Mechanisms for collaboration across health and care systems

Version 1: November 2018

Chapter 1. Introduction

1.1 Purpose

This document is designed to help health and care systems formalise collaboration between their constituent organisations. It is particularly aimed at those systems looking to become Integrated Care Systems (ICSs), or current ICSs seeking to strengthen their existing collaborative working arrangements.

Each ICS's collaborative, governance and commissioning arrangements should support the system's wider objectives and help to improve both quality of care and health and wellbeing for its population. Successful health and care systems are enabled by effective leadership and positive collaboration between organisations. Strong governance should support strong relationships but cannot replace them.

This document draws on work to support the development of governance arrangements in the first ICSs and has been developed in partnership with those systems. It will be of value to CCGs, NHS providers and local authorities in ICSs and Sustainability and Transformation Partnerships (STPs).

Chapter 1 provides an overview of the basic 'building blocks' of an ICS.

Chapter 2 provides an overview of the legal options for formalising collaborative decision-making arrangements between statutory organisations.

Chapter 3 describes the structures that are being used within systems' building blocks, spanning neighbourhoods, places and systems.

Annex A provides detailed technical information on each of the options available for collaboration, expanding on the information set out in Chapter 2.

In addition to the mechanisms described in this document, systems will need to ensure strong engagement with patients, the public and staff and promote a culture of collaboration and transformation.

Key messages

Strong governance should support strong relationships; it cannot replace them.

There are a number of mechanisms that can be used to support collaborative working within systems: across commissioners (including the NHS and local authorities), across providers, and between commissioners and providers.

1.2 Background

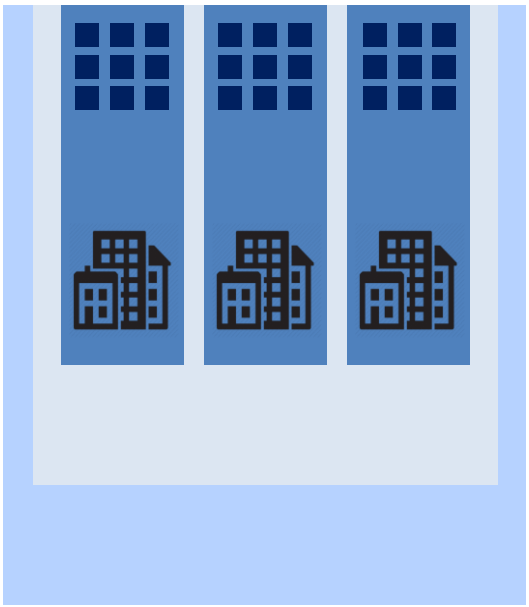
The ICS programme, announced in '*Next Steps on the NHS Five Year Forward View'*, encourages commissioners and NHS providers, working closely with primary care networks, local authorities and other partners, to take shared responsibility for how they use their collective resources for the benefit of local populations in ways that are consistent with their individual legal obligations. Whilst statutory functions, accountabilities and structures are not changing, ways of working are.

1.3 Emerging ICS building blocks

The first ICSs have identified three 'building blocks' within their systems:

- **neighbourhoods** serving tens of thousands of people with networked primary care;
- **places** serving hundreds of thousands of people, particularly focused on improving and expanding community-based services and improving integration with acute hospital services; and
- **systems** mostly serving a million or more people across several places by developing and overseeing implementation of overall strategic goals and strategic planning.

These are shown in figure 1 and chapter 3 describes the structures being used in the building blocks. These building blocks require new ways of working to join up commissioning and delivery of health and care services.



Level	Pop. Size	Purpose
Neighbourhood	~50k	• Strengthen primary care • Network practices • Proactive and integrated models of care
Place	~250-500k	• Borough/council level • Integrate primary, community, council and hospital services
System	1+m	• System strategy and planning • Implement strategic plan
Region	5-10m	• Hold systems to account • System development • Intervention and improvement

Figure 1 – Integrated Care System Building Blocks

Chapter 2. Legal options for collaboration

ICSs are not statutory organisations, but the bodies which form them are. Whilst operating as a system after forming an ICS, commissioners, NHS providers and local authorities all retain their individual statutory duties.

Different partners within ICSs each have distinct statutory obligations. The legislative framework allows for some flexibility in how duties are met or powers exercised, in particular in relation to CCGs, but is predicated on distinct duties for commissioners and providers. As such, it is important to have a clear understanding of the statutory functions of CCGs and NHS providers. The legislation sets out:

- the statutory duties of CCGs and NHS providers – the 'must dos' that they are legally responsible for delivering; and
- the statutory powers of CCGs and NHS providers – the things that they may do.

The term 'function' is used to describe these statutory duties and powers.

For CCGs, there are c.215 statutory functions, which consist of:

- 'commissioning' functions e.g. those relating to commissioning health services; and
- 'non-commissioning' (corporate) functions e.g. those relating to governance of the CCG or employment of its staff.

The distinction between the two groups of functions is important because it is possible for a CCG to enter into a Joint Committee arrangement incorporating its commissioning functions but not its corporate functions. CCGs can operate Committees in Common to exercise corporate functions.

CCGs are accountable and responsible for the delivery of their functions and these cannot be delegated. However, they can ask others, e.g. providers and commissioning support units, to carry out on their behalf 'commissioning activities' related to these functions. For example, a CCG may agree contractual arrangements whereby an Integrated Care Provider (ICP) takes action to support the discharge of certain CCG duties.

NHS trusts and NHS foundation trusts are similarly accountable and responsible for the exercise of their statutory functions, although they may sub-contract the provision of services to third parties, provide goods or services to one another and enter arrangements to provide services collaboratively.

Whenever NHS bodies and their partners are considering proposals for collaboration, it is important that they identify and record their rationale for entering into collaborative arrangements. Considering the 'triple aim' that was set out in the NHS Five Year Forward View – improved health and wellbeing, transformed quality of care delivery and sustainable finances – should assist in developing the rationale for

change. Local systems must be able to describe how they expect integration between the organisations involved to benefit patients.

Where organisations seek to work closely together, there are two approaches to decision-making:

- Joint decision-making – where a single decision is made using a process which binds multiple organisations e.g. joint committees.

- Aligned decision-making – where separate decisions are made by different organisations, but the process and setting for these decisions is designed to encourage the organisations to take decisions that are the same or complement each other e.g. forums.

As set out in the technical annexes of this document, NHS legislation allows for joint decision-making between groups of commissioners including CCGs, local authorities, combined authorities and NHS England. There is also some scope for NHS trusts and foundation trusts to join up their decision-making.

Commissioners and providers will want to consider how they can embed approaches to problem-solving and create behaviours within their local systems which build consensus and support aligned decisions across the system. They will also want to develop processes for handling disagreements between the organisations involved. A Memorandum of Understanding between all local organisations, or Terms of Reference for a Forum Agreement (described in Annex A), are among the tools which can be used to promote alignment.

Collaboration between commissioners and providers must also be undertaken in a way which is consistent with commissioners' obligations in relation to public procurement, patient choice and competition, such as the Procurement, Patient Choice and Competition (No.2) Regulations 2013, including[1]:

- acting transparently and proportionately;

- treating providers equally and in a non-discriminatory way;

- commissioning services from one or more providers that are most capable of meeting people's needs, improving the quality of services and improving efficiency in the provision of services;

- managing conflicts of interest; and

- not engaging in anti-competitive behaviour, unless to do so is in the interests of people who use NHS services.

Providers also need to consider their duties in respect of patient choice and competition, for example under the NHS provider licence.

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[1] https://improvement.nhs.uk/resources/procurement-patient-choice-and-competition-regulations
https://www.gov.uk/government/collections/procurement-choice-and-competition-in-the-nhs-documents-and-guidance

It is likely that local health and social care systems will wish to implement a number of the options for collaboration simultaneously to maximise the potential for integration.

2.1 Collaboration mechanisms summary table

Figure 2 gives an overview of the different mechanisms to enable collaborative working. The organisations within ICSs will need to determine which of these options may be suitable for them, obtaining governance and legal advice as necessary. Further detail about the different mechanisms is contained within Annex A.

Systems can operate a number of these mechanisms simultaneously. For example: shared posts can be used alongside joint committees; and different committees may be able to meet at the same time (in the case of joint committees between CCGs and CCG committees in common) or on the same day (for meetings involving different groups of commissioners and providers).

Mechanism	Collaboration can involve	Description of mechanism	Further Info
Forum Arrangements / Alliance Agreements	CCG/LA/ provider	• A group of individuals who have delegated authority to take decisions on behalf of the organisations they represent come together as a group to discuss matters of common concern. In addition to the decision-makers, there can also be individuals in attendance who do not have decision-making authority but can participate in the discussion in the forum setting. Following such discussions, each individual with decision-making rights will take one or more decisions in relation to the matters discussed on behalf of their organisation. • Alliance agreements built upon forum arrangements could also be put in place by organisations seeking to collaborate with each other.	Technical Annexes 1 and 2
Shared Posts	CCG/LA/ NHS provider	• Individuals working for CCG(s) and/or LA(s) and/or NHS provider organisation(s) simultaneously. Where necessary the individuals should be employees of all organisations for which they are making decisions. • In some instances, individual posts may be shared between organisations; in others, the whole management structure may be shared.	Technical Annex 3
Committees in Common (CIC)	CCG/CCG Or NHS provider/ NHS provider	• CCGs that wish to align decision-making or NHS providers that wish to align decision making form committees with the same membership for this purpose. • Each CCG (or NHS provider) should form a committee with membership comprising one or more of its own employees and one or more employees from each of the other participating CCGs (or NHS providers). The committees of each CCG (or NHS provider), with their common membership, meet at a common time and place where decisions can be taken on behalf of each of the participating CCGs (or NHS providers). • These CICs should each work according to the same agenda and consider the same papers. A single discussion can take place, considering the matters of common concern to the CCGs (or NHS providers), but also addressing issues of specific concern to one or more CCGs (or NHS providers).	Technical Annex 4
Mergers and Acquisitions	CCG/CCG Or NHS provider/ NHS provider	• CCGs can apply to NHS England to merge with other existing CCGs, or to dissolve an existing CCG and transfer member practices to other existing CCG(s). • NHS providers may, subject to relevant approvals, merge with – or acquire – other NHS providers.	Technical Annex 5
Lead Commissioning, Joint Commissioning, Joint Committees and Pooled Funds	CCG/CCG	• CCGs can exercise commissioning functions on each other's behalf, exercise commissioning functions jointly and/or form a pooled fund. CCGs can make payments to each other and make staff and resources available to each other.	Technical Annex 6
Corporate Joint Venture	NHS FT/ NHS FT Or NHS FT/ Independent provider	• NHS foundation trusts have the power to invest money "for the purposes of, or in connection with, their functions". These investments may include forming bodies corporate or acquiring membership of bodies corporate. • A corporate joint venture can hold commissioning contracts, employ staff and own property (including intellectual property).	ACC Guidance
Contractual Joint Venture	Provider/ Provider	• Such ventures do not establish new bodies but can create legally binding rights and responsibilities. Current examples include contractual joint ventures for pathology services.	ACC Guidance
Partnership arrangements between prescribed NHS bodies and LAs **s.75 NHS Act 2006**	CCG/LA Or NHS provider/ LA	• S.75 allows for two or more organisations comprising at least one prescribed NHS body and at least one LA to enter into arrangements including: a) An NHS body exercises its NHS functions in conjunction with exercising health-related functions on behalf of one or more LAs b) An LA exercises its health-related functions in conjunction with exercising NHS functions on behalf of one or more NHS bodies c) The establishment and maintenance of a pooled fund d) Creating a Joint Committee to manage the arrangements at (a) to (c) above e) One or more prescribed NHS bodies making staff, goods, services or accommodation available to one or more LAs in connection with the arrangements at (a) and (c) above, or vice versa.	Technical Annex 7

Figure 2 – Collaboration mechanisms summary table

Chapter 3. Structures within systems' building blocks

This chapter describes the emerging structures that are being used within systems' building blocks, to formalise:

- primary care networks at neighbourhood level
- local commissioning and integrated providers at place level
- whole system collaboration and NHS commissioner collaboration at system level.

We will develop more detailed case studies to accompany this document over the coming months.

3.1 Level: Neighbourhood (primary care networks)

Primary care networks are likely to be formed around natural communities or neighbourhoods based on GP registered lists, often serving populations of around 30,000 to 50,000 and also involving other primary care services, NHS community services, social care, the voluntary sector, and those aspects of secondary care that could be effectively delivered in primary care settings.

'Refreshing NHS Plans for 2018-19' set out the ambition for CCGs to actively encourage every practice to be part of a local primary care network by the end of 2018/19. Returns from CCGs show that c.85% of the country is now covered by primary care networks. NHS England is developing a primary care network reference guide that helps to set out the core components of networks and provides information to local systems on how to develop and implement network-based models (building for example on learning from the new care models vanguards and Primary Care Homes sites). The draft guide has been tested through a series of regional roadshows during the autumn of 2018 and is due to be made available following the publication of the Long Term Plan. Further information is available at: https://www.england.nhs.uk/gp/gpfv/redesign/primary-care-networks/.

Where primary care providers have chosen to come together, creating a Memorandum of Understanding or network agreement can help support collaborative working. Such agreements can set out the governance of the primary care network, how providers will work together, how decisions will be made across providers and how assets or workforce may be shared. There is not a single model for collaboration and the approaches that work optimally for systems will depend on a range of contextual factors, such as the current configuration and maturity of networks, integrated models in place or in development across the full spectrum of 'out of hospital' care, and organisations that can represent the voice of primary care at both the place and system level.

3.2 Level: Place (local commissioning and integrated providers)

Some services will be commissioned and provided at a place level, usually covering a council or borough and a population size of up to c. 500k people.

Local commissioning

To enable integrated joint commissioning at place level, CCGs and local authorities are using Joint Committees underpinned by s.75 agreements. Some have also used joint CCG/local authority appointments.

For example, in Bedfordshire, Luton and Milton Keynes, the ICS is being built around integrated place-based commissioning between the CCGs and local authorities.

Some CCGs are choosing to operate on a scale larger than place. In this instance the Accountable Officer may be supported by senior executives with responsibilities for places or localities. This can give local partners, including member practices and local authorities, confidence that they are engaging with leaders who are focused on local priorities.

Integrated providers

A number of approaches or mechanisms are available for providers to collaborate and integrate with each other at the local level. These include joint appointments, mergers and arrangements such as collaboration agreements. One of the most common approaches that we are seeing is the signing of alliance agreements, built upon forum arrangements between provider organisations.

Mid-Nottinghamshire have had an alliance agreement in place since April 2016 between key providers, the CCGs and local authority. It has a duration of ten years, with a break clause at year three. There has been development and implementation of a number of alliance-wide pathways including: care navigation, multidisciplinary teams (MDTs), new end of life care pathways, integrated discharge, diabetes pathways, and a ‘single front door’.

3.3 Level: System (integrated care system)

At the level of the ICS – usually a population size of over one million - there will be a whole-system approach to the commissioning and provision of services. There will typically be two main types of collaboration at this level: collaboration between all parties in the system (including commissioners and providers); and collaboration between NHS commissioners.

Whole system collaboration – e.g. a strategic partnership group

Forum arrangements between providers, CCGs and local authorities can enable whole system collaboration. A forum arrangement involves a group of individuals each of whom has delegated authority to take decisions on behalf of the body they represent. These individuals will come together as a group to discuss matters of common concern to the organisations. In addition to the decision makers, there can also be individuals in attendance who do not have decision-making authority but can

participate in the discussion in the forum setting. Following such discussions, each individual with decision-making rights will take one or more decisions in relation to the matters discussed on behalf of the organisation they represent. For example, this forum could be responsible for developing and overseeing implementation of a system strategy.

When collaborating systems may choose to:

- Establish a system level governance structure This could include:
    - A strategic partnership group – a forum which brings together chief executives or representatives from the system's constituent organisations who collectively provide strategic direction for the system as whole.
    - A programme group – comprises the programme team who are responsible for ensuring the delivery of the strategy; this may be a subset of the overall partnership group.
    - A project management office/secretariat – supports the leadership groups to function effectively by providing performance management information and secretariat support, documenting decisions and ensuring governance processes are followed.
- Have leaders document how the system will work together, potentially in a Memorandum of Understanding (MoU) between organisations. This could include:
    - setting out values, principles and objectives which are agreed by all the organisations in the system;
    - mapping accountabilities and how organisations hold each other to account;
    - agreeing dispute resolution processes; and
    - clarity on decision-making rights.

Alongside this, systems should focus on securing the capability to meet their overall objectives and implement their transformation agendas. The mechanisms for collaboration are an enabler for systems to work more closely together and ensure effective transformation.

Systems that are introducing new decision-making arrangements will need to follow proper governance procedures and ensure they meet legal requirements, seeking legal/specialist advice where necessary.

NHS commissioner collaboration

Some ICSs have a single CCG so will not need an additional mechanism for commissioning at the system level.

For those ICSs with more than one CCG, commissioners will collaborate to take single commissioning decisions for the system where appropriate.

For example, Lancashire and South Cumbria is planning for some commissioning decisions relating to mental health services, including in-patient beds and urgent and emergency mental health, to be taken at the system level in future.

Under this scenario both a Joint Committee of CCGs (to take decisions on CCG commissioning functions), and CCG Committees in Common (to take decisions on corporate CCG functions) will need to be put in place. CCGs may also wish to put in place joint appointments within their management structures.

The Joint Committee and CCG Committees in Common will ensure alignment and joined-up decision making between the CCGs. The Joint Committee and CCG Committees in Common can, in practice, consist of the same individuals and meet at the same time. However, the participants must at all times have a clear understanding of which functions they are exercising and in what capacity.

3.4 Level: Region (NHS England and NHS Improvement)

NHS England is responsible for directly commissioning: primary medical services; dental services (including secondary care dental); pharmaceutical services; ophthalmic services; specialised services; section 7A public health services; services for members of the armed forces; and health and justice services. It currently commissions these services at a national, regional or sub-regional level. However, there may be a case for commissioning some of these services at a more local level or at least ensure that pathways are aligned between regions and ICSs.

NHS England has largely delegated the exercise of its primary medical service functions to CCGs. NHS England is exploring the extent to which CCGs and local authorities within ICSs can be involved in the exercise of other NHS England functions and, building on the work of the devolution programme, the mechanisms that could be used for sites that wish to do so.

3.5 Emerging system governance good practice

There are a number of emerging elements of good practice that systems may wish to adopt to enhance the effectiveness of their collaborative arrangements. These have been identified from several leading systems:

- CCG lay members and non-executive directors (NEDs) have important roles in leading strategic changes and holding systems to account, promoting a culture of challenge and scrutiny. In addition to the existing processes for challenge in constituent organisations, systems should look to build a strong local non-executive/CCG lay member voice within their systems:
    - this could be through developing joint lay member and NED networks;
    - it may also be helpful to have named NEDs and/or CCG lay members with responsibility for engaging with the wider system.
- Clinically driven transformation is crucial, and we recommend that a clinical lead is appointed and that clinicians are embedded in work streams. Most STPs and ICSs have set up clinical groups as senior advisory forums.

- Successful local systems will take a prominent role in managing system-wide resources and driving efficiency improvement. We recommend that systems appoint a finance lead and embed finance leads within work streams.

- Clear information governance arrangements should be embedded in the work of ICSs. There should be clarity as to the legal basis for information sharing and a common understanding of how the rights and expectations of individuals are being respected. Further information is available from the Information Governance Alliance hosted by NHS Digital.

- In partnership with the Local Government Association, NHS England and NHS Improvement have developed the System Governance and Leadership Support Framework. The Framework, which can be found in Annex B, provides a diagnostic tool to help systems understand their development needs and support action planning.

- Local systems should understand and adopt the principles for the management of conflicts of interest as set out in *'Managing Conflicts of Interest in the NHS'*, particularly with reference to considerations regarding outside employment and loyalty interests of decision makers. CCGs within an ICS will continue to be required to fully comply *with 'Managing Conflicts of Interest: Revised Statutory Guidance for CCGs'*.

Annex A. Technical Annexes

A.1 Forum agreements

Organisations this mechanism is relevant for

Forum agreements can enable collaboration between CCGs, local authorities and providers. They promote alignment between organisations, while preserving the decision-making autonomy of each organisation where joint decision making is not possible.

The legal mechanism, and what it allows/does not allow for

Forum arrangements are not referred to in NHS legislation and the terms used by NHS bodies to describe such arrangements may vary.

They rely upon the powers granted to CCGs[2], NHS trusts[3], NHS foundation trusts[4] and local authorities or other bodies to allow employees to take decisions on their behalf. Generally, decisions can be made on behalf of an organisation by any individual who is considered to have sufficient seniority and can be given that authority under the organisation's governance arrangements. However, in the case of an NHS foundation trust, the individual taking decisions on its behalf in respect of its statutory functions must be one of its Executive Directors. Similarly, any decision-making committee of a foundation trust must comprise solely its Executive Directors.

A forum arrangement involves a group of individuals who have been properly authorised to take decisions on behalf of the organisations they represent and can take decisions on behalf of their respective organisations. These individuals will come together as a group to discuss matters of common concern to the organisations. There can also be individuals in attendance who do not have decision-making authority but can participate in the discussion in the forum setting. The objective of forum arrangements is to align the decisions of the organisations involved as much as possible, but these arrangements do not create a joint decision-making structure.

Another possible forum arrangement would involve committees set up by each of a number of CCGs coming together and having a common discussion before each committee takes decisions on behalf of the CCG of which it forms a part. Under this arrangement, the committees of each can have different membership. Where the committees for each CCG have all their members in common, this is instead known as a Committee in Common arrangement, discussed further later in this document.

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[2] Paragraph 3(3)(a) of Schedule 1A to the NHS Act 2006

[3] Pursuant to NHS Trust Standing Orders.

[4] Paragraph 15, Schedule 7, NHS Act 2006.

Forum arrangements presuppose that there will be consensus between organisations about overarching strategy for the local system. Forums may not be as effective as a tool for collaboration over contentious issues where STPs or ICSs have not already established consensus over key principles.

- Forum arrangements do not provide a basis for lead commissioning, joint commissioning, or the establishment and maintenance of pooled funds.

- There is no limitation to the functions in respect of which forums may be used, but there must be a rational basis for exercising those functions which is consistent with both the law (e.g. procurement and competition law) and principles of good governance (e.g. effective management of conflicts of interest).

- Joint Committees and Committees in Common cannot be used for commissioner-provider collaborations.

Forums can also be used for purposes other than making decisions about statutory functions. They provide an opportunity for senior leaders to come together and discuss issues relevant to the system beyond the scope of their individual decision-making rights.

Governance arrangements

Each organisation must authorise employees or committees to exercise functions on its behalf in accordance with its own internal governance arrangements. It is particularly important for the purpose of forum arrangements that there is clarity as to the scope of the functions which the individual employee or committee can exercise.

Forum arrangements should be supported by a written agreement detailing how meetings of the forum will be conducted.

Decisions should be recorded as being taken separately on behalf of each organisation by the individual with decision-making authority. Governance arrangements should consider the potential for conflicts of interest and adopt the principles set out in both *'Managing Conflicts of Interest in the NHS'* and *'Managing Conflicts of Interest: Revised Statutory Guidance for CCGs'*.

Processes for establishing the mechanism

Currently there are no formal sign-off processes in place for NHS England or NHS Improvement to agree provider/commissioner forums. If forums are established through the STP/ICS, then governance arrangements may be discussed at the STP/ICS stocktake meetings with NHS England and NHS Improvement and any issues addressed here. If the CCG(s) wished to include details of provider/commissioner forums in their constitution (which they are not obliged to do, but may wish to), then these constitutional amendments would need to be made by application to NHS England.

Examples of implementation

All the Wave One ICS sites have put in place forum arrangements to enable them to set the strategic direction for their local area. Amongst the best developed plans for a forum arrangement are those set out by Bedfordshire, Luton and Milton Keynes (BLMK) ICS.

In BLMK, a triple tier model is in place for the ICS. These tiers operate at system level, at place and at localities within these geographical areas.

At BLMK level, all 15 partners work together on delivery of the ICS plan, including using forum arrangements to set direction on:

- opportunities to prevent ill-health;
- primary, community and social care models;
- secondary care;
- digitalisation (including commissioning for whole population outcomes);
- defining outcomes and developing the system's outcomes framework; and
- system re-design.

At place, partners are working together on delivery plans, including using forum arrangements to hold place-based transformation groups that look to shape areas such as:

- whole population needs assessment (JSNA plus);
- commissioning for whole population outcomes;
- defining outcomes and developing each place's outcomes framework; and
- the contractual frameworks used to promote these outcomes.

<u>Advantages, limitations and other considerations</u>

Forum arrangements are the only effective mechanism for commissioners and providers to collaborate and promote alignment at the system level.

Within ICSs, local organisations adopt arrangements and behaviours that enable them to develop and implement a common vision for health and care services and population health. These include:

- a commitment to discuss all issues relevant to the ICS in the ICS forum arrangement;
- a commitment that, where any organisation takes a decision that is inconsistent with those taken by a majority of organisations within an ICS forum arrangement, they will engage constructively in an effort to identify and resolve points of difference;

- a commitment by all organisations to share performance information[5] and to respond to queries raised about their performance within the ICS forum arrangement;

- a commitment to circulate papers approved by a majority within the forum arrangement to Board/Governing Body members of all participating organisations; and

- a commitment to allow a senior system leader representing the majority view within the ICS forum arrangement to address the Board/Governing Body of any organisation which is misaligned with the majority view in relation to any item of business relevant to the ICS.

Where there is difficulty in ensuring alignment between organisations, it may be a challenge to reach and implement decisions through forum arrangements. If particular individuals or organisations are not in agreement with the majority, then, unlike Joint Committees, forum arrangements cannot bind them to implement the decision that has been taken by others. As per other negotiated agreements, members of forums may need to consider how to structure 'packages' of decisions that different individuals or organisations will be able to sign up to as a whole, even if a particular element of that agreement may be unfavourable to a particular individual or organisation.

A.2 Alliance agreements

Organisations this mechanism is relevant for

Alliance agreements can enable collaboration between CCGs, local authorities and providers.

The legal mechanism, and what it allows/does not allow for

An alliance agreement provides a way of implementing a forum arrangement and lays the foundation for its effective operation.

The *'Template Alliance Agreement for virtual MCP/PACs'* models', produced by NHS England, is intended to be used by systems where there is a shared view on the objectives of collaborative working and a desire to set out this agreement in a written document.

The existing template was designed to underpin population-based models of care at the place level – Multispecialty Community Providers (MCPs) and integrated Primary and Acute Care Systems (PACS) – but can be adapted for use by ICSs or primary care networks.

An alliance agreement offers a way of formalising aligned decision making and allows the sharing of workforce and assets and aligning of incentives. As with forum arrangements generally, because decisions depend on consensus, an alliance relies on trust and cooperation of local bodies. Strong local relationships and a commitment to a shared vision are therefore vital to success.

The alliance agreement is designed to complement existing services contracts but is not a contract in its own right. The alliance overlays and relates to – but does not replace – the services contract that each provider holds.

It should be noted that whilst an alliance agreement is usually between commissioners and providers, as assumed by the template, it is also possible for providers only to enter into an alliance.

Governance arrangements

The two main tiers of governance that are set out are:

- the Alliance Leadership Team; and
- the Alliance Management Team.

The Alliance Leadership Team is the group responsible for leading the alliance and holding to account the Alliance Management Team. The rules relating to forum arrangements described above apply to decision making by the Alliance Leadership Team.

The Leadership Team comprises senior representatives of each commissioner and provider member of the alliance, who have been given delegated decision-making authority by their organisation.

The Alliance Management Team is responsible for managing the alliance and implementing the decisions taken by the members of the Alliance Leadership Team Any further layers of governance are then up to individual alliances to decide upon.

Governance arrangements should consider the potential for conflicts of interest and adopt the principles set out in both *'Managing Conflicts of Interest in the NHS'* and *'Managing Conflicts of Interest: Revised Statutory Guidance for CCGs'*.

Processes for putting an alliance agreement in place

There is no formal process that must be followed for putting in place the alliance agreement and it does not require any sign off from NHS England or NHS Improvement. This is a locally driven process, but one which we would expect would involve, at a minimum, the local Director of Commissioning Operations (DCO) and the local Director of Improvement and Delivery (DID).

The organisations that will be party to the agreement will need to agree the aims, objectives, scopes and parameters of the alliance. We recommend that it is drawn up with the benefit of governance and legal advice. It is important to emphasise that the alliance agreement is just a mechanism – it relies on the strength of local relationships, and commitment to a shared vision and the will to make it a reality. So alongside putting in place an alliance, local areas will need to invest time, over a reasonable timeframe, on working through what they want to achieve together and developing their care model locally.

Where commissioners decide to re-procure a set of services (which may result in a new provider configuration), they may wish to overlay the resulting new contracts with an alliance agreement to underpin collaborative working in the delivery of the services.

Some areas have drawn up a Memorandum of Understanding (MoU) as an interim step before moving towards the full alliance agreement.

Examples of implementation and prevalence across England

Mid-Nottinghamshire has had an alliance agreement in place between its CCGs, local authority and key providers since April 2016. The agreement has a duration of ten years, with a break clause at year three. Mid-Nottinghamshire is one of two integrated care partnerships (alongside Greater Nottingham) in the Nottinghamshire ICS.

Some of the key features and objectives of the alliance are:

- It comprises 11 organisations – two CCGs, four NHS providers, one independent sector provider, a not-for-profit out of hours provider, county council (social care), district council (housing) and an umbrella organisation representing the third sector.

- The CCGs represent the 41 GP practices. The elected GP Cabinet has provided input, but the CCGs are working towards a federation model with a locality-based single primary care organisation.

- Of the 11 organisations, there are seven full members and four associates. Associate members do not have veto rights nor do they participate in the risk/reward scheme.

- There are alliance-wide outcomes with an incentive scheme based on 1.8% of contract values and an alliance-wide approach to the whole-population budget and arrangements for sharing gain/loss.

- The alliance has developed a number of alliance-wide pathways linked to New Care Models including care navigation, multidisciplinary teams (MDTs), new end of life care pathways, integrated discharge, diabetes pathways, and a 'single front door'.

Tower Hamlets has had an alliance agreement with duration of 5 + 2 years in place since April 2017. This is a community health service (CHS) based model, secured by an outcomes-based approach. The CHS alliance arrangements were a pragmatic answer to issues arising during the procurement of a CHS contract that meant a lead provider model was not deemed the best approach.

The alliance includes a GP Federation – GP Care Group (GPCG) – which encompasses 37 GP practices. GPCG act as the alliance manager and play a co-ordinating role.

Advantages, limitations and other considerations

As a way of bringing providers together to deliver more integrated services, an alliance agreement carries advantages over procuring a new contract with a lead provider, for example (but it is not an alternative to procurement). An alliance agreement does not require changes to organisation form with the associated challenges that would entail, and it offers flexibility to design an arrangement to fit local objectives. Alliances can evolve over time, as agreed by members, and they very much emphasise local cooperation and integration, recognising everyone's contribution to the design and operation of care models. There is also the possibility of including gain/loss share arrangements, which help promote a shared approach to managing financial resources and risks.

Alliance decisions cannot override members' statutory or contractual obligations. Delivering change through an alliance agreement relies on the goodwill and cooperation of a number of parties; strong local relationships are therefore vital.

A.3 Shared posts

Organisations this mechanism is relevant for

Shared posts can enable collaboration between CCGs, local authorities and NHS providers.

The legal mechanism, and what it allows/ does not allow for

There are criteria set out in legislation as to who can be a member of the board or governing body of an NHS organisation. These should be checked to ensure that any proposed joint appointee meets the criteria for each organisation to which they are to be appointed. For example, in the case of a CCG:

- the Accountable Officer must be an employee of the CCG, a member of the CCG or a member of anybody that is a member of the CCG[6]; and
- the Chief Financial Officer must be an employee of the CCG.

There are additional requirements as to membership of a CCG governing body set out in legislation[7]. There are also eligibility criteria for Board positions in NHS trusts[8] and NHS foundation trusts[9].

Regulations[10] set out that individuals who provide the CCG with support in discharging its commissioning functions (or are employed by or have an interest in an organisation which does) are disqualified from membership of a CCG's governing body. Legal advice should be obtained where there is concern that existing arrangements with a local authority might prevent a joint appointment.

Where it is necessary for a joint appointee to be an employee of both organisations to which they are to be appointed, this may require the use of either a joint contract of employment or two parallel contracts of employment.

Governance arrangements

Organisations will want to ensure that their governance processes address the following matters when considering a proposed joint appointment:

- any restrictions under legislation or organisations' constitutional arrangements on eligibility to hold a position;

7 Schedule 1A to the NHS Act 2006 and the National Health Service (Clinical Commissioning Groups) Regulations 2012/1631.

8 Schedule 4 to the NHS Act 2006 and the National Health Service Trusts (Membership and Procedure) Regulations 1990/2024

9 Schedule 7 to the NHS Act 2006 and the Foundation Trust's Constitution.

10 Regulation 12(6) of the National Health Service (Clinical Commissioning Groups) Regulations 2012/1631 (Paragraph 3 of Schedule 5)

- the precise range of functions of each organisation that the joint appointee will exercise;

- the appropriate employment model to allow the joint appointee to carry out the functions of all organisations, which in many cases will require the individual to have contracts of employment with all organisations involved;

- the implications of the joint appointment for the governance arrangements of all organisations involved, such as amendments to Schemes of Delegation;

- the processes for identifying and managing any conflicts of interest; and

- whether the extent and nature of any anticipated conflicts of interest, and their impact on the ability of the appointee to fulfil the requirements of their roles, mean that the joint appointment should not proceed.

The agreement between the organisations to have a joint appointment should be documented in writing. Once any joint appointment is established, the organisations involved should seek regular assurance that their functions are being effectively exercised by the appointee. There should be provision for the joint appointment to be discontinued in an orderly way if necessary

Processes for establishing the mechanism

NHS England has no role in HR processes in a CCG. The exception is the Accountable Officer post but AOs remain employed by CCGs, not NHS England.

NHS Improvement generally has no direct role in HR/appointment processes in relation to NHS foundation trusts (except, for example, where a foundation trust has an additional governance licence condition in place).

Advantages, limitations and other considerations

A joint appointment can facilitate shared leadership and promote a common vision across organisations. It can also represent a more efficient use of management resource. A joint appointment does not in itself create a joint decision-making structure. The joint appointee must have a clear understanding at all times of which functions they are exercising on behalf of which organisation and where any conflict arises between obligations owed to the different organisations this must be appropriately managed.

Individuals working at board/governing body level often exercise statutory functions on behalf of their organisations, or have accountabilities for the exercise of those statutory functions. They may additionally have roles which are described in guidance from NHS England or NHS Improvement. For example, there is guidance on the roles of CCG governing body members[11].

Board/governing body members have a duty to act in the interests of the organisation to which they are appointed. Where an individual is fulfilling roles in two

[11] *Clinical commissioning group governing body members : Role outlines, attributes and skills October 2012*

organisations, they will owe duties to both of those organisations concurrently. Before entering into a joint appointment, the organisations concerned should consider situations which may arise where a joint appointee is likely to owe conflicting duties to the two organisations. NHS England has published guidance, *'Managing Conflicts of Interest: Revised Statutory Guidance for CCGs'*, that will assist CCGs in identifying prospective conflicts.

In some cases, there may be a significant number of potential conflicts which call into question the ability of the joint appointee to carry out their roles effectively. If that is the case, a joint appointment may not be appropriate

Where there is difficulty in effectively managing conflicts of interest or statutory responsibilities, there may be more scope for joint appointments below the level of board/governing body. For example, joint programme management roles to facilitate the implementation of an ICS are likely to be suitable joint appointments.

A.4 Committees in common

Organisations this mechanism is relevant for

Committees in common can enable collaboration between CCGs or between NHS providers

The legal mechanism, and what it allows/ does not allow for

Committees in Common (CICs) are not referred to in NHS legislation. In the case of CCGs, they are a mechanism which builds upon CCGs' powers to form their own committees and has been developed to allow CCGs to align their decision making in circumstances where formal joint decision making is not possible.

CICs rely upon the powers granted to CCGs to:

- form committees under Paragraph 3(2)(a) of Schedule 1A to the NHS Act 2006; and
- appoint individuals as members of committees who are not members or employees of the CCG concerned, under Paragraph 3(2)(b) of Schedule 1A to the NHS Act 2006.

It is possible for both NHS foundation trusts and NHS trusts to establish committees in common with other trusts, using their powers to delegate functions to their own committees. In brief:

- an NHS foundation trust's constitution normally allows it to delegate any of its powers to a committee of its directors or an executive director[12]; and
- an NHS trust may delegate any of its functions to a committee consisting wholly or partly of its directors or wholly of people who are not directors of the trust.[13]

Given the constraints on membership, these arrangements require joint director appointments if an NHS foundation trust is involved.

Where CCGs wish to operate a CIC to allow them to align decision making between themselves, they should each form a committee for this purpose. Each CCG's committee should then have the same membership. For example, where four CCGs wish to establish CICs, each CCG should form a committee with membership comprising one or more of its own employees and one or more employees from each of the other CCGs.

The committees of each CCG, with their common membership, can then meet at a common time and place where decisions can be taken on behalf of each of the participating CCGs. A single discussion can take place, considering the matters of

[12] See paragraph 15(3) of Schedule 7 to the National Health Service Act 2006 c41.
[13] See regulations 15 and 16 of the National Health Service Trusts (Membership and Procedure) Regulations 1990 (SI1990/2024).

common concern to the CCGs, but also addressing issues of specific concern to one or more CCGs. Any decisions taken should be recorded separately in respect of each CCG.

Advantages, limitations and other considerations

The use of CICs may be relevant to STPs, ICSs, devolution and other collaborative commissioning arrangements. However, it is usually preferable to use a Joint Committee to take decisions about commissioning functions where this is an option. The only notable difference with a Joint Committee is that CICs can be put in place for all CCG functions, not just commissioning functions.

In some instances, it may also be the case that CIC arrangements have been put in place as a forerunner to Joint Committee arrangements. The successful operation of CICs between CCGs can help to build the trust and confidence that subsequently allows for joint decision making through a Joint Committee.

CICs do not provide a basis for lead commissioning, joint commissioning, or the establishment and maintenance of pooled funds.

CICs require all the committees involved to have the same membership. A similar arrangement could involve cross-appointments, where one or more individuals sit on committees across a number of CCGs. Such an arrangement can be useful in aligning decision making but is unlikely to achieve the same degree of alignment as CICs.

The key limitation of CICs is that they are unable to make one single binding decision on behalf of all the CCGs involved.

Governance arrangements

Each CCG must authorise the establishment of a committee, and the appointment of members to allow it to operate as part of CICs arrangements, in accordance with the arrangements under its constitution. The establishment of CICs should also be supported by a written agreement between the CCGs dealing with matters including the following:

- Careful consideration should be given to quorum requirements and how any conflicts of interest can be identified and managed. NHS England has published guidance for CCGs on managing conflicts of interest which may help with this.

- When taking decisions on behalf of CCGs of which they are not an employee, members of CICs must make such decisions in accordance with the interests of the CCG to which the decision relates rather than the interests of their employing CCG.

CICs should be used in circumstances where it is envisaged that the interests of all the CCGs will generally be aligned. If it is likely that the interests of the CCGs will diverge frequently, or infrequently but in relation to matters of real importance, then CICs may not be a useful model.

Processes for establishing the mechanism

Where CCGs put in place CICs (e.g. with other CCGs), this will usually require a change to be made to the CCGs' Schemes of Reservation and Delegation and included in each CCGs' committee handbook which is reviewed by the NHS England regional team.

Examples of implementation

The six CCGs in South West London (Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth) agreed to establish CICs in November 2017. The arrangement enables the participating committees to make the same decision for issues delegated by their governing bodies in relation to:

- any significant change in healthcare service that affects the population of more than one CCG;
- any significant commissioning strategy/plan that affects the population of more than one CCG; and
- any CCG organisational development relating to more than one CCG.

A.5 Mergers

Organisations this mechanism is relevant for

Mergers can take place between CCGs or between NHS providers.

The legal mechanism, and what it allows/ does not allow for

CCGs can apply to NHS England to reconfigure themselves in the following ways:

- a merger of two or more existing CCGs (or a part thereof) to create a wholly new CCG; or

- the dissolution of an existing CCG, whose member practices then transfer to one or more existing CCGs, the boundaries of which are enlarged to cover the additional practices (this can be described as an “acquisition”).

NHS England has separately published detailed guidance on the processes to be followed when implementing a merger or acquisition.

NHS trusts or foundation trusts interested in mergers or acquisitions should refer to NHS Improvement’s transaction guidance. NHS providers which are collaborating with a view to bidding for a novel or complex healthcare contract should refer to the Integrated Support and Assurance Process (ISAP) guidance jointly published by NHS Improvement and NHS England.

Governance arrangements

Governance arrangements are set out in detail in the NHS England merger guidance and NHS Improvement transaction guidance, referenced above.

The rest of this chapter focuses on mergers between CCGs.

Processes for establishing the mechanism for CCGs

Whereas CCGs can put in place Joint Committees and Committees in Common at any time throughout the year, mergers can only be approved and take effect at one point. Applications for merger must be received by NHS England by 31 July and, if approved, will take effect from 1 April in the following year. CCGs considering merger will discuss their proposals with NHS England DCO teams and will seek to gain their support before commencing the formal merger process.

Whereas Joint Committees and Committees in Common will require all participant CCGs to update their constitutions, merger will result in one or more CCGs being dissolved and their membership becoming part of another CCG. Because this will mean the formation of a new CCG with a new constitution, there is a statutory requirement that CCG mergers are signed off by NHS England. This role is fulfilled by the Commissioning Committee.

Examples of implementation and prevalence across England

In 2013 there were 211 CCGs. Between then and April 2018 there have been a number of mergers and, at the time of writing, the number of CCGs stands at 195.

In April 2018, 18 CCGs merged to form six new organisations. These mergers were as follows:

- NHS Aylesbury Vale CCG and NHS Chiltern CCG;
- NHS Newbury & District CCG, NHS Wokingham CCG, NHS South Reading CCG and NHS North and West Reading CCG;
- NHS Windsor, Ascot and Maidenhead CCG, NHS Bracknell and Ascot CCG and NHS Slough CCG
- NHS Bristol CCG, NHS North Somerset CCG and NHS South Gloucestershire CCG
- NHS Leeds North CCG, NHS Leeds South and East CCG and NHS Leeds West CCG
- NHS Solihull CCG, NHS Birmingham Cross City CCG and NHS Birmingham South and Central CCG

Advantages, limitations and other considerations

CCG mergers enable the new organisation to take decisions for its whole population without the need to report back to separate governing bodies or to run separate decision-making processes. Mergers can also help to reduce the costs associated with CCG governance and will reduce the total management cost of the organisation.

The legislation requires that the provisions of a CCG's constitution dealing with arrangements for the discharge of the CCG's functions (e.g. committee structures) and procedures followed by the CCG in making decisions must secure that there is effective participation by each member of a CCG in the exercise of the group's functions.

Merged CCGs with large populations, operating over large geographical areas, will need to consider how to show that their constitutional arrangements secure the effective participation of each of their many member practices. Options to achieve this include:

- GP representation on the governing body, with GPs representing groups of members practices organised by geography;
- a CCG Members' Committee with a meaningful role in decision making which is clearly representative of the entire area of the CCG, perhaps with GPs representing groups of member practices organised by geography; and
- a committee structure, with certain functions delegated by the CCG to 'locality committees' organised by geography.

The precise footprint of the ‘locality committees’ could be determined by reference to legacy CCG boundaries, the development of ‘place-based’ systems at sub-ICS level and/or local authority boundaries. If it was intended that any decisions of the CCG were to be made by reference to the number of locality committees that supported a proposal, there would need to be an approximate equality between the populations covered by each locality committee to avoid any suggestion that some areas had more influence than others. Otherwise, there would be scope for locality committees to service footprints and populations of varying sizes within the same CCG.

Feedback from first wave ICSs has reinforced the importance of effective relationships between NHS commissioners and local authorities if integration is to succeed. When assessing options for restructuring, including mergers, CCGs should consider the impact of those proposals on their alignment with local authorities including existing s.75 partnership arrangements.

A.6 Lead commissioning, joint commissioning, joint committees and pooled funds

Organisations this mechanism is relevant for

Lead commissioning, joint commissioning, joint committees and pooled funds alliance agreements can enable collaboration between CCGs.

The legal mechanism, and what it allows/does not allow for

S.14Z3 allows for two or more CCGs to enter into arrangements including the following:

a) One CCG exercises one or more of its own statutory commissioning functions along with the equivalent statutory commissioning function(s) of the other CCGs that are party to the arrangement. This is described as a 'lead commissioning' arrangement.

b) Two or more CCGs together exercise one or more of their statutory functions, for the purpose of which they may create a Joint Committee. This is described as a "joint commissioning" arrangement.

c) The establishment and maintenance of a pooled fund.

d) The payment of monies between CCGs for the purposes of the arrangements at (a) to (c) above.

e) One CCG making staff or other resources available to another CCG for the purposes of the arrangements at (a) to (c) above.

All functions of a CCG in arranging for the provision of services as part of the health service can be the subject of arrangements under this provision, with the following exceptions:

- Functions which are not given to CCGs directly under legislation but which they exercise on behalf of another NHS body, local authority or the Secretary of State e.g. functions in relation to primary medical care delegated to a CCG by NHS England, or public health functions exercised by a CCG by agreement with NHS England or the Secretary of State.

- Non-commissioning/corporate functions. For example, this provision would not provide a basis for forming a joint audit committee or agreeing common policies on CCG staff recruitment and performance management through the Joint Committee.

Governance arrangements

As part of a lead commissioning arrangement under s.14Z3, all the CCGs involved should seek regular assurance that the lead CCG has the appropriate skills and resources available to it to carry out the function effectively. The arrangements should be documented in a written agreement between the CCGs which details the precise scope of the functions which are to be exercised by the lead commissioner.

As part of a joint commissioning arrangement under s.14Z3, the CCGs should decide on a mechanism for making joint decisions about the functions.. The creation of a Joint Committee should be supported by written terms of reference, including quorum requirements to ensure that all the CCGs are involved in the joint exercise of their functions and arrangements for identifying and managing conflicts of interest. There should also be clarity as to the precise scope of the functions which are the subject of the joint arrangements. All the CCGs involved should seek regular assurance that their functions are being jointly exercised in an effective way.

Where a pooled fund is created, there should be a written agreement which covers matters including:

- the precise scope of functions to which the pooled fund relates;
- the agreed contributions of each CCG, along with arrangements for dealing with overspends and underspends;
- which CCG will host the pooled fund;
- how payments from the pooled fund can be authorised;
- reporting requirements to the CCGs involved; and
- provisions allowing for the arrangements to be discontinued in an orderly way if necessary.

<u>Processes for establishing the mechanism</u>

Where CCGs wish to put in place a Joint Committee they must first seek internal approval in accordance with the governance arrangements set out in their constitutions. In order to obtain such approval, they will need to put together a proposal.

Once the proposal for the Joint Committee has been approved by each CCG, the CCGs will prepare updates to their governance handbooks and SoRDs to reflect the new governance structure. The governance handbooks are sent to NHS England regional teams to be checked. This ensures that the roles and remit of the committee are within legislation. This checking process also enables the regional teams to ensure that there is consistency between the handbooks of all CCGs which are part of the Joint Committee.

Once the Joint Committee is formed, DCO colleagues may attend for the first few meetings to informally ensure that the new committee is operating in the way that had been described.

<u>Advantages, limitations and other considerations</u>

The key advantage of Joint Committees is that they are able to make binding decisions and these decisions do not need to be ratified by the governing bodies of individual CCGs. Joint Committees enable open discussion between parties, and they enable all member CCGs to be represented; this can help to ensure that the locality voice is retained.

Where a lead commissioner arrangement is put in place, it is important to ensure that the lead commissioner is acting in the interests of all the CCGs that they are representing. One possible limitation of this mechanism could be that an organisation acting as lead commissioner may not be best placed to hear the view of individual localities and factor these into its work.

A.7 s.75 arrangements

Organisations this mechanism is relevant for

s.75 arrangements can enable collaboration between CCGs and local authorities or between NHS providers and local authorities.

The legal mechanism, and what it allows/ does not allow for

s.75 allows for two or more organisations comprising at least one prescribed NHS body and at least one LA to enter into arrangements including the following:

a) an NHS body exercises its NHS functions in conjunction with exercising health-related functions on behalf of one or more LAs;

b) a LA exercises its health-related functions in conjunction with exercising NHS functions on behalf of one or more NHS bodies;

c) the establishment and maintenance of a pooled fund;

d) creating a Joint Committee to manage the arrangements at (a) to (c) above; and

e) one or more prescribed NHS bodies making staff, goods, services or accommodation available to one or more LAs in connection with the arrangements at (a) to (c) above, or vice versa.

The arrangements under (a) and (b) above can be described as lead commissioning.

The prescribed NHS bodies for the purposes of s.75 are CCGs, NHS England, NHS Trusts, NHS foundation trusts and combined authorities (in so far as they are exercising NHS functions).

Parties planning to enter into s.75 arrangements must be able to demonstrate that the arrangements are likely to lead to an improvement in the way in which the NHS and health-related functions are exercised. In addition, the parties may only enter into the s.75 arrangements if they have jointly consulted those who appear to them to be affected by the arrangements. The requirement to consult does not apply to s.75 arrangements entered into for the purposes of the Better Care Fund.

Further provision about arrangements under s.75 can be found in the Partnership Regulations.

- Functions of a CCG which can be the subject of partnership arrangements under s.75 exclude those which it exercises under arrangements with another NHS body e.g. functions in relation to primary medical care delegated to a CCG by NHS England, or public health functions exercised by a CCG by agreement with NHS England or the Secretary of State.

- s75 partnership arrangements allow a wide range of CCG commissioning functions and health-related local authority functions to be exercised collaboratively. Non-commissioning (corporate) CCG functions cannot be

exercised through s75 partnership arrangements. In addition, there are a number of NHS functions that currently cannot be included in s75 arrangements:

- surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments;
- s7a public health services;
- primary dental services;
- pharmaceutical services;
- primary ophthalmic services; and
- emergency ambulance services.

- s.75 partnership arrangements between an NHS provider and a local authority allow provider functions to be exercised collaboratively, in particular to allow a trust to provide both NHS and local authority social care or public health services, financed from a pooled fund. Where such arrangements are in place, the trust may be designated as a Care Trust.

Governance arrangements

As part of lead commissioning arrangements, the partners should seek regular assurance that each of them has the appropriate skills and resources available to it to carry on the function effectively. This may include the provision of regular reports and management information to the partners. The arrangements should be documented in a written agreement which details the precise scope of the functions which are to be exercised by the lead commissioner.

Where a pooled fund is created, there should be a written agreement which covers matters including:

- the precise scope of functions to which the pooled fund relates;
- the agreed contributions of each organisation, along with arrangements for dealing with overspends and underspends;
- which organisation will host the pooled fund;
- how payments from the pooled fund can be authorised;
- reporting requirements to the organisations involved;
- provisions allowing for the arrangements to be discontinued in an orderly way if necessary.

Processes for establishing the mechanism for CCGs and LAs

A CCG should update its governance handbooks and SoRD to reflect the s.75 agreements it enters into. The governance handbook should be sent to NHS England to be checked.

Where a CCG intends to enter into a s.75 agreement, it must ensure that its constitution offers it the ability to do so; if it does not, then its constitution should be updated and signed off by NHS England.

Examples of implementation

These arrangements have already been in place for some time in Salford where the integrated commissioning board, comprising city councillors and members of the CCG's governing body, oversee a pooled budget of over £230 million. This budget covers all (CCG commissioned) adult health and care services within the scope of s.75. The CCG has responsibility for administering the pooled budget, with a joint commissioning team comprising CCG and council staff.

Advantages, limitations and other considerations

Joint planning and commissioning of services enables the health and social care needs of the population to be taken into account simultaneously. s.75 partnership arrangements allow health and social care commissioners to take decisions in a collaborative way and ensure that both parties implement the decisions that have been taken. These arrangements help to ensure that timely decisions are taken and reduce the bureaucracy that can be associated with other approaches.

Annex B. System governance & leadership support framework

Background

NHS providers and commissioners, local authorities and other partners are already working together across different settings in their local system to improve services and address system challenges, such as through Sustainability & Transformation Partnerships (STPs) or Integrated Care Systems (ICSs). Many of them are doing this through improved joint working and collective decision making, rather than through formal transactions or structural changes.

Effective leadership and governance arrangements are essential in enabling joint working and ensuring systems are successful in delivering their objectives.

Framework purpose

The following framework has been developed by NHS Improvement and NHS England in partnership with the Local Government Association. The framework should be used:

- as a diagnostic tool to support systems understand their development needs across 8 different areas. The diagnostics should act as a snapshot in time, and should be used to support improvement; and
- to facilitate action planning within a system to address their development needs.

This framework should not be seen as:

- a prescriptive or mechanical checklist, as there is huge scope for innovation relating to governance and systems should adopt those that are best for them; or
- a robust assessment tool, - the tool does not provide detailed outcomes and should be used in a holistic way to help identify areas for further work/development.

The System Governance & Leadership Support Framework describes the characteristics of good system leadership and governance under eight themes and across four stages of "maturity" – commitment, implementing, embedding and sustaining delivery. This is intended to reflect the fact that all systems will be on a journey to achieve sustainable delivery, and outcomes may take time to improve.

Although it is entirely feasible that systems will not always approach maturity in such a linear fashion, we have constructed it in this way to support systems structure their thinking. For the purposes of the framework, each maturity stage builds on the previous one.

Themes

1. Leadership capacity and capability
2. Clear vision and credible strategy
3. Open, transparent and cohesive culture
4. Clear responsibilities, roles and systems of accountability to support good governance and management
5. Risk, issue and performance management
6. Robust and appropriate information
7. Engagement and involvement of people who use the service, the public and staff
8. Robust systems and processes for learning, continuous improvement and innovation

Stages of maturity

Commitment	Systems and processes are clearly defined and articulated "on paper", and have been agreed by relevant partners.
Implementing	There is evidence of commitment being put into practice, though this may be dependent on one or two people; effectiveness is not yet being assessed.
Embedding	There is evidence of commitment being put into practice by a wider base of people and that this is having an impact; there are regular reviews of effectiveness with appropriate responses
Sustaining Delivery	There is evidence of improved outcomes; attention is being given to the medium to long term system impact and effectiveness; there is a culture of continuous improvement throughout the system..

Theme 1: Leadership capacity and capability

Commitment	Implementing	Embedding	Sustaining delivery
• The leadership is representative of the system (including NHS providers, NHS commissioners, local authorities, third sector etc), and leaders across the system are committed to the vision and values. • Leaders are inclusive and bring together partners and stakeholders from across the system through formal and informal engagement. • There is a recognition from all partners that leadership should be collective and distributed across many levels and roles. • NEDs and CCG lay members are incorporated within the system governance structure.	• System leadership is based on negotiation and influence. There is a focus on achieving consensus in decision-making. • Leaders have the capability and capacity to deliver the strategy and address risks to performance. They have a strong focus on outcomes and results, not just the process. • Leaders invest time to build and strengthen relationships across partners within the system, facilitating a culture of community and collective responsibility, and ensuring proactive buy-in from individual organisations' leaders.	• Leaders are highly visible and have developed networks across health and care within the system and beyond. • There are transparent processes for taking decisions across the system, based on dialogue and consensus. • Decision-making across the system has been effective in delivering the system objectives. • Leaders hold each other to account constructively and carry out periodic self-reviews of their leadership, including their impact, leading to continuous improvement. • NEDs and CCG lay members provide oversight and constructive challenge.	• There is adaptive, resilient and effective leadership, which has resulted in improved outcomes. • This is sustained through a leadership strategy and development programme and effective selection, development, deployment and succession-planning. • Leaders demonstrate high levels of trust, collectively overcome difficult challenges/obstacles, celebrate shared success, and drive continuous improvement to shared objectives. • Leadership is distributed widely and deeply throughout the system.

Theme 2: Clear vision and credible strategy

Commitment	Implementing	Embedding	Sustaining delivery
• Leaders have developed a shared purpose and vision through a structured process with significant engagement with partners and stakeholders. • The vision is based on improving quality of care and outcomes for the local population, building on place-based, preventative, person-centred approaches.	• The vision has been translated into a realistic, evidence-based system strategy (which considers the short, medium and long term) and well-defined objectives and multi-year delivery plans, which all partners are signed up to. • The strategy is being delivered through appropriate systems and processes. • The vision and strategy are shared and promoted across all parts of the system through an effective communication plan. • Individual organisational plans are aligned to the wider system strategy, and each partner understands the part it plays in delivering the strategy.	• All key partners can describe the vision, values, goals and initiatives relevant to them, and how they support delivery of local health and care economy and/or national priorities. • Leaders measure the impact of the system's strategy and work programmes through the use of agreed KPIs and other outcome measures. • There is analysis of outliers/poor performance and subsequent action-planning takes place. • Results are shared with partners and stakeholders in a timely manner. • There is a single operating plan in place which covers the management of system activity, finances and workforce.	• There is consideration given to the longer-term vision for the system and the progress being made against this. • Leaders give consideration to how longer-term strategy goals need to be refreshed periodically to account for changes in the strategic and operating environment, through carrying out regular horizon-scanning and scenario planning.

Theme 3: Open, transparent and cohesive culture

Commitment	Implementing	Embedding	Sustaining delivery
• All partners understand the importance of developing a cohesive system culture underpinned by a shared language and values. • Clear vision and values have been articulated and are set out in a Memorandum of Understanding or similar. These principles have been developed through significant stakeholder engagement, and have buy-in from all partners. • There is a development plan in place setting out agreed ways of working and behaviours. • There is a commitment to carry out diagnostic work to support the development of a cohesive system culture.	• Partners are implementing the development plan and have started to develop new ways of working together based on collaboration and openness, and are moving away from silo-working. • Diagnostic work has been carried out to support the development of a shared system culture.	• Partners have supportive and cooperative relationships with high levels of trust. There is evidence that they celebrate shared success and resolve conflicts quickly and constructively. • There are effective processes in place for gathering feedback from partners and stakeholders, and feedback is reviewed and acted on in a timely fashion. • Leaders encourage and value the raising of concerns. • Behaviour and performance inconsistent with the vision and values are acted on.	• Leaders role-model agreed values and behaviours, and these cascade down to organisational level. • Leaders can evidence an embedded culture of collaboration, transparency and collective responsibility across the system. • Constructive challenge is welcome at all levels and there are effective mechanisms in place for turning concerns into improvement actions.

Theme 4: Clear roles and systems of accountability to support good governance and management

Commitment	Implementing	Embedding	Sustaining delivery
• There is an appropriate system governance structure which enables effective strategic alignment and the delivery of shared objectives, while still respecting individual organisations' accountabilities. • Accountabilities (both shared and organisational) have been defined, including any 'red lines' which cannot be crossed. • There is agreement that decisions are taken at the most appropriate level using the principle of subsidiarity. • Governance arrangements are inclusive, equitable and streamlined.	• There are effective collaborative arrangements in place including a sustainable financial operating model and contractual arrangements, which facilitate effective oversight of system resources and risk-sharing. • Partners are clear on the scope of issues considered at a system level / individual organisation level. • Informal and formal escalation routes and dispute resolution mechanisms are in place. • The system is developing governance around integrated systems (including OD, finance and IT).	• Leaders can demonstrate an inclusive decision-making structure which enables timely, collaborative decision-making and reduces bureaucracy. • Partners arrive at decision-making forums with the authority to make decisions. • There is evidence of shared responsibility for delivery and performance. • Leaders can evidence that governance arrangements are proactively reviewed for effectiveness, and lead to improvements in systems and processes.	• Joint governance arrangements have led to improvements in system-wide quality, financial operational performance. • Fully integrated systems have led to efficiencies, economies of scale and improved outcomes. • Leaders regularly review accountabilities and governance processes in light of uncertainties and upcoming changes in policy, with a view to improve and future proof these.

Theme 5: Risk, issue and performance management

Commitment	Implementing	Embedding	Sustaining delivery
• There are processes in place to manage current and future performance at system level, and for collating, quantifying, evaluating, and reporting risks. • All risks have named owners, and are actively managed and reviewed on a regular basis. • Leaders have a clear understanding of and can articulate the system-wide risk appetite. • Conflicts of interest are appropriately managed.	• Performance issues are escalated to the appropriate committees through clear structures and processes. • Leaders are addressing system performance issues collectively. • Leaders are able to describe the current and future system risks and plans to mitigate them. • The risk management process is understood, risks are actively being managed and staff know how to escalate risks. • Leaders can evidence that system emergency preparedness/crisis management planning has been carried out.	• Leaders can evidence that the performance and risk management processes are effective and have resulted in efficient, high quality performance and improved outcomes. • Leaders are able to identify, and quickly and effectively respond to the first signs of deteriorating performance. • There are systems and processes in place for system leaders to hold individual organisations to account for performance, and intervene where necessary.	• Organisational and system performance and risk management are aligned, and there is evidence that the system is collectively managing risk and performance. • Performance and risk management processes are regularly reviewed for effectiveness and improved. • Leaders carry out horizon-scanning and regularly review the policy and legislative landscape to identify and mitigate/manage future risks.

Theme 6: Robust and appropriate information

Commitment	Implementing	Embedding	Sustaining delivery
• All partners are committed to sharing information as appropriate and building business intelligence capacity at system level to enable a single shared view of local challenges, performance and progress against delivery. • There are data sharing agreements in place between partners.	• Leaders can demonstrate that accurate, relevant and timely information, including population outcomes, service-line outcomes and programme board outcomes, is collected and reported. • Reporting is integrated across quality, operations and finances. • Leaders challenge information, use it to inform decision-making and identify problem areas. • Leaders have followed a robust process to identify what information must be collected at system-level. This should include data for both outcomes and outputs.	• Leaders regularly review information being reported to ensure it is relevant, valid, timely and to identify any duplication. • Information is being used to drive planning and delivery across the systems, including services, pathways and workforce. • There are forums and tools in place which monitor the system's progress, built on agreed performance metrics and measures. • Leaders can demonstrate that data assurance arrangements are in place. • Performance information is used to hold individual organisations, programmes and service-lines to account.	• Transparency of information underpins a culture of learning within the system and enables leaders to identify areas of strength and weakness. • There is evidence that reported outcomes have improved over time. • The information reported to system-level is consistent across organisations, enabled by a single information system.

Theme 7: Engagement and involvement of people who use the service, the public and staff

Commitment	Implementing	Embedding	Sustaining delivery
• Partners and stakeholders have been identified from across the system using a robust process, and are involved in co-producing and driving programmes and plans. • Leaders have developed appropriate system communication and engagement strategies, and there is a governance structure in place to capture the voice and needs of partners and stakeholders, including hard to reach audiences. • There is a commitment between partners to work collaboratively and share information.	• The system communication and engagement strategies are being implemented. • All partners are sharing information and collaborating to achieve the system's objectives. • There is proactive engagement on resourcing issues across partners, and exploration of opportunities to collaborate to drive improved outcomes and system efficiencies.	• The system is transparent, collaborative and open with all relevant stakeholders about plans, actions and performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them. • There is an embedded culture of coproduction with stakeholders, including hard to reach audiences.	• Leaders use innovative approaches to gather feedback from a wide range of partners and stakeholders, and can demonstrate acting on feedback, leading to significant, sustained improvement in care provision and experience. • Engagement approaches are kept under review and are adapted as necessary.

Theme 8: Robust systems and processes for learning, continuous improvement and innovation

Commitment	Implementing	Embedding	Sustaining delivery
• Leaders are committed to improving quality, financial and operational performance at individual providers. • Leaders can demonstrate a commitment to embedding continuous improvement approaches and spreading innovation across the local footprint (both at individual organisations and across the patient pathway). • There are effective systems and processes in place to support continuous improvement and innovation work across the local footprint, including a system wide improvement strategy.	• Leaders vocally and visibly champion continuous improvement and the take-up and spread of innovation from the top down. • Partners are regularly sharing good practice and innovation. • Solutions are developed in partnership with relevant stakeholders including clinicians, managers and people who use services. • Leaders can demonstrate that data and knowledge-sharing systems and processes to support improvement and leadership development are in place, and that there are networks for sharing improvement knowledge and experience locally, regionally and nationally.	• System leaders and partners demonstrate an openness to sharing information, learning from others and being challenged. • Leaders can demonstrate an embedded, system-wide, patient-focused intelligence driven approach to improvement, including systems and processes to gather feedback from system partners, the public and people who use services. • Leaders can demonstrate regular time-outs to review objectives, processes and performance, resulting in improvement.	• Leaders incorporate learnings from inquiries, reviews and feedback to improve programmes and services across the system. • Leaders regularly share learning and spread innovation across and beyond their own system. • Leaders adopt innovations in technology which result in improved performance and better health and wellbeing outcomes. • There is system-level improvement capability. The system is able to intervene promptly to improve performance at individual provider level.