West Yorkshire and Harrogate
Health and Care Partnership

2 August 2018

Kirklees Health and Overview Scrutiny Committee
West Yorkshire and Harrogate Health and Care Partnership

Introduction

1. The purpose of this paper is to update the Kirklees OSC on the work of the West Yorkshire and Harrogate (WY&H) Health and Care Partnership, with a specific focus on:

   - Progress to date and shadow Integrated Care System (ICS) Status
   - Relationship between WY&H work and local plans
   - Partnership governance arrangements

2. The accompanying paper on stroke services responds to the OSC request for information about potential service change.

Progress to date and Shadow ICS

3. West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield. Our updated strategy: "Our Next Steps to Better Health and Care for Everyone" is available here.

4. In February 2018, WY&H HCP System Leadership Executive Group put forward an expression of interest to be considered by NHS England [NHSE] and NHS Improvement [NHSI] to be part of the ICS development programme.

5. It was announced in May 2018 that WY&H HCP will join the development programme in shadow format. This gives the green light for further integrating health and care services across organisational boundaries, making it easier for teams to work together and for the benefit of the 2.6million people we serve.

6. Being part of the programme demonstrates that NHSE and NHSI have confidence in local and WY&H plans and leadership. This national recognition for the way we work means we are at the cutting edge of health and care policy, influencing and paving the way and most importantly improving how services are delivered and received locally for the 2.6 million people living across WY&H.

7. This approach recognises the importance of integrating services for people at a local level, for example in our six places [Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield]. All decisions on services are made as locally and as close to people as possible. Our move to becoming an ICS is predicated on this continuing to be the case.

8. The focus for these local partnerships is increasingly moving away from simply treating ill health to preventing it. It is also important to tackle the wider determinants of health, such as housing, employment, social inclusion and the physical environment i.e. green spaces.

9. We also need to tackle deep rooted financial problems or recruitment and workforce challenges by bringing together all of our precious resources locally and working with communities to self-care and stay healthy.

10. Through working more closely together we have brought in an additional £70miilion funding for areas such as cancer, diabetes and mental health.

Purpose of the ICS

11. An ICS is a partnership that is given flexibility and freedoms in return for taking responsibility for the delivery of high quality services now and in the future. It brings together some elements of NHS regulatory functions with health and care commissioning and service delivery. It allows us to work together in a more joined up way towards shared objectives.

12. Moving to an ICS in shadow form is seen as the natural progression for WY&H HCP. It sits with the ethos of being ambitious for the people we serve and demonstrates the partnership's commitment to improving health and care for everyone.

13. It is clear that our local places will have different plans and what is right for one may not be for another. In line with the WY&H plan, all decisions on services need to be made as locally and as close to people as possible.

14. Being part of the ICS Development Programme will:

    a) Give greater financial backing in terms of access to transformation funding. This is particularly important to help reach our ambition for a more radical approach to empowering people to get the care and support they need as early and as locally as possible and to build up our community based services to deliver more preventative care.

    b) Provide clearer routes for democratically elected councillors to influence, challenge and inform the development of integrated care for the people of WY&H. This will continue to enhance public accountability and transparency. We anticipate that working more closely with elected representatives will add value to the partnership.

c) Help to ensure we ambitiously pursue more capital developments and build on our early success in attracting £32 million of transformation funding and £38 million of capital funding. This included funds for mental health, cancer, diabetes and learning disabilities. In recent weeks we have also been successful in attracting £7.5m to Yorkshire and Humber to support joining up health and care records (the Local Integrated Care Records Exemplar programme).

d) Bring with it capacity, support and access to expertise from national bodies and international best practice, including new models of care, transformation and analytics. We know that a better and more integrated approach to data and analytics could enable us to direct our resources more efficiently and that by investing in and supporting innovation, we can develop better, more person-centred solutions.

What next?

15. Over the rest of 2018-19 we will continue to strengthen our partnership working arrangements as we work towards taking greater autonomy from NHSE and NHSI. This specifically will include:

- Development of a WY&H 'Partnership Board' which will meet in public, and include Executive, Non-Executive and Elected Member representation, along with clinical, public and voluntary sector representation. This will ensure greater transparency and democratic accountability in our work;
- Development and implementation of our 'mutual accountability' framework, including new financial arrangements through which we will take greater collective responsibility for living within our means;
- Progression of integrated models in each of our six places – including strengthening role of primary care networks in this;
- Continue to deliver progress against our priorities set out in the 'next steps' document;
- Development of 'population health management' capabilities to enable more personalised approach to management of health conditions in the community.

Relationship between WY&H and local plans

16. Partnership working across WY&H is based on the principle of subsidiarity – i.e. the work is done at the most appropriate level, as close to local as possible. When we work across WY&H, we apply three tests:

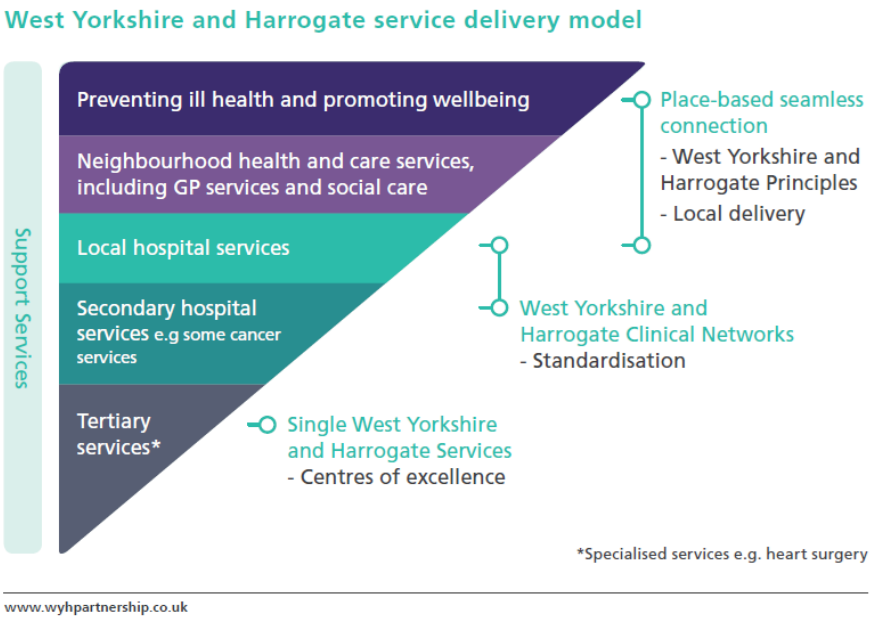
- Do we need a critical mass beyond the local level to achieve the best outcomes? – for example cancer or stroke services
- Will sharing and learning from best practice and reduce the variation in some outcomes for people across different areas? – for example the Wakefield Health and Housing partnership; the Kirklees model of identifying and supporting carers

- Can we achieve better outcomes for people overall by applying critical thinking and innovation to wicked issues? – for example the establishment of 'primary care networks', or workforce issues.

The WY&H delivery model

17. We have developed a high level delivery model which describes how we will work, based on the principle of subsidiarity. The vast majority of services will continue to be planned, agreed and delivered locally, and services are planned across WY&H level, Kirklees are fully engaged in this process as equal partners.

18. Our Next Steps document sets out a high level framework this – this is provided at figure 1 below.



19. The bedrock of the approach is a strong focus on prevention, wellbeing and addressing inequalities and the wider determinants of poor health. This is about local delivery in place, through close partnership working between health and local government.

20. Health and care services will be tailored to meet the needs of people living in neighbourhood or communities of 30,000 to 50,000 people. These networks will bring together health and social care professionals, from general practices, mental health community and social care providers and the voluntary sector to provide co-ordinated and personalised care for local people. Again, these models are being led locally, supported by expertise from across WY&H and nationally.

21. Local hospital services will continue to be planned and delivered locally in each place, and they will increasingly seamlessly with primary and community services to improve co-ordination as people move between settings. Across WY&H, the 6 trusts will

collaborate to share good practice and develop clinical networks where this will improve outcomes and improve the resilience of local services.

22. Some hospital services need to be planned and delivered for larger areas (such as some cancer services). For these services clinical networks will develop standard clinical procedures and processes which will help improve local services.

23. As currently happens, the most complex services (such as heart surgery or hand transplants) will be planned and managed or a WY&H footprint, or in some cases a Yorkshire wide or national footprint. Some people will need to travel further for these services, but the chances of a positive outcome will be higher.

24. Working at West Yorkshire and Harrogate level also provides the scale to tackle other specific problems in different ways – for example working together to address workforce issues; building a stronger relationship with the Academic Health Science Network to roll out innovation across WY&H; and a stronger collective voice to influence national policy.

Partnership Governance Arrangements

25. The Partnership does not replace or override the authority of the Partners' Boards and governing bodies. Each of them remains sovereign and Councils remain directly accountable to their electorates.

26. A schematic of our governance and accountability relationships is provided at **Annex 1**

Place based governance

27. There are well established governance arrangements in each of the six places that make up the WY&H partnership. These are comprised of organisational boards, Health and Wellbeing Boards, and other partnership arrangements. In line with our principle of subsidiarity the vast majority of decisions continue to be taken within these structures in line with statutory responsibilities.

'Sector' level arrangements

The West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

28. The nine CCGs in West Yorkshire and Harrogate are continuing to develop closer working arrangements within each of the six Places that make up our Partnership.

29. The CCGs have established a Joint Committee, which has delegated authority to take decisions collectively. The Joint Committee is made up of representatives from each CCG. To make sure that decision making is open and transparent, the Committee has an independent lay chair and two lay members drawn from the CCGs, and meets in public every second month. The Joint Committee is underpinned by a memorandum of understanding and a work plan, which have been agreed by each CCG**.**

30. The Joint Committee is a sub-committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the West Yorkshire and Harrogate programmes of work that have been expressly delegated to it by the CCGs.

West Yorkshire Association of Acute Trusts Committee in Common

31. The six acute hospital trusts in West Yorkshire and Harrogate have come together as the West Yorkshire Association of Acute Trusts (WYAAT). WYAAT believes that the health and care challenges and opportunities facing West Yorkshire and Harrogate cannot be solved through each hospital working alone; they require the hospitals to work together to achieve solutions for the whole of West Yorkshire and Harrogate that improve the quality of care, increase the health of people and deliver more efficient services.

32. WYAAT is governed by a memorandum of understanding which defines the objectives and principles for collaboration, together with governance, decision making and dispute resolution processes. The memorandum of understanding establishes the WYAAT Committee in Common, which is made up of the Chairs and Chief Executives of the six trusts, and provides the forum for working together and making decisions in a common forum. Decisions taken by the Committee in Common are then formally approved by each Trust Board individually in accordance with their own internal procedures.

West Yorkshire Mental Health Services Collaborative

33. The four trusts providing mental health services in West Yorkshire (Bradford District Care Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership Foundation Trust and South West Yorkshire Partnership Foundation Trust) have come together to form the West Yorkshire Mental Health Services Collaborative (WYMHSC). The trusts will work together to share best practice and develop standard operating models and pathways to achieve better outcomes for people in West Yorkshire and ensure sustainable services into the future.

34. The WYMHSC is underpinned by a memorandum of understanding and shared governance in the form of 'committees in common'.

Local council leadership

35. Relationships between local councils and NHS organisations are well established in each of the six places and continue to be strengthened. Complementary arrangements for the whole of West Yorkshire and Harrogate have also been established:

    - Local authority chief executives meet and mandate one of them to lead on health and care partnership;
    - Health and Wellbeing Board chairs meet;
    - A Joint Health Overview and Scrutiny Committee

- West Yorkshire Combined Authority
- North Yorkshire and York Leaders and Chief Executives

Programme governance

36. Strong governance and programme management arrangements are built into each of our West Yorkshire and Harrogate priority and enabling programmes. Each programme has a Senior Responsible Owner, typically a Chief Executive, accountable officer or other senior leader, and has a structure that builds in clinical and other stakeholder input, representation from each of our six places and each relevant service sector.

37. Programmes will provide regular updates to the System Leadership Executive and System Oversight and Assurance Group. These updates will be published on the partnership website.

Partnership wide arrangements

Partnership Board

38. Our intention is to establish a Partnership Board to provide the formal leadership for the Partnership. The Partnership Board will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together as Partners on the range of matters highlighted in section 7 of this Memorandum, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

39. The Partnership Board is to be made up of the chairs and chief executives from all NHS organisations, chairs of Health and Wellbeing Boards and chief executives from councils and senior representatives of other relevant Partner organisations. The Partnership Board will have an independent chair and will meet at least four times each year in public.

40. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time our expectation is that regulatory functions of the national bodies will increasingly be enacted through collaboration with our leadership. It will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

System Leadership Executive

41. The System Leadership Executive (SLE) Group includes each statutory organisation and representation from other Partner organisations. The group is responsible for overseeing delivery of the strategy of the Partnership, building leadership and collective responsibility for our shared objectives.

42. Each organisation will be represented by its chief executive or accountable officer. Members of the SLE will be responsible for nominating an empowered deputy to attend meetings of the group if they are unable to do so personally. Members of the SLE will be expected to recommend that their organisations support agreements and decisions

made by SLE (always subject to each Partner's compliance with internal governance and approval procedures).

System Oversight and Assurance Group

43. A new system oversight and assurance group (SOAG) will be established in 2018/19 to provide a mechanism for Partner organisations to take ownership of system performance and delivery and hold one another to account. It will:

    - be chaired by the Partnership Lead;
    - include representation covering each sector / type of organisation;
    - regularly review a dashboard of key performance and transformation metrics; and
    - receive updates from WY&H programme boards.

Conclusion

44. Kirklees OSC are asked to note and comment on the developments set out in this paper.

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Annex 1: Partnership Governance Arrangements