Proposal – for consideration by all partner organisations

A Strategic Partnering Agreement (SPA) for the Airedale, Wharfedale and Craven & Bradford Health and Care Partnerships

Version 12 (FINAL) – at 27/02/2019

1

Introductory narrative (1)

- The Strategic Partnering Agreement (SPA) is a framework to formalise how we work together
- It builds on how we already collaborate
- It describes an approach to shared decision making on how CCGs' resources *(and potentially those of the Local Authority)* are committed
- It does not take away any statutory authority or responsibilities from Boards or Governing Bodies of the partner organisations
- It is something we could further empower and delegate to
- It does not create a decision taking body

2

Introductory narrative (2)

- It does not create a new legal entity (such as a formal partnership)
- It does not close the market of provision nor remove patient/client choice
- It is not limited to only NHS healthcare services
- It is not the final point for the collaboration of the Parties … there is more work to do, for example:
  - Clarify the Local Authority's position regarding scope
  - Draft terms of reference (ICB, HCPBs etc) to agree
  - Programme reporting arrangements to review
  - Timescales for SPA review to confirm
  - Ways of working across the VCS to develop further
  - Associate membership of other organisations *(not party to the SPA)* to consider

3

Building consensus

Consensus now achieved:

✓ Vision
✓ Objectives
✓ Our approach
✓ Values and behaviours
✓ Community partnerships / localities / HCPs / place
✓ Membership
✓ Leadership principles
✓ Decision making and decision taking principles
✓ Financial and risk management principles
✓ Workforce principles
✓ Partnership (including governance) arrangements

4

Vision

People will be healthier, happier, and have access to high quality care that is clinically, operationally and financially stable.

People will take action, and be supported to stay healthy, well and independent through their whole life and will be supported by their families and communities through prevention and early intervention with greater focus on healthy lifestyle choices and self-care.

When people need access to care and support it will be available to them through a proactive and joined up health, social care and wellbeing service designed around their needs and as close to where they live as possible.

In short … ***Happy, Healthy at Home***

5

Objectives

To improve population health through integrated health, care and support we will:

- ✓ **Deliver** our Bradford District and Craven Health and Wellbeing Plan (sustainable services against a backdrop of increasing demand)
- ✓ **Achieve** greater autonomy and control within community partnerships to develop and transform our community based health, care and support services
- ✓ **Share** collective responsibility for the deployment and management of our resources to secure better outcomes for our population
- ✓ **Develop** population health management capabilities to:
  - improve primary and secondary prevention
  - better target interventions
  - Inform the planning and delivery of services

6

Our approach

- **We need a new integrated approach to leading performance development and culture change, encompassing:**
  - ✓ operational performance
  - ✓ quality and outcomes
  - ✓ service transformation, population health management
  - ✓ finance and efficiencies
- **Our approach must be value adding to the system and where it is sensible to do so to cover Bradford District and Craven 'place' and West Yorkshire and Harrogate. It will feature:**
  - ✓ a single framework, covering individual organisations
  - ✓ an increasing focus on making judgements about a whole system, while understanding the positions of individual organisations
  - ✓ a strong element of peer review and mutual accountability
  - ✓ a clear approach to improvement-focused intervention, support and capacity building

7

Values and behaviours

We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

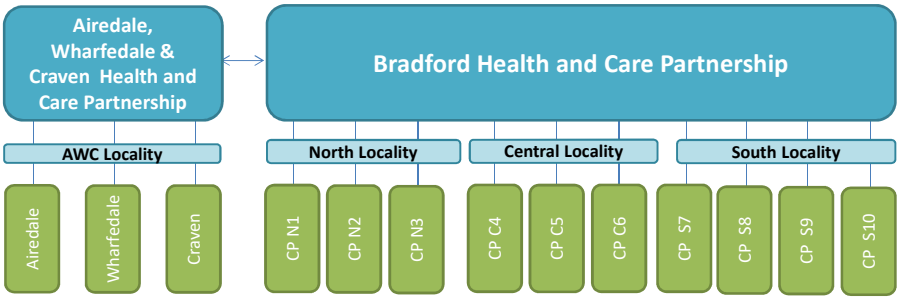
- We are leaders of and within our organisation, our health and care partnership[s] and our place (Bradford District and Craven)
- We support each other and work collaboratively
- We act with honesty and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

8

CPs -> localities -> HCPs -> place

Bradford District & Craven is 1 of 6 places of the **West Yorkshire & Harrogate Health and Care Partnership** (*aka* Integrated Care System *[ICS]*)

We are delivering services in 'place' through 2 local **health & care partnerships** which comprise 4 **localities** and 13 **community partnerships** (people, VCS, GPs, social care providers, community services, intermediate care), four hospitals (AGH,BRI,SLH,LMH), independent and other health and care sector providers (e.g. YAS, LCD, independent hospitals and care home / domiciliary providers)



AWC:
3 community partnerships,
1 locality,
1 health and care partnership

Bradford (City & Districts)**:**
10 community partnerships, 3 localities,
1 health and care partnership

Initial membership (2019)

Airedale,Wharfedale and Craven Health and Care Partnership	**Bradford Health and Care Partnership**
Airedale NHS Foundation Trust	Bradford Care Alliance CIC Ltd *[General Practice]*
Airedale, Wharfedale and Craven CCG	Bradford City CCG
Bradford District Care NHS Foundation Trust	Bradford District Care NHS Foundation Trust
Bradford VCS Alliance Ltd	Bradford Districts CCG
City of Bradford Metropolitan District Council	Bradford Teaching Hospitals NHS Foundation Trust
Local Care Direct Limited (LCD)	Bradford VCS Alliance Ltd
Modality Partnership	City of Bradford Metropolitan District Council
Wharfedale, Airedale and Craven Alliance (WACA)	Local Care Direct Limited (LCD)
AWC HCP Board members /invitees (but not a party to the SPA):	**Bradford HCP Board members/invitees (but not a party to the SPA):**
Members: YOR Local Medical Committee Ltd (LMC) North Yorks County Council / Craven District Council	**Members:** YOR Local Medical Committee Ltd (LMC)
Invitees: Independent sector (e.g. Care Homes, Domiciliary Care) NHSE-commissioned sector (e.g. Community Pharmacy, Optometry, Dentistry)	**Invitees:** Independent sector (e.g. Care Homes, Domiciliary Care) NHSE-commissioned sector (e.g. Community Pharmacy, Optometry, Dentistry)

Leadership principles

We have agreed a set of guiding principles that shape everything we do through our two partnerships:

- We will be ambitious for the people we serve and the staff we employ
- The Airedale, Wharfedale and Craven and the Bradford Health and Care Partnerships belong to our citizens and to commissioners and providers, councils and NHS so we will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing
- 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

11

Decision making and decision taking (1)

Decision making

As a system we will construct and build (make) decisions, in a collaborative way between partners. This may include gathering information, creating and exploring options as a system and exploring potential actions and their implications for the system. Decision making may require detailed analysis, reflections and discussion between partners.

Decision taking

The actual taking of a decision remains with the individual partner organisations, i.e. once a consensus is reached **as a system**, commissioners (as the 'payers') will take their decisions and, similarly, providers will take their decisions around service change.

12

Decision making and taking principles (2)

- Decisions should be made at the most local level possible.
- As a system we will 'make' decisions in a collaborative way between partners.
- Responsibility for decision 'taking' remains with individual partner organisations. Once a consensus is reached as a system, individual organisations will take decisions through their internal governance processes.
- Decisions may be made and taken at WY&H ICS level where any of the criteria set out at 2.12 of the WY&H MoU are met (critical mass, reduce variation, tackle complex intractable issues).
- In the case of new / unforeseen situations, the default is that decisions are made collectively at place level, unless otherwise specified, or agreed.
- Parties may need to specify 'reserved matters' over which the principle of collective decision making cannot apply (e.g. in respect of areas where there are legal or statutory obligations). The onus is on parties to set out these exceptions.

13

Decision making and taking principles (3)

Delegated authority

- Decision making involves a meeting of a group of representative individuals (each of whom has delegated authority to make decisions on behalf of the body they represent). In addition to decision makers, there can also be individuals in attendance at the meetings who do not have decision-making authority but can participate in the discussion.
- Following discussions at, e.g. a programme board meeting, each individual with decision-making rights from the member organisations will take one or more decisions in relation to the matters discussed on behalf of the member organisation they represent. Where the decision requested sits outside of the level of delegated authority for the individual then this would need to form a recommendation from the individual (as part of the governance group) to be taken back into their organisation for approval.
- Each organisation must authorise employees to exercise functions on its behalf in accordance with its own internal governance arrangements. It is particularly important for the purpose of the arrangements that there is clarity as to the scope of the functions which the individual employee is allowed to exercise. This should be supported by the terms of reference for each group which will detail how meetings of the forum will be conducted. Decisions will then be recorded as being taken separately on behalf of each organisation by the individual with decision-making authority.

14

Decision making and taking principles (4)

When consensus cannot be achieved

- Where there are difficult decisions and no consensus agreement is reached then there will be difficulty in ensuring alignment between member organisations. Given the structures, it would be expected that agreement of the strategy, visions and objectives (as well as the principles of working in the SPA) would inform the discussions and minimise any areas of dispute. There is also a dispute resolution process for these to be escalated.
- If particular individuals or organisations are not in agreement with the majority then these arrangements cannot bind them to implement the decision that has been taken by others. Structurally the members of the SPA may then want to consider structuring 'packages' of linked decisions so that different individuals or organisations will be able to achieve consensus, even if a particular small element may be unfavourable to a particular individual or organisation.
- It will be important for each organisation to set out clearly the delegated authority to its representatives within the structure so that there is transparency around where decisions need to be taken.

15

Financial and risk management principles (1)

- The parties will aim to live within their means, i.e. work in the model to the level of resources available to provide services
- We will develop and shape the strategic capital and estates plans across *Bradford District and Craven*, maximising all possible funding sources and ensuring our plans support the delivery of our *health and wellbeing* strategy
- We will ensure that we have the best information, data, and intelligence to inform the decisions that we take

16

Financial and risk management principles (2)

Key assumptions

- All financial decisions should be supported by a rigorous Quality Impact and Equality Impact Assessment process for both transformational and in-year changes
- Future financial investment should be a result of partnership oversight and agreement on commissioning intentions
- Whilst there will not be a detailed risk/reward mechanism in the initial documentation agreed by the parties, the intent is to develop the risk reward mechanism for adoption by FY 2020/21
- The mechanism will be based on the parties' shared desire for payment and incentives to fairly reward effort and to drive the behaviours that the system requires in order to achieve the Objectives

17

Financial and risk management principles (3)

Risk/reward mechanism

- The principles between the partners which will underpin the development of the Risk Reward Mechanism are that:
  - transactional costs should be minimised
  - there will be cost transparency between the parties (subject to compliance with competition law and the need to ensure non-disclosure of commercially sensitive information)
  - definitions of costs are agreed by all parties in advance
  - value for money must be demonstrated
  - no party shall derive unreasonable advantage or suffer unreasonable disadvantage

18

Financial and risk management principles (4)

Finance principles

- There is a need to agree and utilise one set of activity and finance data for the purposes of planning, managing transformational changes, and agreeing any risk reward mechanism
- Commitment to managing NHS expenditure in aggregate across the system, including joint management of stranded costs [focus on costs and expenditure, not tariff or funding]
- We will build on the way WYAT Risk/gain share works as the basis for how we develop for any local agreement
- Implications of any changes resulting in a net NHS deficit will be considered a failure for all NHS parties
- The financial focus for decision making will balance service delivery, quality and safety, and cost/expenditure rather than tariff or funding with the inevitable need to end PbR
- A transition mechanism process is agreed to support the impact of transformative service changes. This may include approaches to managing and mitigating losses and gains, double running costs, and unintended financial consequences

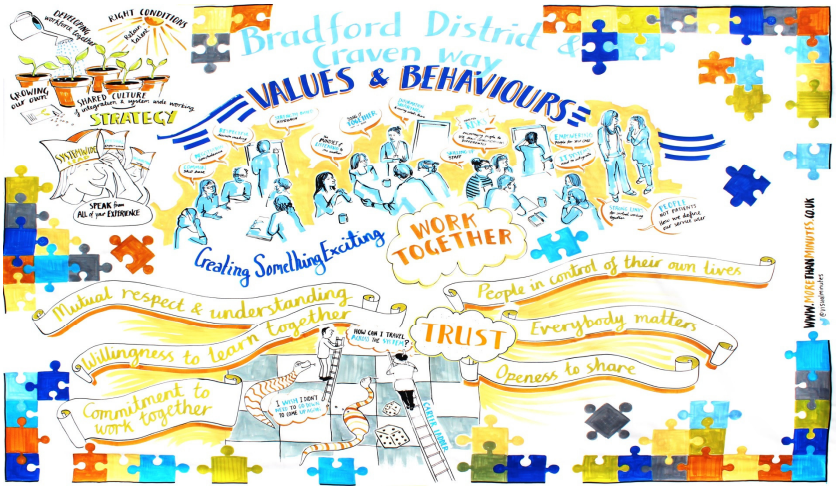
19

Financial resources

- The CCGs' intent is to put all of their £950m commissioning resource into the partnerships and make collective decisions on how it is spent
- The Local Authority will consider which of its commissioning budgets will be in scope of the SPA

Workforce principles (1)

We will work to a co-created and mutually agreed set of 6 overarching 'values' for integrated working - underpinned by a commitment of trust and working together



Workforce principles (2)

More specifically we will:

a. Ensure we keep the person at the centre of everything we do; striving to ensure no decision is taken in isolation of the wider system and taking collective ownership of the key workforce challenges within the system as they present

b. Endeavour to embed an ethos of working for a system rather than an organisation by demonstrating these values in our everyday actions and behaviours through the development of a shared set of core competencies

c. Put difficult workforce issues on the table, with a high support and high challenge coaching approach to effecting change; surfacing the early warning signs of things not working by encouraging a learning and no blame culture

d. Work on the most appropriate footprints to strategically plan our collective workforce; aiming to secure the best people by being inclusive, striving to ensure our workforce is representative of the communities we serve and by working in ways to make employment across our system attractive to all.

e. Optimise the knowledge, experience, skills and strengths of our shared workforce by developing our people together and maximising our collective resources (eg apprenticeship levy) wherever possible

Workforce principles (3)

f. Involve the right people, at the right time to enable workforce transformation; enabling movement around the system to provide the right care and experience for our local people eg streamlining our HR processes and ensuring transferability of statutory mandatory training requirements

g. Develop our workforce in response to current and emerging local population needs; including equipping people for working across new and emerging care pathways and for the digital revolution

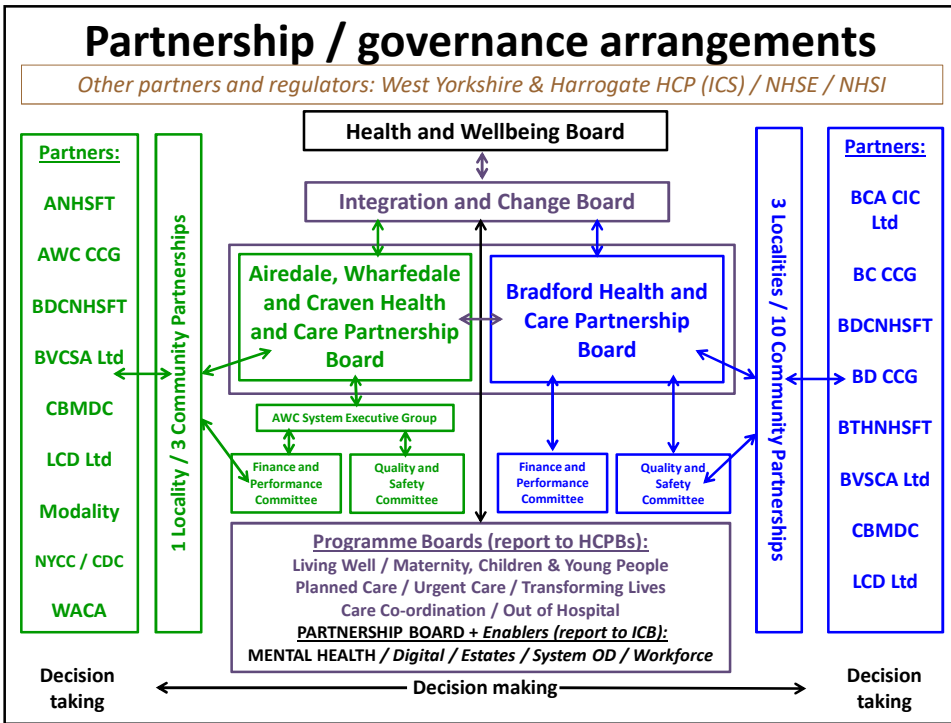
h. Create formal and informal opportunities for our leaders to develop together as system leaders; systematically using evidence based approaches

i. Take collective responsibility for proactively supporting the health and well being of our workforce; retaining staff by being good employers and offering flexible working and career opportunities across the system

j. Work collectively to develop agreements to retain talent within the system; retraining people and supporting them to transition to new roles, in particular during times of organisational change (whilst recognising and working within employers statutory responsibilities)

23

Partnership / governance arrangements



Appendices

The following slides are included for information and to stimulate discussion

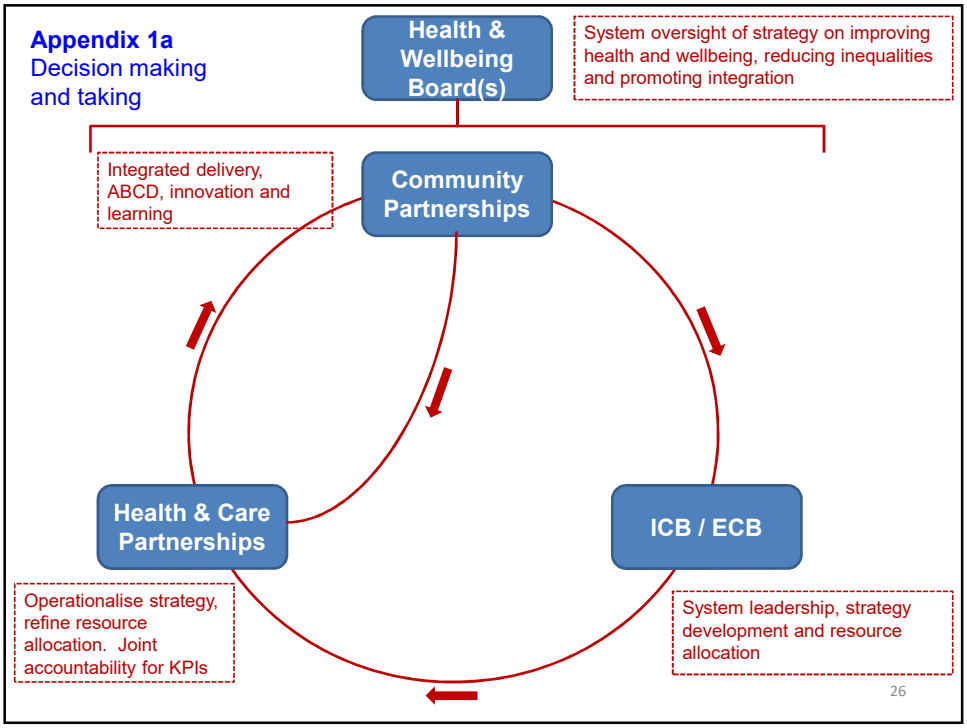
1a – 1i: Decision making and decision taking

2: Workforce principles – 'stress testing'

3a – 3c: Proposed structure of the SPA

25

Appendix 1a
Decision making and taking



26

Appendix 1b
Decision making and taking

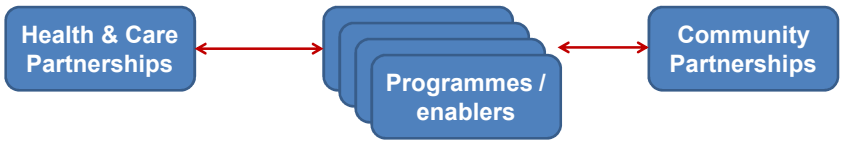
	Processes	Outputs
Community Partnerships	Integrated delivery, ABCD, innovation and learning	Operational Delivery Tactical resource allocation Learning – inform strategy. Operational plan and resources
Health & Care Partnerships	Operationalise strategy, refine resource allocation. Joint accountability for KPIs .Take a systematic, whole population focus to improve management of risk	Operational plans Enabling requirements Refined resource allocation Programme oversight
ICB / ECB	System leadership, strategy development and resource allocation	Vision and Outcomes Happy Healthy at Home Resource allocation Interface with ICS
Health & Wellbeing Board(s)	System oversight of strategy on improving health and wellbeing, reducing inequalities and promoting integration	Joint Health and Wellbeing Strategy JSNA

27

Appendix 1c
Decision making and taking

Roles of programmes and enablers

- Overall purpose is to deliver the changes required to achieve our strategy
- Provide expert guidance and recommendations to HCPBs to enable them to create an operational plan for the delivery of our strategy
- Work with Community Partnerships to deliver 'where the work happens'
- Inform strategy and prioritisation by HWB, ICB, ECB
- Operate within mandate provided by HCPBs
- Customers of support from Enablers (along with the rest of the system)

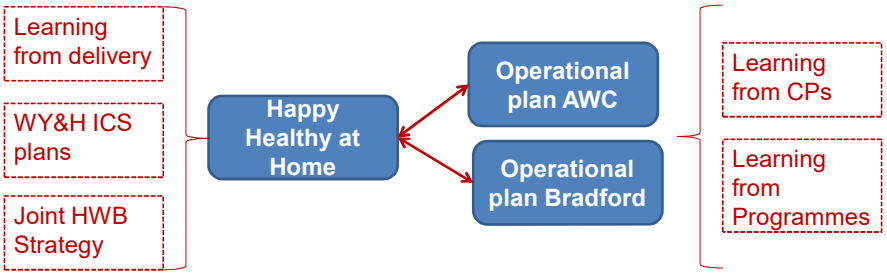


28

Appendix 1d
Decision making and taking

Alignment of strategies and plans

- We have one strategy: *'Happy, Healthy at Home'.* Informed by learning from Community Partnerships, Programmes and HCPBs, as well as Joint Health and Wellbeing Strategy and WY&H ICS Plan.
- We have two operational plans for the delivery of our strategy in AWC and in Bradford, owned by HCPBs. Informed by Community Partnerships and Programmes



29

Appendix 1e
Decision making and taking

Types of decision making

	Community Partnerships	Health & Care Partnerships	ICB / ECB
Strategy			✓
Resource allocation	✓	✓	✓
Operational deployment	✓	✓	
Change (programmes projects)	✓	✓	✓

30

Appendix 1f
Decision making and taking

Types of decision making

	Definitions	Examples
Strategy	Long term direction setting – Vision for the future, identifying the gap compared to current reality, and how we will change. What and how we want to be.	Organisational strategies, shared system strategies and plans.
Resource allocation	Setting budgets, spending money, allocation of financial resource in line with strategy, and setting expectations on value for money	Programme budgeting – e.g. more on X / less on Y. Funding projects
Operational deployment	What teams do, how, where and when they work, which other teams they align to, which people/ citizens they work with	Decision to co-locate teams/ manage them together/ focus on people with multiple LTCs etc
Change (programmes projects)	Not 'business as usual'. Deciding which changes to make in order to deliver strategy. Structured delivery (programmes projects)	Establishment of system programmes and projects. Delivery and governance of the same.

31

Appendix 1g
Decision making and taking

Roles of provider alliances

- Overall purpose of provider alliances is to foster a culture of collaboration rather than competition
- Accountability of provider alliances is to their member organisations.
- Provider alliances are not decision making bodies, except where the member organisations of an alliance agree to delegate elements of their own decision making responsibility to the alliance.
- Provider alliances may provide expert guidance and recommendations to 'the system' where any of the system decision making groups (e.g. ICB or HCPBs) request that and the provider alliance agrees. Scope and requirements should be clearly defined.

32

Appendix 1h
Decision making and taking

Roles of elected members

Community Partnerships

- Ward members may be active participants in their local Community Partnership. Bring the community voice. Connect and align Ward Forum and Community Partnership activity and decision making.

Health & Care Partnerships

- Elected members, particularly Portfolio Holders may attend the HCPBs where designated as representatives of the Local Authority. Learn, gain assurance, align HCPB and LA decision making (where elected members make decisions).

Health & Wellbeing Board

- Membership of HWB, including as Chair. HWB is a formal committee of the Council. HWB sets high level strategy for health and wellbeing and maintains oversight of the health and care system, including duties to promote integration and address inequalities.

Overview & Scrutiny Committee(s)

- Elected members scrutinise health and care decisions and their implementation via the OSC and the joint OSC in relation to the ICS

WY&H ICS Partnership Board

- Elected Members will be part of the WY&H ICS Partnership Board, which will provide non-executive oversight of the ICS, and consider recommendations from the System Leadership Executive. Also has a role in dispute resolution.

33

Appendix 1i
Decision making and taking

Decision making and the non-executive role

- CCG lay members and non-executive directors (NEDs) would potentially have a role in strategic changes and holding systems to account, around challenge and scrutiny. In addition to the existing processes in member organisations, we may also want to have a local non-executive/CCG lay member voice within the structure which by way of example could be through either:
  - developing joint lay member and NED networks; or
  - have named NEDs and/or CCG lay members with responsibility for engaging with the wider system.

34

Appendix 2: Workforce principles 'stress test'

The workforce principles were tested and amended/agreed accordingly using the following 3 scenarios as a 'stress test':

1. **Nationally imposed challenges (e.g. reductions in running costs)**
   - Putting difficult workforce issues on the table and taking collective responsibility for solving and addressing a challenge that would have traditionally been expected to be dealt with by the affected organisation
   - Strategically planning our workforce and having collective HR agreements for retaining staff in the system
2. **A system wide pathway (e.g. diabetes)**
   - Keeping the person at the centre of everything we do
   - Embedding an ethos of working for a system rather than an organisation
   - Training and developing our leaders and workforce together in response to local and emerging needs and new roles and pathways
   - Maximising our collective resources to develop our shared workforce
3. **Taking and implementing local procurement decisions that have implications for services in the wider system**
   - Striving to ensure no decision is taken in isolation
   - Putting difficult workforce issues on the table, with a high support and high challenge coaching approach; surfacing the early warning signs of things not working well by encouraging a learning and no blame culture
   - Having collective HR agreements for retaining staff in the system
   - Developing our leaders together
   - Living our values

35

Appendix 3a: Proposed structure of the SPA (1)

- In view of the timescales for implementing this new approach (April 2019), initial implementation is likely to be through a **new "alliance-style" agreement** for all parties.
- The SPA is then an enabling agreement to set up the collaborative working and governance between the parties on the terms of the operating framework focussed on jointly meeting the objectives and operating under the principles. It will cover the relationship between the parties – both commissioner and provider – across the systems.
- There will be areas of the agreement which are intended to be "legally binding" and these will be made clear. The areas which are specifically legally binding will include Information Sharing / Conflicts of Interest, Charges and Liabilities, Confidential Information and Intellectual Property.
- Some areas of the SPA will be more aspirational and others will be selective depending on the legal nature of the organisation (for instance the Local Authority may not be permitted to sign up to all the obligations in the SPA in a similar way to the WY ICS MoU) but all parties will enter into the SPA intending to honour their commitments to each other.
- Costs and liability will remain for each party to bear their own unless you otherwise agree.
- The SPA will facilitate the parties developing up plans for the key service areas together and these could then be appended to the SPA schedules.

36

Appendix 3b: Proposed structure of the SPA (2)

- The SPA would not just be about NHS services and is intended to work with all parties who are signed up whether or not they hold an NHS Contract.
- The governance under the SPA does not replace the parties own internal governance and there is no voting as the decisions are based on a consensus approach – if a party doesn't agree it is not bound to follow the other parties decision.
- The SPA will not override or replace any element of the current services contracts – the SPA is around the relationships and development of a more integrated approach for the system and not replacing existing services contracts. The intention is that the parties will work together to identify areas of cross over and integration and where appropriate they could look to make some variations (limited in line with law) but this would be via agreement of the relevant parties.
- The SPA should set out via the Operating Framework a method to enable a more collaborative approach to deliver services across organisational lines in accordance with the objectives.
- There is no financial / risk sharing initially in the SPA – there could be principles and a mechanism to start to work towards this but any such modelling and any changes to services contracts would need to be under the current processes or by agreement with the relevant parties.
- The parties will be able to add additional parties into the SPA by agreement and where they agree to sign up to comply with the SPA terms.

37

Appendix 3c: Proposed structure of the SPA (3)

Clauses or schedules to the **SPA** will be prepared to cover:

- Legal status of this Strategic Partnering Agreement (i.e. define which clauses are legally binding)
- Terms of Reference of the ICB, AWC HCP Board, the Bradford HCP Board and any sub-committees of either of the HCPBs
- Management of and ownership of Intellectual Property Rights
- Charges and liabilities between the Parties
- Change mechanism
  - process for developing changes to Services Contracts
  - role of the Programmes
- Sharing information and managing conflicts of interest
- Disputes and complaints resolution
- Monitoring and review of the performance under the SPA
- Termination, withdrawal and exclusion

38