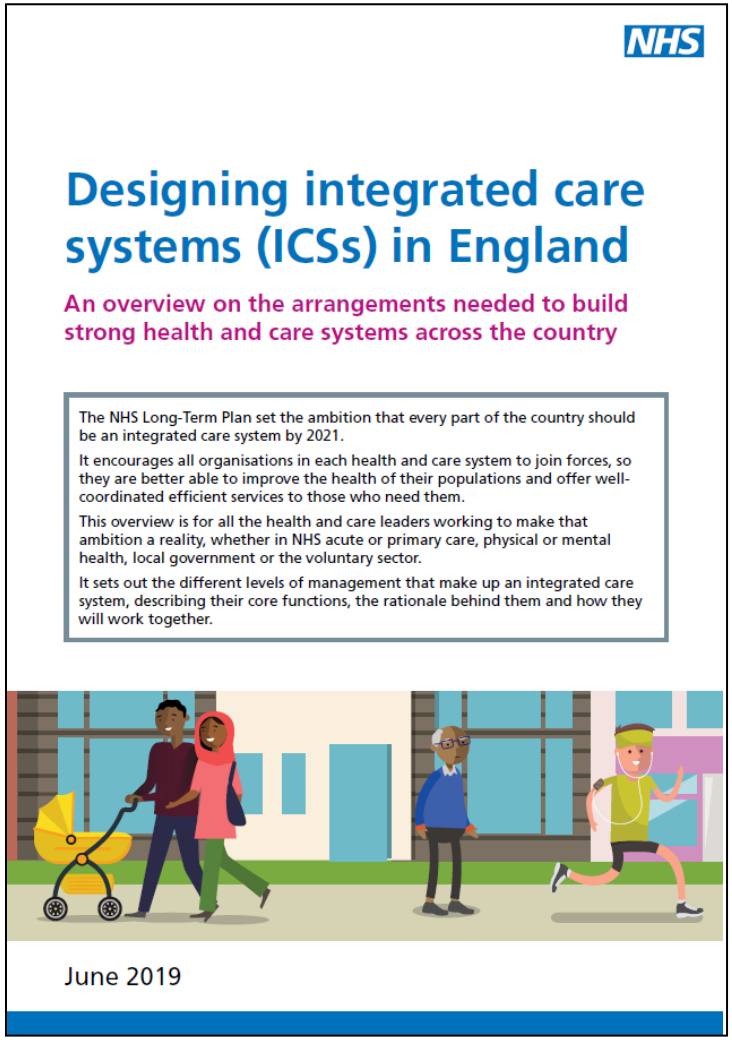
Hierarchy

- Socio-economic
- Behaviours
- Health Care
- Genetics

Health and Care Policy

The NHS Long Term Plan encourages all organisations in each health and care system to join forces, so they are better able to improve the health of their populations.

This overview is for all the health and care leaders working to make that ambition a reality, whether in NHS acute or primary care, physical or mental health, local government or the voluntary sector.



HCV Plan - 2016

- We will focus on the Triple Aims:
  - Improving health and wellbeing
  - Improving services and quality care
  - Improving efficiency
- We want everyone in our area to:

  Start well, live well and age well

- We want to become a health improving system rather than an ill health treating system

Measurements of Success

- Increased life expectancy
- Reduced incidence of ‘preventable’ disease
- Fewer unplanned admissions to hospital of patients with Long Term Conditions
- Increased focus on outcomes rather than contracted activity levels and proxy performance targets

HCV Long Term Plan - 2019

- **Helping people to look after themselves and to stay well**
- **Providing services that are joined-up across all aspects of health and care**
- **Improving the care we provide in key areas (e.g. cancer, mental health)**
- **Making the most of all our resources (people, technology, buildings and money)**

Partnership Update

- ICS Accelerator Programme complete
- Continual Development Plan agreed
- About to start the Population Health Management Programme
- Application for ICS status being finalised
- Hoping to secure ICS status by April 2020

ICS Assessment

- Ability to undertake two core roles
  - System transformation
  - Performance management
- ICS leadership team with sufficient capacity
- Effective governance arrangements
- Effective working with Local Authorities and other partners
- Agreed financial management arrangements
- Confidence in Long Term Plan delivery
- Progress on key system transformation priorities
- Agreed ways of working on key enablers (workforce, estates and digital)

What are STPs, ICSs, Partnerships and Systems?

Final Questions & Close