Integrated Governance II:

Governance Between Organisations

Whole system governance across the boundaries of care

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Foreword

The eager adoption of localism by both the political class and the service providers of health and social care appears as a core principle in current thinking about how these services are to be delivered to local communities.

That is an exciting shift away from attempts to establish common pathways of care to be adhered to irrespective of local circumstances, in accordance with performance measures set by a plethora of regulatory bodies and in accordance with "central guidance".

The current complexity of care pathways in which a client, patient or customer passes from one care agency after another - and sometimes back again - will require no mechanistic management of such pathways. The agencies involved may be in the public, commercial or voluntary sector. Their style may reflect the politics of a local authority, the financial imperatives bearing down on a small GP practice or the competitively won contract of a commercial or charitable healthcare organisation.

This study addresses these ever more complex and unpredictable processes.

Clarity in the expectations organisations may have of each other is required. Cultural competence is required of the staff of an organisation able to understand the differences between organisations and manage the disjunctions before service users become aware of them must be developed. The development of an easy facility to handle swiftly points of transition (and possible misunderstanding) at times of urgent need must have occurred before systems are stressed and emergencies arise.

The Good Governance Institute has again presented a map of the new areas of potential misunderstanding and confusion. They lay out the requirements which interacting organisations with entirely different systems of accountability must address if the need for effective coherent and compassionate care is to continue to be provided.

The current changes in our systems of care will take place at a time of unprecedented financial pressure. Local Government cannot afford the margins of safety to which we have been accustomed. The NHS pathway is now stretched out between the commissioning and referral processes of general medical practice and the quasi -commercial ambitions of the Foundation Trusts and any other "willing provider". Without the oversight of health authorities or primary care trusts able to provide oversight and a "smoothing" function we may see gaps widen between the organisations of care.

Bullivant and Corbett-Nolan understand that danger. Here they lay out the means by which self-regulated governance can protect against inter-organisational breakdown. They will require an enthusiastic response from both the new and existing bodies providing care along the way.... and time must be of the essence!

Professor Bryan Stoten

1 - Introduction: what is Governance between Organisations (GBO) and the approach of this book

No man is an island, entire of itself. (John Dunne)

Governance between organisations (GBO) is a term we have developed to help us highlight and understand the governance and accountability issues where a service element is of concern to more than one organisation. This concept we initially floated in our debate paper (IHM, 2008) [1], and has three themes:

1. Governance across the whole pathway or continuum of care, where one episode of contact with health and social care services is the responsibility of more than one organisation
2. Partnerships, where a formal or quasi formal but ongoing relationship exists between more than one organisation to further a common endeavour
3. Mutual aid, where some kind of emergency or unexpected situation requires an organisation to seek help from others. Often this is in an unplanned way, and brings with it a variety of governance and accountability issues that have not been thought through or rehearsed.

This book takes these issues further, and provides us with the opportunity to bring together in one place much of the thinking that has taken place since the debate paper was published. We ourselves have been working with many organisations grappling with these issues at a practical level, and in researching this book we have uncovered many others who are on the same odyssey even if occasionally different words are used, such as systems governance, partnership governance and inter-organisational governance.

We cover the three themes in the round but focus on a key element of each together with an overall concern as to how boards seek assurance at the boundary

The focused areas are:

- Continuity of Care: focusing on **joined up commissioning** for outcomes and **patient handover**
- Partnership: focusing on **joint decision taking and accountability**
- Mutual Aid: focusing on **business continuity and anticipating unknowns** together with a section covering assurance issues at the boundary between organisations

We recognise the changes in the health landscape and are working up a practical set of guidance as part of the GGI body of knowledge (see Appendix) for GP Consortia which follows this model and allows GPs to ensure that Governance principles:

- will be no less than required by statute or expected of any commercial entity
- will be robust in providing public confidence in GP Consortia's ability to deliver the tasks set out in the White Paper
- will support and maintain GPs individual and collective reputation

The format for this is as follows:

1. What is required by statute?
2. What is required as licensing requirements?

[1] J Bullivant, M Deighan, B Stoten and A Corbett-Nolan, Integrated Governance II: *Governance Between Organisations – a debate paper*, Institute of Healthcare Management June 2008

3. What is common practice by NHS partners and suppliers and other commissioning bodies?
4. What is better practice to aspire to?

This also reflects the terminology used in the South African Corporate Governance guidance (King III) with "must" indicating a legal requirement (nos 1&2) and "should" indicating where application will result in good governance (Nos 3 &4).

In distilling both our work and that of others, we have tried to ensure that GBO becomes a useful arm of reform for the NHS. The overall focus is on:

1. helping organisations deliver better, more cost effective healthcare - GBO must be a means to an end not an end in itself
2. reflecting the complexity of a world seeking to reconcile competition and collaboration
3. anticipating GP Consortia (GPC) and working with local authorities and other partners

All in the public sector understand the need to work together, but this often produces tensions at the boundary. Often in these 'white spaces' we find no one is in charge or responsible. However, for patients and service users, this is where important handoffs between functions should be happening and happening well. They find it frustrating and worrying that their care falls between the cracks, or their case disappears into a black hole. This often results in misunderstandings and delays. However, it is at these fissures between services that organisations often have the greatest potential for improvement.[2]

David Nicholson echoed this opportunity in the Operating Framework for 2010/11[3], where he stated;

'The quality and productivity gains we need to make lie not within individual NHS organisations but at the interfaces between primary and secondary care, between health and social care, and between empowered patients and the NHS'

This is a dilemma, which the government now both recognises and seeks to address: 'We are also acutely conscious of the need to balance the dual imperatives of clear and unambiguous accountability, and properly joined-up services. The Government will therefore publish three separate frameworks for the NHS, public health and social care which are designed to incentivise collaboration and, in some cases, hold organisations to account for providing integrated services'. (Liberating the NHS: Legislative framework and next steps, December 2010, Gateway 122707)

In this book we discuss in detail the importance of effective partnerships and networks and the responsibility to provide joined up services. We also consider just how well do we react in an extended emergency when the tension exceeds our span of control or geographical influence. GBO embraces some of the overarching themes of these issues. This book discusses the roles and tensions for individual boards and top teams in responding to factors that extend beyond their 'set' boundaries and we believe this raises a series of important and timely issues for GP consortia and other commissioning and scrutiny boards seeking to operate with a lighter touch governance.

The environment for this is not healthy. We know how difficult it can be to deliver individual public

[2] Geary A. Rummler and Alan P. Brache, *How to Manage the White Space in the Organization Chart,* Jossey Bass Business Management and Series 1991

[3] D Nicholson, NHS Operating Framework for England for 2010/11, Department of Health December 2009

services in a political environment at a time when management is not getting its best press and encouragement to take risks. It has prompted testy behaviour in the best of us. For example, BBC's Director General Mark Thompson's statement that 'we are not a county council; if you want someone to run BBC One or develop iPlayer, you need the very best people in the world.[4]" provoked the ire of those managing care services who pointed to the complexity of their task, a task which increasingly comes under the light of public scrutiny[5]. GBO takes this one step further still, requiring us not to shirk the responsibility for a joined up experience of care, while building confidence that we can deliver with others across organisational boundaries.

In such a complex system, and with services managing the care for such a large proportion of the population, there will always be some degree of failure, and often this will be presented in the press as a scandal. Recent years have shown that it is not just the public sector that can fail badly. It is quite possible that this pattern of failure will be exacerbated in the radical changes facing us from 2011. However, getting it right in a complex and unstable environment is much harder. It requires unleashing the power of innovation, and learning the telling lessons from failure. Tom Peters quotes David Glass on Sam Walton, Wal-Mart founder, saying 'his number one secret was that he was unafraid to fail'[6].

Perhaps our public services have become just too controlled and complex to manage. There are lessons to be drawn from 'small is beautiful'[7] messages whereas our current organisational trend despite devolution to GP consortia is towards ever larger, conglomerates. Examples include the creation of the super Health boards in Wales and Trust mergers and takeovers in England. Jessop comments 'Given the growing structural complexity and opacity of the social world, indeed, failure is the most likely outcome of most attempts to govern it in terms of multiple objectives over extended spatial and temporal horizons -- whatever coordination mechanism is adopted.'[8]

Rick Belluzzo, CEO of Quantum spoke in London in October 2010 and reflected on his experiences at Microsoft and Hewlett Packard. He encouraged NHS leaders, whether managers or clinicians to:

- Embrace the disruption- look for opportunity
- Suspend disbelief- it can be done
- Be on the right side of gravity: use the forces going your way and get alignment to a common path

(Leading for Health leadership master-class, London (21.10.10))

Governance is not management of course but good governance creates the environment to ensure that services we are responsible for are on track, and that staff are held to account. Seeking to secure safe and effective services across boundaries is considerably more complex. We argue here that this cannot be just a management issue, but is also a governance concern. Failure by our partners can compromise the services for which we ourselves are responsible. If we find constantly that it as the boundary that we let our service users down, then this must be a concern of our boards and commissioners. The clear challenge is to develop the skills and authority to ensure that

[4] Bridget Middleton, *"Mark Thompson looks ahead",* Ariel January 2010

[5] James Robinson and Sam Jones, *"Mark Thompson sparks new BBC row with county council comment"*, Guardian 8th January 2010

[6] Tom Peters, "Excellence: Don't Fear Failure", www.tompeters.com 2010

[7] E F Schumacher, *"Small Is Beautiful: Economics As If People Mattered"* 1973

[8] Bob Jessop, *"The Dynamics of Partnership and Governance Failure",* from G. Stoker, ed., *'The New Politics of Local Governance in Britain,"* Oxford University Press 1999

constructive partnerships are designed, built and deliver better care.

In 2008 we wrote[9] in our GBO debate paper:

'*In our complex world we cannot operate without the support of others but partnerships and other relationships bring risks as well as opportunities to both service delivery and our reputation. We must manage these but our Board must also seek assurance that risks to our strategic objectives have been identified by our partners with adequate controls in place'* (IHM 2008*).*

In September 2010 reflecting on the new governments agenda David Nicholson said:

'…we can only succeed, both in supporting the design of a new system and in continuing to deliver, by working in partnership. This will mean NHS organisations working more effectively together, with their staff, and more closely with colleagues in local government, the proposed new public health service and the independent sector. And it will mean seeking genuine partnerships rather than competing for leadership space.'

Managers in the public sector are strongly tied into their accountabilities within the organisation and up the accountability food chain to meeting regional and national policy and targets. This is universal but especially so in nationally managed organisations such as the NHS and Police. There is local accountability too, but career prospects are largely determined by adherence to these directives and reporting requirements. Boards can suffer from this but in a legal entity (such as an NHS Trust) their sovereignty carries both freedoms and accountability to a wider group of stakeholders. This means shifting accountability away from simply doing the ministers bidding to a responsibility to meet the needs of their local constituencies. NHS Managers used to the 'comply or else' regime need to be supported towards the better governance focus of "application" versus "compliance". This approach of doing the right thing and explaining why requires a greater degree of authority and independence.

In South Africa the King III Corporate Governance Framework (2009) applies to all public and private institutions and has moved beyond the more common 'comply or explain' UK model to embrace 'apply or explain'. A board may conclude that applying a recommended practice is not necessarily in the best interests of the enterprise and apply a different practice provided that it *explains* the practice adopted and its reasons for doing so.

John Bullivant speaking at the 2010 HSJ Conference on Integrated Care said 'I would go a step further and use '*apply **and** explain*'. The Board should disclose which principles or practices they have decided to apply and explain why these, and not others. This explicit level of ownership would allow stakeholders to comment on and challenge the board to improve levels of governance. We believe this would be a suitable model for GP commissioners seeking a streamlined system of governance'

'How do you know what you don't know?' is a common plea by board members worrying about high impact events outside normal scanning. Such 'black swans' are by definition not predictable. When we use predictive models of possible outcomes based on historical trends we ignore and minimizes the impact of events, which are outside the model. For example, a simple model of daily stock market returns might have anticipated 1987's Black Monday, but not the market breakdowns following the 9/11 attacks. A fixed model considers the "known unknowns", but ignores the "unknown unknowns". As Donald Rumsfeld so eloquently put it:

[9] J Bullivant, M Deighan, B Stoten and A Corbett-Nolan 2008, Ibid

'There are known knowns. There are things we know that we know. There are known unknowns. That is to say, there are things that we now know we don't know. But there are also unknown unknowns. There are things we do not know we don't know.'

(This statement was made at a press briefing given by former US Defense Secretary, Donald Rumsfeld on February 12, 2002. Mr. Rumsfeld's statement relating to the increasingly unstable situation in post-invasion Afghanistan, was widely viewed as elusive and indicative of arrogance, whilst at the same time reflecting a profound, almost philosophical truth. The statement has been acclaimed as poetry but also won the 2003 Foot in Mouth award from the Plain English Campaign.)

2. Context- How the Governance between Organisations (GBO) programme has developed

In 2008 at the NHS Confederation Conference Professor Bryan Stoten, then Chair of the Confederation, launched the *Governance Between Organisations* debate paper – the second step in the development of integrated governance. Whereas our first series of papers concentrated on Integrating Governance within an organisation (see HFMA and DH guides on integrated governance), this new programme he explained would 'focus on alignment between organisations. Covering mutual aid, care co-ordination and partnership working the debate paper identified steps that NHS organisations need to be taking to ensure joined up accountability in an increasingly complex local health and social care market.'

The concept of *Governance Between Organisations* is predicated on the principle that it just as important to have good governance between organisations as within organisations. 'A service that stops at the doors of the hospital or when a partner fails to deliver is not really a service, it's a broken link in the chain of care.'

Nearly all investigations seem to highlight the communications and handover failings between organisations. These often seem to be a factor of ill conceived partnerships, a lack of planning or a failure to ask questions or receive assurance that extends beyond the boundaries of individual organisations. Even in systems that have integrated health or health and social care services there are still boundaries with criminal justice and educational agencies and a tendency for pre-existing cultures and systems to persist beyond merger (see GBO in Catalyst. PSMW, Issue 16 Nov 2009 '*Problems often occur at the borders between one organisation or team and another*' (Learning from investigations, Healthcare Commission Feb 2008)

However the same investigations make it clear that public bodies in particular cannot absolve themselves of responsibility when things go wrong just because they have referred or transferred the patient, the records or the monies.

The Healthcare Commission (HCC) report on Mid Staffs NHS FT (March 2009) was reported to NHS City and Hackney Board in October 2009 as finding that:

'The PCT's commissioning process did not inquire closely enough into specific aspects of quality of care being provided (e.g. process of complaints handling, the Trust's performance around cancelled operations, appointments and A&E waiting times etc). The PCT had been assured by the Trust's ratings in the Annual Health Check and the successful application of Foundation status. The Trust had also achieved a saving of £10 million however it had not been made aware that the savings could have affected the quality of care provided.'

Patient safety reporting still seems to fail to reach boards of both providers and commissioners. One

in 10 hospital trusts have confessed to not regularly reporting patient safety and outcomes at board level, more than a year after Lord Darzi's next stage review said care quality should be "at the heart of the NHS". Dave West, HSJ, 26.11.09

Of course it is the manager's job to manage and whilst it has been argued that ''dealing with boundary risks is a function of *management* between organisations, not *governance' (Healthcare Governance Review, June 2009),* the Board must hold not only its own organisation to account but also its partners and suppliers. 'You cannot outsource your reputational risk'. Governance between Organisations therefore seeks to tackle the key areas of governance where relationships are critical.

There is support for this argument from the Audit Commission who in 2005 argued *'In the absence of formal governance arrangements, responsibility for supporting the governance of partnerships falls to partners' own corporate governance mechanisms'*. (Governing Partnerships, AC, 2005).

In other words *'you look after your governance an I'll look after mine but if yours is failing I cannot stand by'*

This raises important questions such as: 'Who is accountable when our staff work in other's premises?' ; 'Who can cut pooled budgets?'; 'Who is responsible to see a patient home to a place of safety?'; 'Will we send staff into harm's way to help our colleagues elsewhere in the *National* Health Service?' Does our board assurance framework (BAF) cover boundary and reputational risks?

A working definition of GBO is **"the means by which organisations whether in the public or private sector can mutually assure themselves and their wider stakeholders that they have in place the mechanisms to align their governance requirements where their activities inter relate in order to provide greater accountability, transparency & mutual aid awareness".**

As an NHS Oldham representative pithily explained at a CIPFA conference 'in English this means… boundary risks are identified & controlled. Accountability & Assurance & Awareness (is present) at all stages in the process' (Andrew McGrath, CIPFA 2008)

At the July 2008 conference on GBO (Healthcare Events, 2008), speakers identified safeguards they felt ought to be taken when embarking on partnerships. For example, partners should ensure they take time to understand each other and check that they share common objectives, a similar culture, values and ethical standards. Good relationships between partners need to be fostered continually at all levels, individual as well as corporate. They had to share regular and open communication, and understand fully how the actions of one organisation could have considerable and lasting effects on the other. Regular and constant monitoring of how the partnership is working is important – as are an ability and willingness to act swiftly and positively when necessary.

The NHS Operating Framework for 2010/11 challenged all NHS organisations to reduce overheads and management costs. This was not intended at that time 'to cause a rash of cuts or mergers, but to generate imaginative thinking about how organisations could better collaborate on some of their commissioning or provisioning functions, not just within the NHS, but with Local Authority and other partners'.

The GGI has published a number of papers since the original debate paper. Following consultation the debate paper was reissued on the IHM website in December 2008 and a set of board assurance prompts were published by Bradford & Airedale PCT and the Institute of Healthcare Management: (Board Assurance Prompts: Key questions to ask when scrutinising governance between organisations (IHM, 2008/9 edition.). These allowed boards and local authority scrutiny panels to

consider likely scenarios they might face at the boundary and to consider how they would react or expect their partners to respond.

In a series of workshops and conferences held in 2008/9, a partnerships etiquette was developed and the first set of GBO simple rules were published by GGI and IHM (see GBO bookmark). The simple rules followed the three themes of continuity of care, partnerships & networks and mutual aid and business continuity with a fourth theme covering overall assurance at the boundary.

Governance between Organisations (GBO) Simple Rules

Continuity of Care

1. Joint commission outcomes and connectivity of care pathways from primary through acute, diagnostics, tertiary to community and home.
2. Patient handover, referral or data transfer: Take the extra step – have they arrived: What has not arrived?
3. Review and apply lessons from investigations elsewhere (NHS and other sectors) - could it happen here?

Partnerships & Networks

4. Jointly audit critical processes across the boundary (clinical, financial, information etc) at appropriate depth & frequency respective to risk
5. Be consistent in telling patients/carers what they are entitled to and when they are holding responsibility for their own care
6. Check our partners/suppliers have the capacity to deliver their obligations to us. Mutual Aid & Business continuity
7. Engage with other organisations to support us in case of long term or widespread service collapse
8. Establish and test partner forums including mutual aid agreements to coordinate planning with escalation proportionate to the developing risk Assurance
9. Include reputational risks and potential failure of partners and suppliers in the Board Assurance Framework (BAF)
10. Apply rules for new staff (CRB checks, data handling, competence, qualifications etc) to existing and agency staff

(IHM/GGI ISBN 978-1-906877-02-6)

The rest of this book expands on these 10 themes in the simple rules guide, drawing on the board assurance prompt scenarios, some of the boundary issues identified in the OUBS/SDO Research and further described in the Routledge 2010 publication: 'Governing the New NHS: Issues and Tensions in Health Service Management' published by the authors together with Professor John Storey.

At the end of each section we have identified some questions that Boards and commissioners might like to ask to scrutinise their own and partner/supplier governance and built these into a maturity matrix to support self-assessment.

Finally we conclude with some issues which we believe still need debate and resolution.

3.1 CONTINUITY OF CARE

GBO is relevant at levels of planning and commissioning of services up through the more complex levels of large-scale emergency planning and mutual aid but is most important to the patient at the relatively simple level of individual patient pathways,

"The NHS will refer people but won't check whether the person has arrived. That's a very similar issue to the loss of data at HM Revenue and Customs. If anyone had checked that the disks had arrived the same day they wouldn't be struggling months later when they found they hadn't." In View Issue 18 July 2008, The Institute for Innovation and Improvement

Simple GBO rules – such as staff taking one more step to ensure the patient or the data has arrived – would help in such instances.

Key Elements:	GBO Progress Levels:					
	NO	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
1. Joint commission outcomes and connectivity of care pathways from primary through acute, diagnostics, tertiary to community & home.	**NO**	Recognition that patients expect continuity of care	Services are jointly commissioned and measured by health and social care on basis of pathway of care	Focus on Outcomes is being achieved through focus on Intelligent Funding/results based approach	Metrics and Audit shows patients are being managed along pathway of care without delay or confusion	Patient Pathways are main currency of commissioning, planning and enabling better outcomes

Pathways of Care have a long tradition but curiously do not form the main currency of commissioning which in England is still largely based on activity levels.

Some innovative commissioners are testing the option of buying the service from a single provider who must then deliver the whole pathway of care. This has the potential for both improved quality and lower costs. As David Nicholson says in the introduction to the 2010/11 Operating Framework:

'At the heart of this is the importance of transforming patient pathways, leading to the integration of services and in some cases, the integration of organisations. Where organisational change takes place, it is not necessarily one organisation taking over another, but creating new services with patients and their needs at the centre.'

Others are exploring managed care options and developing integrated care organisations., Housing based services and housing related support for example have grown up in an environment where discreet funding and commissioning is the norm, under the Supporting People (SP) funding programme and the funding which preceded it. Now following the removal of the ring fence from SP, there is all the more reason for these services to be integrated in a way that delivers crisis

diversion, reduce out of borough placements and delivers a more effective pathway to recovery[10].

3.1.1. Joint commissioning

The public expect joined up services but our systems are not designed either to manage systems in a holistic way or to hold public service providers to account. This is a real dilemma for governance. The public consultation for '**The NHS Plan: a plan for investment a plan for reform**' (DH, 2007) sought the public views to find that:

- The inability of the NHS to work properly with social services is a real cause of concern for elderly patients. (Appendix section 1.5)
- Members of the public said that they wanted to see better transport and access to services, better community care, and *more joined up services*. (Appendix section 1.8)

Joined up services was a key element in the first phase of the Labour Party reform programme and the vision of responsive public services set out in the Modernising Government White paper (1999) sought better ways of doing things and better information systems too. This recognised that people had rightly grown impatient about barriers to good, convenient services that stemmed simply from the way the Government was organised.

'One of the problems is the way central government organises itself, in silos, makes it difficult to construct other ways of organising on the ground . We have policy silos, funding silos and regulation silos. We have to get beyond that' (Sir Michael Bichard, Director of the Institute for Government who is overseeing the Total Place scheme quoted in the Guardian 30 9 09).

One response to this has been the creation of an explicit duty, for the first time, for, for all arm's-length bodies to co-operate in carrying out their functions, backed by a new mechanism for resolving disputes without the Secretary of State having to act as arbiter. In particular, Monitor and the NHS Commissioning Board will have to work jointly in setting prices, rather than have Monitor decide and the Board able to appeal.

Joined up delivery requires joined up and accessible information systems; the then health minister claimed in the House of Commons at the end of 2009 "To put it simply, the (NPfIT) Programme is a key part of delivering modern, safe, joined-up health care. It is supporting the ongoing reform of the NHS by giving choice and convenience to patients. The NHS could not function without it," (Andy Burnham HoC 7 12 09).

In 2010 the incoming Coalition government also emphasised the need for an information revolution in Excellence and Equity: Liberating the NHS. The Secretary of State for Health Andrew Lansley said:

'The first principle of the White Paper is that the NHS should ensure that for patients, 'no decision about me, without me' is the invariable practice.'

"To realise this means patients must have more say and more choice" In October 2010 the Government published an information strategy for the NHS. '

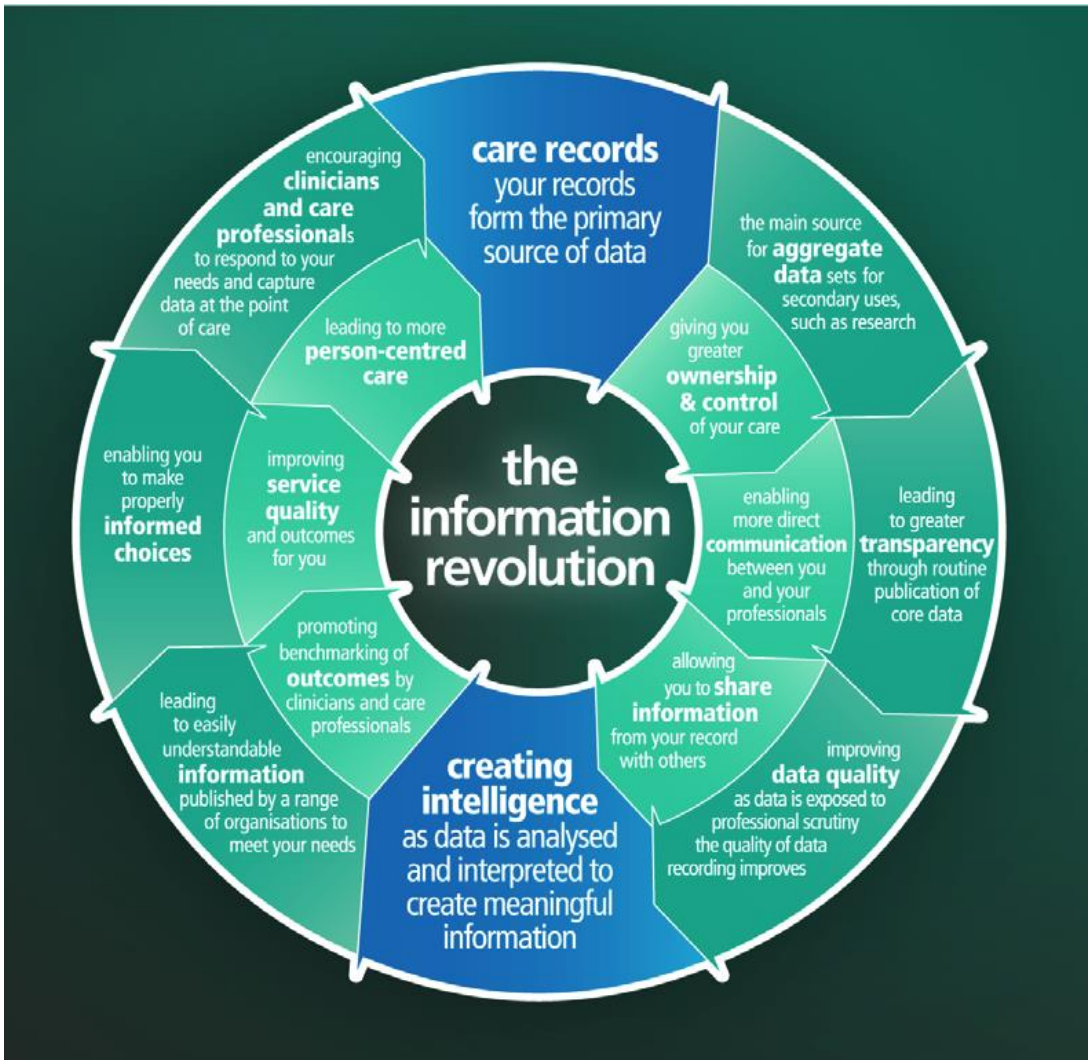
Director General for Informatics Christine Connelly said:

'We live today in an information-rich environment. The information we have changes our perspective

[10] Molyneux P (2010) Health and Housing : World's Apart ? National Housing Federation : London.

and influences the decisions we make each and every day.'

'The time has come to apply these principles to the delivery of health and care services. Building from a base of accurate care records, the Information Revolution will deliver more informed patients, more engaged professionals, more efficient organisations and, ultimately, improved outcomes.'



From: An Information Revolution: a consultation on proposals. 18 October 2010 Gateway number: 14748

Wells Park Practice has been offering patients free online access to their GP records for some years. Patient and practice reactions include:

'I have been able to have some control over my illness rather than allowing it to control me - a very very important thing when dealing with long-term illness/pain.'

'I have a chronic disease and feel a real partner in the management of my health. Whether I am at home or abroad, I can monitor information and share it with any other health professional involved in my care. I would be lost without it now!'

What does patient and service user control of records mean? At present, there is no single overall record of a person's entire health and care history.

A number of local authority-led partnerships are beginning to share assessment, care and support planning information through Common Assessment Framework demonstrators. These are designed to identify and meet individual needs by effective information sharing. Projects will run to March 2012 and be subject to national evaluation. Emerging learning from the work of both the phase 1 and phase 2 demonstrator sites is published on the Common Assessment Framework (CAF) Learning

Network[13].

Joined up working is not, however, a panacea. The National Audit Office report of 2001 "Joining Up to Improve Public Services"[11] notes the five requirements that as a minimum are needed to promote successful joint working. These were said to be:

- **Goals** - working towards clearly defined, mutually valued, shared goals
- **Progress measurement** - evaluating progress towards achieving the desired goal, and taking remedial action when necessary
- **Resources** - ensuring that sufficient and appropriate resources are available
- **Leadership** - directing the team and the initiative towards the goal
- **Working well together** - to achieve a shared responsibility

More recently the Audit Commission reported 'Instead of concentrating on the mechanics of joint financing and the processes of partnership, councils and the NHS should look at how their joint funding can improve people's lives."[12] 'The same report continued, "Outcomes should be the focus of joint working to help older people and those who need mental health and learning disability services[13]'. Michael O'Higgins, the Chairman of the Audit Commission, said when promoting the report:

'Councils and their healthcare partners must agree what they want to achieve through joint funding. Pooling funds can secure improved services for patients and those in need of social care, but often the actual financial arrangements can become the focus of attention.'

These points build on "Clarifying Joint Financing Arrangements"[14], a report published the previous year. That report argued that joint funding should not be happening just for the sake of it.

'There are success stories, and councils and the NHS can also achieve better value for money this way, which should be an added incentive with the financial squeeze ahead.'[15]

Central government was recognized as promoting joint working to achieve better services, but some councils and NHS bodies complained the joint funding arrangements were too complex. It was agued too that it was hard to show whether joint financing has led directly to improvement. Councils and primary care trusts (PCTs) that have joint funding agreements often lack specific, measurable outcomes to identify successes. "Means to an end"[16] shows where joint financing has worked and makes recommendations to councils, the NHS and the Department of Health. These included advising NHS bodies and councils to review how they provide services for health and social care users and the financial frameworks underpinning them.

In December 2009, the Audit Commission published the results of the Comprehensive Area Assessment (CAA). These are local studies called 'Oneplace'. They identified improvement outcomes, and showed what services are like for people living all over England. CAA is the mechanism for assessing locally-delivered public services, bringing together judgements from six inspectorates into

[11] National Audit Office, *"Joining up to Improve Public Services",* National Audit Office 2001

[12] Audit Commission, *Means to an end: Joint financing across health and social care,* Audit Commission, October 2009

[13] Audit Commission 2009, Ibid

[14] Audit Commission, "*Clarifying Joint Financing Arrangements",* Audit Commission 2008

[15] Audit Commission 2009, Ibid

[16] Audit Commission 2009, Ibid

one coordinated view of public services in an area. The primary focus is on the place (outcomes achieved for the community and assessing the risk to future improvement) rather than on individual organisations and past performance. The inspectorates published an annual joint assessment for every area covered by a local area agreement (LAA) on the CAA website.

The Audit Commission gave Torbay as a Case study:

Torbay Care Trust and Torbay Council joined forces (and funds) to improve the user experience, partly in response to a poor assessment rating for adult social care provision. To test the success of their partnership and any weaknesses in coordination between organisations, they invented Mrs Smith, a fictional older person with health and social care needs. They examined how the 'jigsaw' of health and social care services responded to Mrs Smith's needs. Also, how combined staffing (for example, using integrated health and social care coordinators as a single point of contact for users) and joint financing could improve her care. Evidence shows that users can now access services more quickly. More urgent intermediate care cases now see a therapist within four hours, while overall, 30 per cent more care packages are now in place within 28 days of assessment.

The Audit Commission concluded that:

- Whilst the government backs pooled funds and joint working, not all NHS bodies and councils understand what options are available and how to make them work.
- Better joint working and improved understanding between councils and the NHS are benefits from joint financing, but they cannot be quantified. There is a lack of evidence to show the value for money from pooled funds or jointly financed services, let alone the benefits for people using services.
- Joint financing should focus on outcomes for service users rather than processes or the specific method by which the service is paid for.

In 2010 The Coalition Government abolished the CAA. This was been questioned by the New Local Government Network (NLGN) as it 'would remove a key driver for joined up, outcome focused local service delivery' [17]

The Audit Commission in noting all work on updating the area assessment and organisational assessment will cease with immediate effect said:

'We will work with the government and our partner inspectorates to ensure we can continue to increase accountability for local public services through more transparency, richer data and less inspection'.

The Audit Commission itself is also scheduled for closure in 2012.

The White paper Equity and excellence: Liberating the NHS (DH July 2010) focuses specifically on outcomes based commissioning and expects a step change from recent experience. The English NHS has for the last 3 or 4 years been immersed in a formalized and complex World Class Commissioning (WCC) process; a process rejected in Scotland and Wales in favour of whole health board models. The WCC approach managed to join up the various elements of needs assessment, prioritization and planning intentions but proved expensive and short of some commissioning skills, not least because

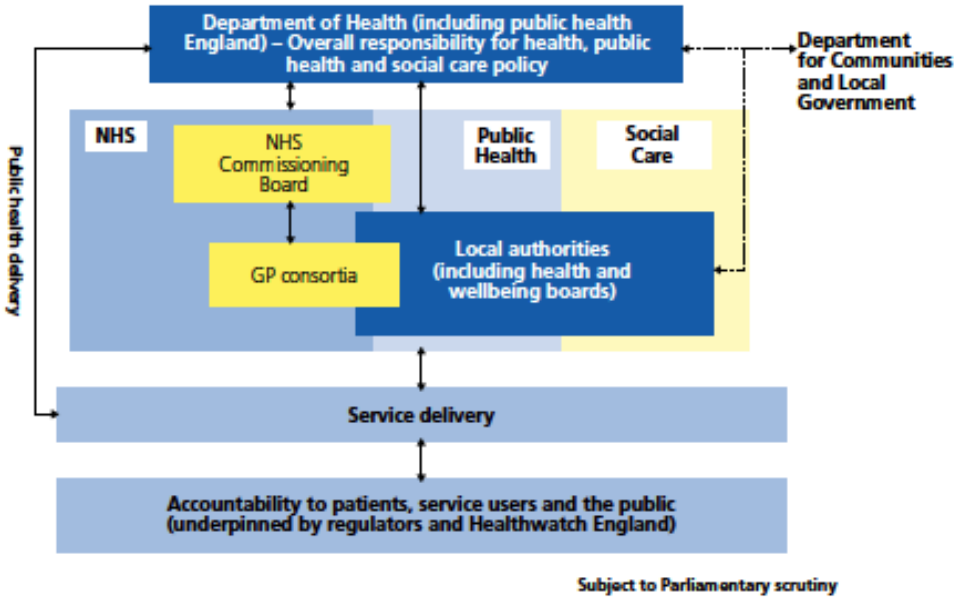
[17] Chris Leslie and Liam Scott-Smith, *Control Shift: A constructive analysis of Conservative proposals for local government and decentralization*, New Local Government Network 2009

the expertise of service innovation was recognised as living in the provider base.

The new NHS Outcomes Framework

The current performance regime in England will be replaced with separate frameworks for outcomes that set direction for the NHS, for public health and social care, which provide for clear and unambiguous accountability, and enable better joint working. The Secretary of State, through the Public Health Service, will apparently set local authorities national objectives for improving population health outcomes. It will be for local authorities to determine how best to secure those objectives, including by commissioning services from providers of NHS care.

However as the 2011/12 Operating Framework made clear when published in December 2010 (Gateway 15216) the Commissioning Board will hold consortia to account for improving outcomes through a new Commissioning Outcomes Framework, and for financial management through its accountability relationship with consortia Accountable Officers.



Local authorities' new functions

Each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement. Local authorities will therefore be responsible for:

- Promoting **integration and partnership working** between the NHS, social care, public health and other local services and strategies;
- Leading **joint strategic needs assessments**, and promoting collaboration on local commissioning plans, including by supporting joint commissioning arrangements where each party so wishes; and
- Building partnership for **service changes and priorities**. There will be an escalation process to the NHS Commissioning Board and the Secretary of State, which retain accountability for NHS commissioning decisions.

These functions would replace the current statutory functions of Health Overview and Scrutiny Committees. However following consultation the government said we 'recognise that our original proposal to merge local authorities' scrutiny functions into the health and wellbeing board was

flawed. Instead we will extend councils' formal scrutiny powers to cover all NHS-funded services, and will give local authorities greater freedom in how these are exercised'; (Liberating the NHS: Legislative framework and next steps (December 2010, gateway 122707).

As well as elected members of the local authority, all relevant NHS commissioners will be involved in carrying out these functions, as will the Directors of Public Health, adult social services, and children's services. They will all be under duties of partnership. Local HealthWatch representatives will also play a formal role to ensure that feedback from patients and service users is reflected in commissioning plans.

As the 2011/12 Operating Framework makes clear (gateway 15216) the Commissioning Board will hold consortia to account for improving outcomes through a new Commissioning Outcomes Framework, and for financial management through its accountability relationship with consortia Accountable Officers

There was even before the coalition White Paper a strong pressure towards joint and specialist commissioning; merger of back room services and a question mark over the transaction costs of 152 PCTs. There must now be a question of how commissioning by GP consortia evolves to achieve improved outcomes and we rehearse below some of the existing intelligent funding / results-based management (RBM) models which in essence focus on buying outcomes through investment in innovation rather than simple activity.

An essay on Intelligent Funding

A focus on outcomes is a feature of modern Overseas Aid programmes including **Intelligent Funding** which was developed for large scale international and domestic funding. Intelligent Funding has been adopted in the UK by the Big Lottery Fund as well as Welsh and Scottish Funders. There are many dimensions to the concept of intelligent funding - it takes account of issues and interactions between policy (what to fund), practice (how to fund), partnership (who to work with) and performance (learning from the funding and sharing that learning).

Principles of Good Practice for the Intelligent Funder

1. UNDERSTAND CIVIL SOCIETY.
   Through innovative tools and mapping exercises, understand civil society and the context in which it operates; identify the "agents and drivers of change" in civil society, and understand their motivations and restrictions.

2. RESPECT CIVIL SOCIETY'S NATURE.
   Respect the diversity and variety of civil society. Do not impose your own agenda, but symbolically acknowledge civil society's diversity through statements of intent that mirror your ethos and determine the rules of your engagement.

3. ENGAGE AS PARTNERS.
   Listen to the stakeholders and beneficiaries, and find frameworks for dialogue and applied learning. Act on what you have been told – engage your stakeholders and ultimately aim to build a real partnership with the recipients of your funding. Find forums to channel the engagement, such as multi-stakeholder groups. Build ways of engagement with other donors from your sector, and other sectors.

4. HAVE A LONG-TERM VIEW.

Balance the short-term goals with long-term, strategic approaches. Be in it for the long haul – become an effective partner for your beneficiaries, and help them build their capacity through long-term and core support. Find ways to make your funding approaches clear and consistent.

5. MAXIMISE COMBINED RESOURCES.
Be responsive to the local context in your programming. Tap into the ideas, resources and enthusiasm of your civil society partner and maximise those combined resources.

6. FOCUS ON ACCOUNTABLE RESULTS.
Adhere to self-regulation, good practice guidance and standards set with your peers. Agree on expected and realistic outcomes with the grantee through results-based management and consequently ensure a shared strategic approach. Inform your beneficiaries about any changes in your approach.

7. BE TRANSPARENT.
Be open about your opinion and evaluation processes and results and your aims and motivation in entering a funding relationship. Be clear in your purpose and intentions, about the source of your funding and the process of your decision-making.

8. INVEST WITH PURPOSE.
Funding civil society is an investment of more than money. You invest time, intellectual and financial capital. Define why you are investing in a specific partnership, what your purpose in this relationship is, and what you wish to receive in turn from your partner.

9. LEARN.
Innovate, test and implement methods of evaluation and assessment to continually improve your understanding, effectiveness and responsiveness, in a manner that is neither too arduous nor just ticking boxes. Work with your civil society partner on learning lessons from your partnership.

10. SHARE WITH YOUR PEERS.
Share your learning and knowledge with other donors, through formal and informal engagement. Become a more effective donor through harmonisation with other donors.

(The Scottish Council for Voluntary Organisations / CIVICUS)

The New Opportunities Fund & Community Fund Draft Report on **'The Intelligent Funder'** prepared by CRG Research Ltd and the Wales Funders' Forum in 2004 pointed to clear internally- and externally- focused characteristics an Intelligent Funder will tend to demonstrate.

Externally, the Intelligent Funder will tend to:

- 'Scan the sector' – keeping up-to-date with new thinking (internationally) in relation to funding and more widely, maintaining an appropriate research and intelligence capacity
- Understand where it fits into the overall pattern of funders: adjusting its role in different funding arrangements and keeping open communication channels with other funders
- Retain a clear customer focus, covering not only those receiving grants directly, but end-users too
- Work openly and equitably with partners
- Give community involvement and programme sustainability high priority
- Support capacity building in high priority areas where constraints can be identified

- Know when to cease funding.

Internally, the Intelligent Funder will need to:

- Establish clear values and priorities for action
- Take care to learn from experience, and evaluate effectively
- Retain sufficient flexibility in processes to adjust to emerging needs and opportunities
- Have a clear understanding of the impacts it expects, and how these will be recognised
- Be prepared to be appropriately innovative end take responsible risks
- Adopt 'proportionate' management controls and procedures – whilst retaining **accountability** for the funds it distributes
- Seek balanced cost-effectiveness – requiring good value for money without compromising the attainment of high quality outcomes

The concept of accountability encompasses a wide variety of standards and good practice. In the context of intelligent funding, it can mean anything from self-regulation, to transparent communication with CSO* Partners and adherence to good practice (*CSOs or Civil Society Organizations are defined by Oxfam as NGOs, community-based groups, networks and associations).

The intelligent funder can optimise their accountability by undertaking steps to establish clear and more consistent funding practices, increase their efficiency by reducing response time to proposals and consider overall strategic approaches such as results-based management (RBM) and Outcome Based Accountability.

RBM is essentially an approach that incorporates every stage of the life-cycle of a project into its design from the earliest stage. This means defining realistic, expected outcomes, clearly identifying the beneficiaries of the programme, identifying the risks to a programme and how to manage them, as well as tools to monitor progress, report on outcomes and draw lessons from the findings. An extension of this approach can be found in the New Zealand originated benchmarking model TRADE which seeks to identify and achieve better outcomes through improved process design (see http://www.coer.org.nz/trade)

TRADE consists of five stages:
Terms of Reference (plan the project)
Research (research current state)
Act (undertake data collection & analysis)
Deploy (communicate & implement best practices)
Evaluate (evaluate the benchmarking process & outcomes)

The approach is promoted in the UK by the Benchmarking Institute benchmarkinginstitute.co.uk and the Best Practice Club (see http://www.bpclub.com/content/home.asp)

The Scottish Council for Voluntary Organisations (**SCVO**) quote as a RBM case study the example of the Canadian International Development Agency (CIDA) who since 1996 have integrated results-based management into all their policies. In 1998, this was complemented by the Agency Accountability Framework.

The basic definition of accountability in the framework requires that CIDA identify its objectives and demonstrate that the resources allocated to it for official development purposes are managed to

achieve the intended results. It also requires that the Agency report the results achieved in its development programs to Parliament and the Canadian public. The framework indicates that, through its partnerships with developing countries and Canadian and international partners, CIDA share accountability for development results and its own accountability must be viewed in that light. CIDA accepts responsibility and accountability for monitoring actions by its recipient partners as well as other events that may affect development goals, and for acting to ensure that momentum toward these goals is maintained.

This shared accountability for ODA delivery makes it especially important for CIDA to follow through on its programs and projects so it can be in a position to report on whether Canada's ODA is producing the expected results. This type of information would be useful to include in CIDA's Performance Report to Parliament.

CIDA accepts that it is fully accountable for achieving operational results. This means that it is fully accountable for the setting of objectives, formulation of policies, selection of development initiatives, allocation of resources, monitoring and performance reporting. This also involves identifying expected outputs and outcomes, assessing related risks and monitoring them, and taking appropriate corrective action.

A joint task force, representing CIDA and the community, defined results-based contracting as "a contracting method which employs an iterative and participatory approach to results definition and seeks to promote the achievement of development results through appropriate contractual terms such as the statement of work, the basis of payment (including incentives) and mutually accepted performance indicators."

Results-based management is expected to help CIDA to be an accountable funder by clearly defining the roles and responsibilities, expected results and parameters for reporting. RBM obligates CIDA to better reporting and transparency. For its partners, the existence of a standard project cycle makes the work with CIDA predictable. At the core of CIDA's RBM is the results-chain", describing the steps of a project from inputs to activities to development results – broken down into three categories: outputs (immediate, visible consequences), outcomes (short or medium-term effects) and impacts (broader, longer-term effects). While RBM makes CIDA more accountable in its funding relationships, it tends to favour quantifiable results over qualitative evidence in the way the evaluation is set out. This limits RBM for reporting on multi-lateral development activities, where it can be difficult to measure outcomes in the short-term and on a regular basis.

RBM should be viewed less as a tool and more a way of working that looks beyond activities and outputs to focus on actual results; the outcomes of projects and programs. CIDA claim they use RBM to effectively and efficiently manage Canada's international development aid.

However the Agency has not been as successful in its attempt to develop results-based contracting as it hoped. It has recognised that the complexity of trying to develop a results-based contracting approach was much greater than expected and the Agency sought to review and simplify CIDA's contracting for results regime. A revised and updated policy was approved in 2008.

The CIDA mantra now is that effective accountability is central to the achievement of development goals.

- Citizens of donor countries expect their donor agencies to be accountable to them for sound management of aid budgets, aimed at contributing to meaningful development results.
- Donor agencies expect recipient country governments to be accountable for using aid

resources in line with agreed plans and expectations.
- Citizens of developing countries expect their own governments to be accountable for using available resources (domestic and well as external aid) in ways that promote agreed social and economic development goals.
- When all these forms of accountability are working well, the result is healthy, sustained pressure on donor agencies and recipient governments to make effective and efficient use of development assistance. "Sector Wide Approaches" (SWAps) present important challenges to the design and management of accountability relationships involving donors, developing countries and the people of developing countries who are the ultimate intended beneficiaries of development assistance.

Recent commentaries focuses on challenges arising in connection with three kinds of accountability relationships:

- accountability between the donor agency and its own government and public;
- accountability between the donor agency and the developing country government;
- accountability between the developing country government and its citizens.

These might be translated in the modern NHS as:

- accountability between the GP Commissioner and its government through the Accountable Officer and to the public in part through local government scrutiny and the new Healthwatch;
- accountability between the GP Commissioner and the service provider
- accountability between the service provider and its patients and wider stakeholders.

The Australian Agency for International Development (AusAID) recognised these challenges and developed a "Multi-lateral Assessment Framework" (MAF) to assess the performance both of AusAID and of the regional and global CSOs it supports. MAF focused on three performance indicators only – *relevance, efficiency and effectiveness*. The MAF reports are based on "explicit acceptance of fundamental problems related to measuring results" Intended to be short and pragmatic, and focused on what the donor can measure and take responsibility for – the rationality of its overall strategy.

The new AusAID health policy signals a major shift from stand-alone projects to a focus on working through **partner government-led approaches**, including government ownership of a single strategic plan We are making efforts to align AusAID inputs closely with national strategic plans and priorities, to harmonise aid procedures with other donors and to use government systems rather than create parallel ones. Common M&E frameworks foster a commitment to mutual accountability for results. The approach generally involves significant capacity development of partner government systems. Although these principles are often associated with sector-wide approaches (SWAps), Australia's health policy stresses that there is no single blueprint for the approach; the principles outlined above will guide Australia's assistance (**AUSAID** HEALTH: ANNUAL THEMATIC PERFORMANCE REPORT 2006–07).

The shift from project-based delivery of development assistance to SWAps has implications for the accountability relationships between all of these parties. Most obviously, it involves a redrawing of the lines of accountability between donors and the developing country governments to which they provide assistance. But it affects other accountability relationships as well. Involvement in SWAps is, for example, forcing donor agencies to find new ways of accounting for their performance to their home governments and their publics. SWAps also focus attention on accountability between the developing country government and its own people, who are the ultimate intended beneficiaries of

development assistance. This vital relationship has often been masked by the fragmented, project-by-project approach to development assistance, which minimized the apparent need to factor the developing country's governance environment into assistance strategies. The SWAp by its very nature makes it more difficult to ignore the impact of governance on development assistance.

The success of SWAps depends on the capacity but also the willingness of the recipient to support the design and implementation of effective programs. This is unlikely to happen in the absence of a robust accountability relationship between the recipient and its citizens. No approach to a SWAp can ignore broader questions of accountability and governance in the recipient. CIDA must do a better job of building governance knowledge and expertise into the design and implementation of SWAps. A governance perspective must not be viewed as an "add-on" to a SWAp; rather, it is a fundamental constituent

The critical implications of this approach for the NHS are that:

- *It re-positions the donor or commissioner in the accountability relationship; we move from a situation where the commissioner is the focus of accountability – the provider reports to the donor – to one where the commissioner and the provider are joint stakeholders with an interest in the success of the sector program; and*
- *The approach requires that commissioner and the provider hold themselves jointly accountable for the success of the SWAp.*

The above is drawn and adapted from 'Sector Wide Approaches, Accountability and CIDA: Issues and Recommendations' By Mark Schacter Institute On Governance Ottawa, Canada *www.iog.ca Prepared for: Policy Branch Canadian International Development Agency January, 2001 and* **AUSAID** HEALTH: ANNUAL THEMATIC PERFORMANCE REPORT 2006–07.

The authors own experience of working with the Wales Funders Forum (WFF) suggested that the building blocks of an Intelligent Funding strategy needed to be classified distinguishing those elements, the removal of which would be critical, and those that if underperforming or absent would not compromise the strategic aims.

This may all appear as a rehash of MBO or **Management by Objectives** (MBO) first popularized by Peter Drucker in 'The Practice of Management' (1954). The essence of MBO was participative goal setting, collectively choosing course of actions and decision taking. An important part of the MBO is the measurement and the comparison of the employee's or external contractee's actual performance with the standards set. Ideally, when employees or providers themselves have been involved with the goal setting and the choosing of a course of action to be followed, they are more likely to fulfil their responsibilities. There were several limitations to the approach including an over-emphasis on the setting of goals compared to using a plan as a driver of outcomes and the under emphasis of the context in which the goals are set. That context can include everything from the availability and quality of resources, to relative buy-in by leadership and stake-holders. In 1991 Rodgers and Hunter concluded that companies whose CEOs demonstrated high commitment to MBO showed, on average, a 56% gain in productivity. Companies with CEOs who showed low commitment only saw a 6% gain in productivity but MBO has waned as a management tool, possibly because it underestimated the continued need for leadership in goal achievement. (Rogers and Hunter (1992, 27))

A review of the impact of outcome based approaches in Hungary in 2004 concluded that:

- commitment to high-quality partnership and management is of vital importance for achieving

projects' objectives, and sustaining their results
- recognition of equality between partners, expertise and flexibility of project management, as well as dedication to success, are the fundamental requirements for flourishing ventures
- strengthened cooperation among international donors could provide for better synergy of projects, thus, leading to exceptionally effective outcomes of assistance programmes.

(See iva Kokolj, Fitting a Circle into a Square: Review of CIDA's work in Hungary – fourteen years later (2004))

None of this is easy. We have been down the outcomes based approach before and it has been found troublesome. The Intelligent Funder model promoted by many philanthropic agencies, including Kellogg's in the US and the Health Foundation and the Big Lottery Fund in the UK suggests:

> *'I'll invest in your great ideas to deliver outcomes not on the means to get there'*
> *'All I ask is that you share your success and failures'*

These statements are both attractive mantras but are difficult to reconcile with accountability for public funds. This is not to say they cannot work or be effective but they need a brave political system and a tolerance for temporary failure not well rehearsed in the NHS and UK government.

Outcome Based Accountability as a methodology is a disciplined way of allowing leaders and stakeholders to identify priority outcomes and build a shared agenda. Key to the work is to avoid the common trap of confusing what we want to achieve for a community and what we need to do among ourselves and by ourselves. When those in the room bring different perspectives and different backgrounds this is far from a simple exercise. In his work 'Turning the Curve' Friedman describes how groups can build a shared view of what needs to happen as well as a shared story of what the critical influences are: Moving from 'checking compliance to helping programmes succeed'. The GGI working with NHS London and 'Learning for health' have developed a series of lock ins that have focussed on building consensus on a conjoint vision of the future and then reflecting back on what would have been needed to get there, A snakes and ladders board provide the visual stimulus to what helps and hinders.

(See Turning the Curve Toolkit: 'From Talk to Action – Making a Difference to Children, Young People and Families' Lives' Portsmouth Children's Trust Development Team, December 2006)

"Developing boards and senior teams- the how to do it guide" from Leading for Health, with a supporting Board Assurance Prompt, NHS London 2010)

Trying Hard Is Not Good Enough – How to Produce Measurable Improvements for Customers and Communities M Friedman 2005

The lock-in approach to Turning the Curve: Steering Through Tough Times in Public Service, Social Enterprises & Charities prepared by Sue Stirling and John Bullivant, Good Governance Institute 2010.

Turning the Curve NLC Board Development Programme video is available from the NLC and GGi websites.

Example Scenario 1: Do we jointly plan/commission/provide joined up pathways of care between service providers? (Derived in part from 'Board Assurance Prompts Key questions to ask when scrutinising governance between organisations 2008/9 edition. Institute of Healthcare Management

ISBN: 978-1-906877-01-9.)

'The GP Consortia is seeking to commission on the basis of joined up pathways of care. There is a feeling that this is frustrated by Payment By Results/ model national contracts, the number of providers, clinical and financial resistance at the Foundation Trust. Although there has been some progress with designing patient pathways from primary to acute to community and social care, there is increasing evidence in complaints and serious untoward incidents (SUIs) that patient care is not joined up and is potentially compromised. The Chairman of the GP Consortia is frustrated that attempts to establish community based services have not released acute resources and she has invited all partners (GPs, Acute, Social Services, the local Hospice and the Community Services social enterprise) to join a service development board to design and build a number of fully joined up and funded pathways. The first examples are to be diabetes, stroke, community acquired pneumonia and 'first fit' epilepsy clinic. There are financial and departmental implications - the acute trust could expect to lose about 40 staff and £4m annual revenue. And there may be governance and competition issue too. The GP Consortia has been advised that "technically although GP Consortia and NHS Trusts have powers to act jointly this does not extend to a power to formally establish joint committees." GP Consortia have the right to form joint committees to carry out their functions and can do so with other GP Consortia but not NHS provider Trusts. The appropriate power is a legacy from Regulation 9 of the Primary Care Trust (Membership procedure and administration) Regulations 2000 (SI no 89 of 2000). They have also been advised that "GP Consortia are of course entitled to appoint non GP Consortia individuals to sit on their committees and this would also apply to a joint committee. Accordingly there is no objection, and indeed it seems to be eminently sensible for the GP Consortia to formally adopt the joint committee and appoint to that not only their own chairs but the chairs of the two Acute Trusts".'

Questions

- Have agreed joint commissioning arrangements?
- Are we focusing on outcomes rather than activity?
- Does our commissioning cover the whole patient pathway or simply that which providers have available? If the later who is responsible for joining up the pathway?
- Do we have effective audit between organisations? See the HQIP documents on board use of clinical audit and audit of patient pathways ('Clinical Audit: A simple guide for NHS Boards & partners' by John Bullivant and Andrew Corbett-Nolan, published by HQIP, January 2010) and 'Facilitating Clinical Audit across Different Care Settings' (HQIP 2010)

Issues for consideration

The internal market behind both the World Class Commissioning (WCC) process and GP Commissioning has been rejected in Scotland and Wales in favour of whole health board models and although the Nuffield Foundation have indicated (*Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution*) that the devolved nations have more expensive healthcare there must be lessons to be learnt from these and other single tier planning and enabling models such as New Zealand even in a commissioning framework. (note that the higher costs were disputed by Scotland and Wales 'the nhs is a lovely apple' see http://news.bbc.co.uk/1/hi/wales/8468687.stm

The immediate challenge though is to work within a reformed commissioning framework creating incentives to deliver safe joined up and cost effective services which deliver a return on investment (ROI) (see the GGI/Datix report: Cost savings in healthcare organisations: the contribution of patient safety A guide for boards and commissioners (GGI 2010)

Key Elements:	GBO Progress Levels:					
	NO	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
2. Patient handover, referral or data transfer: Take the extra step – have they arrived: What has not arrived?	**NO**	Providers have protocols for handover within organisation	Providers have protocols for handover between organisations	All patients & their data checked for arrival at next care setting	Audit shows handover is being achieved without delay or confusion	Handover procedures working well and lessons shared

3.1.2. Patient handover, referral or data transfer: Take the extra step – have they arrived: What has not arrived?

Clinical handover is a recognised issue in maintaining patient safety. Evidence for this can be found in Sentinel Event Program Annual Reports, outcomes of Health Service inquiries, Coroner's recommendations and the international literature. The clinical handover serves as the basis for transferring responsibility and accountability of patient care from outgoing to incoming healthcare teams across shifts, across disciplines and across care settings.

In most areas risk there are agreed protocols for giving and assuming responsibility In the military and high risk sports such as climbing, unambiguous communication is essential. 'You take the helm' is not just a command but a question. 'I have the helm' is the necessary confirmation that reasonability has been acknowledged and assumed.

There are several simple points on which most researchers agree:

- Handovers are a vulnerable time in patient care.
- There is little standardisation and great variation across disciplines and healthcare organisations in the ways in which handovers are.
-

(Johnson & Arora in *Qual Saf Health Care* 2009;18:244-245)

Handover of responsibility for a system from one individual or team to another makes a vital contribution to the safety and effectiveness in many areas of work. Poor handovers have been identified as contributory causal factors in high profile disasters. The Health and Safety Executive found that accidents occurred because of failure of communication at shift handover noting the majority of these involving planned maintenance work. In the 1983 Sellafield Beach Incident, highly radioactive waste liquor was accidentally discharged to sea, due to a failure of communication between shifts. The Cullen Report concluded that one of the many factors that contributed to the Piper Alpha disaster was failure of information transmission at shift handover. (See Health and Safety Executive: Effective Shift Handover - A Literature Review, June 1996).

In 2010 a delivery driver told an inquest that he mistakenly dumped 20 tons of aluminium sulphate into the wrong tank at a water treatment works at Camelford, causing Britain's worst mass poisoning. The relief driver said he let himself into the Lowermoor treatment works, near Camelford, north Cornwall. When no one from the South West Water Authority, which ran the works, turned up, he opened what he thought was the correct manhole and emptied his tank. His error affected water supplied to about 20,000 homes, causing rashes, diarrhoea, mouth ulcers and other health problems. (http://www.dailymail.co.uk/news/article-1325747/Driver-admits-poisoned-water-supply-20k-homes-Camelford.html#ixzz14dM4xtks)

The World Health Organization (WHO) listed "Communication during Patient Care Handovers" as one of its High 5 patient safety initiatives. Improving effective communication throughout the hospital is a lead patient safety goal put forth in the USA by The Joint Commission and the The Australian Commission on Quality and Safety in Health Care (ACQSC) has identified clinical handovers as a particular focus for 2009. In Europe 'HANDOVER**:** Improving the Continuity of Patient Care Through Identification and Implementation of Patient Handover Processes' is a major project coordinated by the University Medical Centre, Utrecht (UMCU) and co-funded by the European Commission.

The overall objective of HANDOVER is to optimize the continuum of clinical care at the primary care / hospital interface by reducing unnecessary and avoidable treatment - medical errors and loss of life, by identifying and studying best practices and creating standardized approaches to handover communication at the primary care hospital interface, and by measuring the effectiveness of these practices in terms of costs and impact on patients.

Handovers in the healthcare sector have come under increased scrutiny with the implementation in 2004 of the European Working Time Directive, which resulted in the introduction of shift working for junior hospital doctors in order to reduce their working hours. This saw a corresponding increase in the frequency of shift changeovers and made effective clinical handover all the more imperative. Yet current practice is highly variable: it varies from ward to ward and hospital to hospital. Handovers are often impromptu, informal and supported by ad hoc artefacts such as paper-based notes. A number of well publicised scandals highlighted the issue and in 2010 the new UK Government seemed to be turning a blind eye to working time rules. The HSJ (14.10.10) reported that the Department of Health has moved to "limit" the impact of the European working time directive on the NHS,

'The DH has stopped monitoring whether trusts are complying with the directive, which restricts workers to a 48 hour working week and was extended to junior doctors last August. It is estimated to cost the NHS hundreds of millions of pounds each year. While trusts are still officially responsible for complying with the European regulations, no data has been collected centrally since the new government came to power.'

An essay on handover initiatives worldwide

Whilst the importance of good clinical handover has been recognised internationally, there is limited research to guide the development of best practice. There has been surprisingly little research (until recently) in the UK into this crucial aspect of patient safety. More attention seems to have been paid in Hong Kong, Australia and New Zealand

Australian guidance on clinical handover for clinicians and managers argues that:

'Handover is a two way process. Good handover practice is characterised by the team who are taking

over the patient's care asking questions and having the opportunity to clarify points they are uncertain of. They should not be passive recipients of information.'

(See app iv *Innovative Approaches to Enhancing Clinical Handover* by *Christine Jorm, Senior Medical Advisor, Australian Commission on Safety and Quality in Health Care* and *Rick Iedema, Professor of Organisation Communication, University of Technology, Sydney, Australia)*

Jorm and Iedema in their paper for the Quality and Safety in Health Care Forum (2010) make the case for clinicians to:

- Understand the critical roles of accountability and responsibility in successful handover
- Distinguish structural (top-down) handover improvements from observational and reflexive (bottom-up) ones

The Australian Council for Safety and Quality in Health Care –described *Clinical handover as 'the transfer of information from one health care provider to another when:*

- *a patient has a change of location of care, and / or*
- *when the care of a patient shifts from one provider to another".*

(May 2005*)*

The Victorian Quality Council (VQC) Clinical handover survey in July 2006 identified three problematic areas as:

1. Shift to shift
2. Acute to community
3. Inter-hospital

Western Australia Country Health Service In partnership with Royal Perth Hospital reported on a Study on Improving Clinical Handover in Inter-hospital Patient Transfers in April 2009.

'Adverse events relating to handover impact on patients and the organisation, leading to situations such as delays in treatment, increased length of stay, patient complaints, injury, and may contribute to a sentinel event. The development of clinical handover systems, such as standard operating procedures, has been shown to help in the reduction of system failures that currently exist but tracing and remedying failures is always complex and trying to incorporate these remedies across several systems and providers is challenging.'

'The quality of current clinical handover practice could be described as ad-hoc in its delivery and format. It depends too heavily upon individuals and does not enlist systems to help rectify identified issues'.

There have been a number of serious handover failures in the UK. In Wales in 2005 a 93-year-old woman died after a fall when she was left at the wrong house by an ambulance crew.

The South Wales Echo reported on Jan 29, 2005 that the crew only realised their mistake when they arrived at Mary P's correct address in Penarth, an inquest heard. Mrs P was later found lying in the garden of a house in Dinas Powys. Cardiff coroner's court was told that the widow, who had dementia, had suffered a fractured femur and died about five weeks later in hospital. The hearing heard Mrs P had gone to Morfa Day Unit, in Barry, on August 20, 2003, for respite care.

At the end of the day she was collected by an ambulance crew which also had six other patients to take home. The crew were given a list of names and addresses, but the list contained details of people due to travel on one of two ambulances. They said they were not told which patients would be on their vehicle.

When the ambulance arrived at the house in Dinas Powys they assumed that Mrs P lived there. The ambulance staff found a key under the front-door mat, took Mrs P into the empty house and left.

After they realised their mistake the crew went back to Dinas Powys but not before dropping off the other patients. Back at Dinas Powys they found Mrs P on the patio crying in pain. She was taken to hospital for surgery but died on September 29.

The Cardiff and the Vale coroner said:

'Mrs P, who suffered from chronic lymphatic leukaemia and dementia, died following a fracture of the femur that she sustained when she fell in the garden of a premises to which she had been returned from a day centre.'

The coroner recorded a narrative verdict - one in which a chain of events have led to a person's death.

In March 2006 The Wales Ambulance Service, and the Cardiff and Vale NHS Trust admitted a criminal charge in failing to discharge their duty of care by exposing the patient to serious risk of injury.

The prosecutor said there was a failure to ensure adequate systems of communication were in place.

In October 2009 North West Ambulance Service apologised to a patient in Manchester who was locked in an ambulance for five hours after the driver went home and forgot about him.

The man, 65, was stranded at Sharston ambulance station, Wythenshawe, after being collected by an ambulance from Manchester Royal Infirmary. A spokesman for the ambulance service said:

'We are very sorry this incident took place. This has never happened before and it will never happen again.'

City University in the UK has been commissioned to undertake some research in this area. The Generic Handover Investigation (GHandI) led by Stephanie Wilson ran from 2007-2010 with the overall aim to conduct a detailed investigation of clinical handover and its contribution to patient safety by developing and evaluating a generic theoretical model of handover and deriving detailed recommendations and prototypes for innovative handover support technology.

This work has the following objectives:

1. To develop a generic model of clinical handover from a socio-technical system perspective that will capture its many commonalities and variations. This will be achieved at both practical and theoretical levels.

2. To design and evaluate prototypes for innovative handover support technologies, integrating

results from 1 and 3.

3. To investigate the role of simple codes and graphic languages in improving communication and reducing ambiguity in information resources used in clinical handover.

4. To investigate the nature of an effective handover and determine how this can be measured.

Some specialist guidance is already available.

Skills for Health – Workforce Projects Team (WPT), the organisation tasked with assisting NHS organisations implement and sustain EWTD compliance, announced the roll out of a new Handover 24/7 IT solution in partnership with Salisbury NHS Foundation Trust.

As one of the successful European Working Time Directive (EWTD) pilot site partners working with WPT, Salisbury achieved EWTD compliance as part of the programme of work, undertaking a risk assessment of the previous handover arrangements.

The results enabled the trust to identify areas where improvements were required and the new IT solution has resulted in a multi professional system supporting verbal handover which can be implemented by any trust with a Hospital at Night (HaN) process in place (or in trusts currently implementing HaN).

Tim Lund, divisional manager and lead for the EWTD programme at Workforce Project Team said in October 2009.

"The necessity for the NHS to meet the EWTD has not surprisingly brought about much debate. We believe that multi professional staff handovers are essential and lead to crucial and relevant information being shared across teams 24/7."

Salisbury and WPT intend to make this IT system software available to twenty NHS trusts providing training and support as part of the package. See *www.healthcareworkforce.nhs.uk/salisbury*

Elsewhere specialist guidance has been developed for example by the Hong Kong College of Anaesthesiologists who created Guidelines on handover during an anaesthetic back in May 1994. This was reviewed in 2002 to provide a detailed clinical approach that could be applied between organisations.

The Guidelines make explicit that during an anaesthetic, the major responsibility of the anaesthetist is to provide care for the patient. This requires the continuous presence of the anaesthetist. In certain circumstances, it is necessary for the anaesthetist to hand over that responsibility to a colleague. Specific procedures must be followed. Handovers will not compromise patient safety provided that these procedures are followed. In prolonged anaesthetics, handover may be advantageous to the patient by preventing undue fatigue of the anaesthetist.

1. Temporary relief of the anaesthetist

This is necessary when the primary anaesthetist must leave the patient but will return to resume management of the anaesthetic.

1.1 The primary anaesthetist will leave only while the patient is in a stable state and no potentially adverse events are likely to occur.

1.2 The primary anaesthetist must be satisfied as to the competence of the relieving anaesthetist to provide care and must have explained all facts relevant to safe management.
1.3 The primary anaesthetist must be available to return at short notice.

2. Permanent handover of responsibility for care

This is necessary when the primary anaesthetist must leave the patient under the care of another anaesthetist for the remainder of the anaesthetic.

2.1 The primary anaesthetist will only hand over responsibility at a time when the clinical status of the patient is appropriate.
2.2 The primary anaesthetist must be satisfied as to the competency of the relieving anaesthetist to assume management of the case. The handover procedure must include a briefing as to the patient's pre-operative status, events during the anaesthetic and discussion of any foreseeable problems.
2.3 The relieving anaesthetist has responsibility to be fully conversant with the patient's present and ongoing anaesthetic management and must indicate a willingness to accept that responsibility.

3. Protocol for transfer of responsibility

The following items must also be considered by the primary and the relieving an anaesthetist:

3.1 The patient's health status having regard to past history and the present condition.
3.2 Observations of the patient according to College Policy Document - *Monitoring During Anaesthesia* as shown by the anaesthetic record.
3.3 A check to ensure correct functioning of the anaesthesia machine and any other equipment which is interfaced to the patient as well as of all monitoring devices in use.
3.4 The provision of information about the handover to the surgeon and (in the case of a trainee) the consultant anaesthetist.
3.5 The time of handover should be documented in the anaesthetic record.

The guidance offers a formal model for transferring responsibility echoing the issues regarding the handover of patients between hospital and ambulance or vice versa ; for example to Accident and Emergency (A&E) departments. Often ambulance crews are seen waiting outside the A&E departments unable to respond to other calls. This is sometimes due to the need of the A&E departments to achieve their own target that no patient should wait for more than four hours from arrival in A&E to admission, transfer or discharge.

This illustrates how performance requirements for one service and the lack of an influential leadership role of the ambulance services in the NHS network by implication, works against good cooperation between different services within the health economy.

Paresh Wankhade and John Brinkman presented a paper Ensuring timely handover of patient care – ambulance to hospital at the "Leading the Future of the Public Sector"— The Third Transatlantic Dialogue May 31–June 2, 2007, University of Delaware · Newark, Delaware USA . They argued that Ambulance services can actively contribute to improve services. For instance, with proper training and equipments, the crew can take appropriate cardiac arrest patients directly to coronary care units reducing pressure on the A&E departments (Audit Commission, 1998). The evidence from their research indicates how the peripheral position of the ambulance service within the system can adversely affect its own performance and put pressure on other organisations.

The South West SHA has developed an assertive protocol to support local NHS organisations in taking effective action to eliminate ambulance handover delays, the guidance: 'Ensuring timely handover of patient care – ambulance to hospital' (October 2008) argued that:

'Delays in the handover of patient care have no place in the modern 21st century NHS. In the majority of NHS trusts across the country handovers happen smoothly and are well managed, but there are still areas where dedicated work is needed to reduce delays and improve the service offered to patients.'

Whilst this guide does not change the existing and established definitions that govern the collection and reporting of patient handover delays, there is very clearly an operational need to ensure a culture of co-operation and an attitude of zero tolerance for delays is embedded across all organisations.

In addition, even where excellent processes, good intentions and the presence of appropriate governance are in place there can still be occasions when a breakdown in communication between the patient, the ambulance crew and the acute team may leave patients feeling as though their experience is not at the centre of the process. This in itself highlights what a key impact patient handover has in patients' experience of emergency care and the importance of always making every effort to promptly acknowledge a patient's arrival in the department, and indicate the next action that will occur.

The report was disseminated by the Department of Health as part of preparations for winter of 9 October 2008 to all Strategic Health Authority Chief Executives (Gateway reference 10645) with the recommendation that all organisations should consider implementing the 14 recommendations:

1. Commissioners should identify an executive lead with responsibility for ensuring timely patient handover delays. Executive leads should commit to working together with other organisations in the local community.
2. Acute Trusts and Ambulance Trusts should appoint a clinical lead to oversee the development and Implementation of clinical handover protocols for acute departments.
3. Acute Trusts and Ambulance Trusts should review and agree protocols for handover, and how data is captured at each stage of the handover process with their ambulance trust for each location that patient handovers occur. Local variance between receiving departments in Trusts should be clearly identified and variances documented in local operational procedures.
4. Acute Trusts, Ambulance Trusts, Primary Care Trusts and Strategic Health Authorities have a responsibility to ensure that handover data definitions are consistently applied.
5. Executive leads should communicate handover data definitions to all staff involved in the management of patient handovers.
6. Ambulance Trusts and Acute Trusts should develop local processes to agree data and sign off collections – including joint reporting.
7. There should be a regular reconciliation process between the Acute Trust and the Ambulance Trust on the number of patient handover delays that have occurred, and to ensure consistency with reported returns.
8. Acute Trusts and Ambulance Trusts should develop a system to categorise patient handover delays to ensure full operational understanding of all delays lasting more than 15 minutes.
9. Ambulance Trusts and Acute Trusts should develop a seven day breach analysis tool for patient handovers lasting more than 15 minutes. 1
10. Executive leads should link patient handover delay improvement actions into other trust-wide operational management plans. 1

11. Acute Trusts should develop an algorithm for detecting early signs of potential escalation status to allow time for local health community response to be prepared ahead of escalation.
12. Local escalation plans should be jointly agreed and aligned with community wide plans. Escalation should be implemented as applicable and in accordance with the agreed plan. 1
13. Commissioners should understand the detailed issues behind the delays and intervene if the key causes continually re-occur.
14. The performance management arrangements for handover delays should be specified by primary care trusts and strategic health authorities.

Delays in handover

The delay in discharge or transfer of care back to the community following an acute admission to the hospital in older adults has also been recognized as a challenge in the UK health system. This has implications both for the patients' well being and cost to the NHS organisations. The Department of Health has defined a delayed transfer of care as "Occurring when a patient is ready for transfer from a general and acute hospital bed, but is still occupying such a bed. A patient is ready for transfer when:

1. a clinical decision has been made that the patient is ready for transfer;
2. a multidisciplinary team decision has been made that the patient is ready for transfer; and
3. the patient is safe to discharge/transfer

The National Audit Office reported its findings in 2003 on the common contributory factors for delayed transfer of care across the UK. While there is increasing pressure on clinical teams, the NHS organisations, Primary Care Trusts and Social Services, the problem of delayed discharge is compounded by the lack of community beds due to recent closure of nursing homes and community hospitals in England.

A 2009 study (Jasinarachchi et al) found that 36.7% (58/158) of patients had a delay in transfer of care. They tended to be older, had poorer pre-morbid mobility, and were more likely to be confused at the time of admission. Compared to the 2003 National Audit Report, a significantly higher percentage (29.3%vs.17%) awaited therapist assessments or (27.6%vs.9%) domiciliary care, with a lower percentage (< 1%vs.14%) awaiting further NHS care. Of 18 in-patient deaths, five occurred during the delay. Seven patients developed medical conditions during the delay making them unfit for discharge. The number of extra bed days attributable to delayed discharges in this study was 682 (mean = 4.8) days.

A 2008 Independent Review of Delayed Transfers of Care in Wales by the Welsh Institute for Health and Social Care identified two fundamental problems:

- Lack of a full range of local services, resulting in unnecessary hospital admission and delayed discharge: Many parts of Wales do not have in place a proper balance of services to meet people's needs. Every community should have services to support vulnerable people in maintaining their independence at home, and supporting them when things go wrong. They should also have a full range of support when they are ready to be discharged from hospital, from home care teams and assisted housing, community health services and residential and nursing homes – for both physically and mentally vulnerable people. As Professor Longley points out:

  "It is the lack of this range of support that results in people being admitted to hospital when they could have been supported at home, and also in people being stranded in hospital beds

when they have recovered – simply because there aren't enough home care, supported housing or nursing homes available locally. Every community should have this range of services supporting people at home as they become more vulnerable."

- Inefficient use of existing services, and hardship for patients and their families – More also needs to be done to ensure that discharge and transfer systems work efficiently, that assessments are carried out promptly and that all the services are available when they are needed. More should also be done to make this difficult time much easier for patients and their families – when they are having to make crucial decisions about people's futures.

The Review made 46 recommendations. It called on all agencies – health, local government, housing, private and voluntary organisations and the Welsh assembly Government – to work together to ensure that there is a proper balance of care available in each part of Wales. Each community should have a clear view about the range and quantity of services they need now, and in the future (as the number of older people increases). Putting those services in place then requires serious 'joined up' thinking, and a determination to tackle some deep-seated problems. In the meantime, more can be done to improve the efficiency of current services.

Professor Longley applauded work that had been done to improve efficiency and make services more responsive to patients' needs but argued that what is still required is:
'an equal determination to make sure that the full range of services is put in place across Wales, to support people at home, and give them real choices about where they want to live in their old age. Otherwise we will continue to keep people in hospital unnecessarily, putting their well-being at risk and depriving other patients of care."

(See Marcus Longley et al., Independent Review of Delayed Transfers of Care in Wales, 2008, Welsh Institute for Health and Social Care/University of Glamorgan).

In 2009 the Wales Audit Office (WAO) further reported on delayed transfers suggesting that leaders will need to plan for the longer-term to deliver a more integrated approach to promoting the independence of vulnerable older people.

'An example of significant success in leaders committing to improving services for vulnerable older people is the Pan-Gwent Frail Older Person's Project where 11 chief executives from Gwent signed a declaration to work together. The lessons learned from this example are that collaboration is difficult to achieve and it requires patience, the building of trust, the letting go of power and a constant focus on what is important for individual citizens. If partner organisations are to work together formally then there must be strong governance arrangements between these bodies.'

Too often in the hospital, we hear that important information or tasks "just fell through the cracks" after a transfer of patient care. Yet this analogy is wrong. The problem with transfer of patient care is that it is not a clear pathway with some dangerous cracks that need fixing. Patient handoffs in medicine are astonishingly variable. We cannot simply "improve handoffs" with a checklist or some training. We must instead review our handoff *processes*. Relevant improvement will only come after understanding that different clinical scenarios require different handoffs. Each handoff must be reviewed, dominant framings discovered, and changes thoughtfully designed to fit work flow and be measurable. Several of the authors' measures are things that care providers do or remember during busy clinical work. Those who use this review's important framework in a careful handoff redesign must beware of focusing too many interventions on the workers at the sharp end while failing to overhaul handoff conditions and supporting tools that are created in the organization's upper echelons—where more lasting improvements ought to be made.

All stakeholders, including the patients, agree upon the need for an active patient role in the handover process. However, both patients and professionals are concerned about the amount of responsibility to be put upon patients. Family members are perceived as of great importance to facilitate handover, both by patients and professionals. The lack of awareness to different professional perspectives, inherent to primary and secondary professional domains, seems to influence the roles and responsibilities in patient diagnosis and treatment. Though most professionals think they carry a shared responsibility in this respect, in practice there is no shared responsibility.

The general practitioner plays an essential part in the coordination of patient care but factors such as the lack of direct contact between professionals, involvement of multiple professionals and the lack of feedback, make it difficult for the general practitioner to fulfil this role excellently and to be accountable.

(See: Improving the Continuity of Patient care through Identification and Implementation of Novel Patient Handoff Processes in Europe HANDOVER – 2008 – 223409)

Scenario Example 2 Patient Discharge

A patient is ready for discharge in December but not able to return to her home because of access issues. Social services have been contacted and can normally provide suitable care and or adaptations but have no resources left for the rest of the financial year. The Trust and Commissioners are reluctant to incur long-term non clinical support in the community and the patient stays in hospital. Social Services in England are potentially liable to fines if they delay discharge. The Trust and Local Authority are invited to negotiate a protocol endorsed by Commissioners that patients will be discharged into suitable accommodation as soon as clinically able. The various players will then negotiate a compromise at a monthly-mediated meeting.

Questions to help guide local implementation of handover strategies and to measure the impact of the changes:

- What are the clinical handover situations that carry the most risk for patients?
- What information and critical success factors are needed to better understand the process of handovers in this setting?
- What handover interventions are the most effective?
- What resources and tools are available to improve handover communication?
- Which individual clinicians are willing to serve as “champions” for improving the handover process?
- What mechanisms can be put in place to spread, sustain and transfer improvements across the organisation?
- What improvements can be built into information systems tools to enhance their successful adoption (eg, checklists, reminder systems, information technology solutions)?

From: Patient care handovers: what will it take to ensure quality and safety during times of transition? (Julie K Johnson and Paul Barach) **Published in:** MJA Volume 190 Number 11, 1 June 2009

Issues

As the WAO report found collaboration is difficult to achieve and requires patience, the building of trust, the letting go of power and a constant focus on what is important for individual citizens. If

partner organisations are to work together formally then there must be strong governance arrangements between these bodies' (WAO 2009)

There needs to be a commitment to the right outcome first and then real drive to put workable mechanisms in place. Partners need to use the authority of their Boards and Cabinets to drive resolution or better still to solve the problem for the service user now and resolve the funding and jurisdiction issues later.

3.1.3. Review and apply lessons from investigations elsewhere (NHS and other sectors). Could it happen here?

In spite of research and protocols things still go wrong and then the important point is how timely and well do we absorb and apply the lessons. Do we have assurance that although as a board or committee we have discussed the failure that actions have followed and we now have systems and behaviours that will protect our patients and reputation? The similarity of a series of review findings suggests not.

	Progress Levels:					
Key Elements:	**NO**	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
3. Review and apply lessons from investigations elsewhere (NHS and other sectors) Could it happen here?	**NO**	All staff trained and updated in communication skills between professionals and with patients and carers	Failures of communication identified elsewhere in NHS and lessons reviewed	Failures of communication identified elsewhere outside NHS and lessons reviewed	Audit shows decline in communication caused untoward incidents	Lessons from internal and external reviews are learnt and applied

Mid- Staffordshire

The various reports on mid Staffordshire (2009/2010) expressed concern in the way that complaints and SUIs were reported to the board under broad groupings led to Mid Staffordshire losing focus on some of the individual issues which were being raised. E.g. grouping complaints under 'communication issues' masked the fact that many problems occurred at handover times.

Mid Staffordshire shows the importance of the Board being in touch with the frontline. The Board did receive the usual monitoring data but had no direct knowledge of the front line services. There was a clear discrepancy about the way medical staff felt about the services delivered by Mid Staffordshire that the Board was unaware of.

This is the main lesson I take from the problems experienced at mid-Staffs – that in future, we must never separate quality and financial data. They are always two sides of the same coin .(Then Secretary of State, Andy Burnham)

Serious question for all NHS boards must be 'do we spend enough time understanding the medicine? Whilst we concentrate on strategy and finance 'when do we drill down to make sure the service are safe, joined up and effective?' Do we have a culture that at the expense of patient safety

and learning lessons avoids adverse publicity?

Brent PCT

Michael Taylor, an Independent Investigator uncovered 'serious and serial failings' in the leadership of Brent PCT during 2006/7. A new management team and board is now in place leading the recovery of the PCT. Brent was known as an innovative PCT, but the Taylor report says it was 'unable to reconcile this with finite resources and the effective monitoring of performance'.

The principal causes for the financial position deteriorating in 2005/06 and 2006/07 were:

- Poor budgetary control.
- No linkage between activity and costs for both commissioning and service developments.
- Failure to achieve planned savings.
- Reliance on accountancy adjustments and one-off savings.
- Weak financial management and accounting systems.
- Absence of a performance culture.
- Weak scrutiny by the PCT Board.
- A divided senior executive team.
- An inexperienced PCT level Chief Executive during 2006.
- Failure to heed early warnings from Auditors.

Some of the specific findings included

- The PCT Board failed to ensure that balance existed between its developmental work and executive grip (18)
- The PCT Board, under the leadership of the Chair, was perceived as intolerant of dissent and being averse to any bad news about the operation of the PCT (76)
- The PCT's Clinical and Corporate Governance Committee had very thorough debates about Clinical Governance matters. It did not exercise an effective oversight role of other aspects of Corporate Governance including financial risk and financial standards (99)
- In 2005 and 2006, the PCT indicated that it was ***Fully Compliant*** in the area of governance. These were erroneous Declarations (101)
- The movement towards Integrated Governance has been slow. This will accelerate as part of the aforementioned ongoing internal review (107)

Not all the lessons come from within the NHS. David Walker's review of corporate governance in UK banks and other financial industry entities (July 2009) concluded that the Combined Code remains fit for purpose but needs amplification of guidance; better observance- Failures in BOFI boards relate more to patterns of behaviour than to organisation –the essential *challenge* step often being missed.

- *Comply or explain* (not our NHS model of '*comply or else'*) should be retained but perhaps with support to move to the more pro-active South African *King III approach: 'apply or explain*')
- Distinguish between corporate governance code and principles of stewardship

Walker argued that board must focus on the key objective of the organisation- for banks this is the successful arbitrage of risk; in health it is health improvement and enabling safe, cost effective services although an argument can be made that PCTs are like an insurance company holding the risk of the populations health. They have money to invest in the risk of ill health and the more successful they are in mitigating risk through health improvement and containment in the

community the les exposure they have to high cost acute and tertiary costs. This makes Walker's advice more pertinent and worthy of consideration. He suggested a number of themes for improvement:

1. Board Structure

- Regular thematic business awareness sessions
- Substantive personalised approach to induction, training & development
- Dedicated advice and support for NEDs
- Chair near full time commitment, NED commitment of 30-36 days, limited other commitments
- Regulators should be concerned at the balance of the board assessment, induction & development to equip board deliberation

2. Board functioning and performance

- Ready, able and encouraged to challenge and test proposals on strategy
- Decision taking on risk based on intelligent information, analysis and input
- Chair leadership responsible for leadership, effectiveness, agendas, substantive discussion, effective exec/ned communication and timely relevant information.
- SID as sounding board for and evaluation of Chair, trusted intermediary for NEDs; accessible to shareholders
- Formal and rigorous evaluation with external facilitation with evaluation, statement of skills and experience required reported in annual report

3 External communication

- Distinguish between corporate governance code and principles of stewardship- the principles should be adopted by all agents and partners of the organisation on a comply or explain basis
- To support collective engagement MOUs should be prepared for investors(partners) to affirm their commitment to the principles

4. Governance of risk

- Separate board risk committee (not audit) with responsibility for oversight and advice to board on current risk exposures of the entity and future risk strategy, appetite and tolerance
- Board Risk Committee will have a senior Chief Risk Officer (CRO), with external expertise/input available and separate report in annual report
- Board Risk Committee will undertake due diligence with appropriate external advice in respect of acquisition and disposal

5. Remuneration

- Remuneration Committee should cover all aspect of remuneration policy

Scenario

Have we tested our systems to ensure we can correct mistakes promptly before others suffer harm or delay? How do we know or find out what we need to know?

At a board away day it was set out - 'As you know we regularly review our Assurance Framework,

SUIs, Risk Registers and Complaints. We routinely review trends from other trusts, but we do not systematically pick up on service failures identified by social care and private sector regulators unless these are given significant attention in our professional or mainstream media. A recent criticism from the health service ombudsman has pointed out that the incident of a car park barrier which in high winds slightly injured a member of our staff had also been a feature of a number of health and safety reports as well as prosecutions.' Our challenge is how do we protect our staff and service users from harm and our reputation from criticism that we should have known?

Asda pays £267,000 for car park death

Supermarket chain Asda has been fined £225,000 plus costs after admitting safety failures over the death of a customer in a store car park. In March 2006 an inquest jury returned a verdict of unlawful killing. The accident happened in May 2002 when a sudden gust of wind swung the barrier into a customer's car. The inquest heard that the steel barrier should have been padlocked in place but was unsecured that day. There had been two other incidents involving swing barriers at Asda stores - one in Bloxwich, Walsall, in January 1999, three years before Mr B's death. There was confusion about who was responsible for checking that the barrier was properly secured. Asda's divisional environmental health manager said it was the security team's job, but a guard told the inquest he had not been told to check it. Following the accident, Asda removed all similar barriers from its car parks. Cardiff Council decided to bring safety charges against the supermarket chain after a Crown Prosecution Service review of the case concluded there was insufficient evidence to justify a manslaughter charge. On 21 January at Newport Crown Court, Judge Cooke fined Asda £175,000 under Section 3(1) of the Health and Safety at Work Act and £50,000 under Regulation 5 of the Management of Health and Safety at Work Regulations, with costs of £42,000. Imposing the fines, he said, "Expressions of intention were all present. The systems were all present. But a potentially fatal danger was left unaddressed." (from Health and Safety Professional 22.1 08)

Questions

- Do we need to elevate the role of risk to be a delegated committee of the board alongside but different to the audit committee?
- Do we have memory of what we have already learnt and intelligence systems in place to learn promptly from others mistakes. Do these systems extend outside our health system (England only?) and include other sectors than health. Do we share our mistakes promptly?
- Do we spend enough time understanding the medicine?. Whilst we concentrate on strategy and finance 'when do we drill down to make sure the service are safe, joined up and effective?'
- Do we have a culture that at the expense of patient safety and learning lessons avoids adverse publicity?

3.2 Partnerships and networks

Our **partnerships** and other relationships are well meaning but frequently ineffectual, often based on a *commitment* to change or work together efficiently but not an *agreement* to deliver. As in the EFQM business excellence model, Partnerships need to be treated *as a resource not just a relationship* with explicit purpose, etiquette, understanding of roles and responsibilities and commitment to deal with difficulties as well as opportunities. The Good Governance Institute developed with *NHS Kensington and Chelsea* and others a partnership decision tree (see ISQUA 2009) to codify our various forms of relationships with others, to then challenge if we have good governance systems in place to meet the purpose of the partnership and our ongoing obligations. If not we will change them. If we set up new groups we will design the governance as fit for the purpose and outcomes we want.

In an NHS where partnership has for some time been not merely a matter of exhortation but legal obligation (a Statutory Duty of Partnership was introduced in the Health Act 1999) the relevance of governance between organisations (GBO) is obvious. NHS bodies find themselves enmeshed in relationships not only with traditional partners such as local government and product suppliers but increasingly with private sector and third sector providers of clinical services.

Despite slamming the previous government for a wasteful approach to running local government, Communities secretary Eric Pickles has confirmed that its plan to encourage public sector bodies to pool their property resources, under the Total Place initiative, was the way forward. He said at the Conservative Party conference in Birmingham in October 2010:

“Councils must fundamentally rethink their finances. Councils should share services, work across boundaries to drive down costs and protect front line services.

It is clear we must seek an accommodation to plan, enable and hold to account services provided *jointly and severally.* (a term used to describe a partnership in which individual decisions are bound to all parties involved and thus undivided). In the NHS in England this must be a key role for the new commissioners and apply to the relationship between all the NHS players as well as colleagues working in local government, other public services such as police and colleges and the independent sector (private business, charities, social enterprises etc). Elsewhere in the UK the NHS has sought various levels of integration to better provide cost effective and joined up services. The new larger LHBs in Wales for example are expected to result in:

- improved health outcomes and access to services
- reduction in the admin cost and burden of working across multiple organisations
- enhanced service delivery through the removal of vertical boundaries
- the achievement of improved service integration through closer working with its partners (see the pocket guide to Governance in NHS Wales, (see Welsh NHS confederation/GGI, 2010)

Example: **The Sheffield Way**

In 2008 NHS Sheffield developed the ‘Sheffield Way’ – a set of collective principles between the PCT and the city’s NHS providers.

‘Agreeing the ‘rules of engagement’ of how we’ll do business in the new competitive NHS world was an essential step we needed to take together as a community and the resulting principles are an endorsement of the strengths and ambitions of not just the Foundation Trusts in the city but also the

Council and social care providers. The Sheffield Way also provides a clear framework for all partners to work within.'

The intention of 'The Sheffield Way' is to build on good working relationships and increase trust between stakeholders, so that cooperation increases alongside competition, and any potential conflict is well managed.

All organisations providing or commissioning health and social care services in Sheffield are invited to sign up to these principles. NHS Sheffield will ensure that any new and potential providers are fully aware of 'The Sheffield Way' during the commissioning process.

The principles are an expression of good working relationships. In practice they mean that senior leaders of participating organisations will:

- Make time for good conversations about challenging issues;
- Be open with each other about the strategic intentions of their separate organisations;
- Work together to maintain public confidence in NHS services;
- Look for opportunities to reinforce good working relationships at all levels, for example, joint staff development and a staff conference.

Principles and rules for cooperation and competition:

1. *We are committed to working for the health and well being of the population of Sheffield by responding to their diverse needs and promoting equality. We balance the interests of our own organisation with this aim.*
2. *We will take into account national and regional priorities and our primary focus is 'doing the right thing' for Sheffield. In particular, we will ensure that any business agreements between our organisations provide value for money.*
3. *Decisions about service provision will be made through open, transparent processes and based on criteria that include quality, cost and consideration of the wider socio-economic benefits of the available options. We will account publically, openly, and honestly for the decisions we take.*
4. *From the beginning we will be clear about the outcome we are seeking to achieve. The service specification will be clear about how patients will access and pass along the service pathway, what will and will not be provided. We will check regularly to make sure our assumptions and intended outcomes remain valid.*
5. *From the outset and throughout we will be clear about the improvement process so that current providers can contribute their experience and expertise knowing where they stand.*
6. *We will consult widely at each stage so that all stakeholders have a voice in deciding priorities for action. In particular, we expect patients and the public to be involved at each and every stage and we will work together to ensure their experience informs every decision.*
7. *Decisions will be based on the best available evidence, including qualitative data such as stories of patient and staff experience. We will draw on local, national and international expertise and we will not be unduly delayed by a quest for 'perfect' evidence.*
8. *Once a procurement decision is taken we will work together to engage staff, the clinical community, patients and the public in the process of change. We will work together to provide the population with a seamless health and social care service.*
9. *We expect every service to have a robust audit and evaluation process, which includes service user, patient, public and staff voices. We expect the results of audit and evaluation to be shared widely in order to stimulate improvement.*

NHS Sheffield Board Paper prepared by Jan Sobieraj, Chief Executive 24 October 2008

Towards the end of the Labour Government regime it was clear that there was a stronger push towards merging of PCTs in the Capital and elsewhere. A planned recycling of £20bn of the NHS budget to afford anticipated increases in demand prompted greater delegation to sectors, the merger of management teams and back office functions supported by PCT level boards reflecting the local context. The Coalition victory in 2010 took many by surprise in proposing in the White Paper 'Equity and Excellence: Liberating the NHS' a wholesale removal of PCTs and (SHAs) to be replaced by up to 500 GP Commissioning Consortia. This was planned to take several years but the decision to protect the overall NHS budget and maintain the QIPP agenda accelerated the need for system i.e. management economies.

PCTs although now to be closed have been setting the groundwork for partnerships working for collective working for some time (e.g. Barnet Primary Care Trust Board Meeting in Public 25 January 2007). This kind of work is an important legacy for the new GP Consortia.

The board paper clarified that each PCT is a freestanding NHS body with its own governance arrangements and local partnerships with Local Authorities, GP practices and other key stakeholders. However, London PCTs need to work together in order to discharge some of their key responsibilities most effectively. The principal objectives for PCT collective working are:

- To work with NHS London in planning and implementing strategic change.
- To sustain collective commissioning and uniform contracting.
- To coordinate other activities as required (e.g. emergency planning).
- To promote shared learning to improved performance. It is essential that robust arrangements are put in place to enable London PCTs to work together and to work collectively with NHS London. This paper sets out proposed arrangements for collective working across London PCTs. It contains:

It was anticipated even then that London PCTs would need to work closely together over the coming years and it was proposed that PCT collective working be underpinned by a partnership agreement that made explicit what the 'duty of partnership' means in practice. These structures provided a mechanism for collective working at London and sector level. However a guiding principle was that matters should be handled by the most local competent authority and it was important to select carefully the issues requiring collective resolution. Many issues continued to be best handled by individual PCTs or by PCTs working together in smaller groupings. The involvement of clinicians in commissioning though practice based commissioning was recognised as a key component of the London commissioning model. The collective working arrangements outlined were intended to complement and support the work of local commissioners including practice based commissioners.

In Autumn 2009 Alwen Williams, Chief Executive, Tower Hamlets PCT and Tom Easterling, Director, Office of London PCT Chief Executives drafted a new paper on Design principles for collective working of London PCTs. They stated:

'It is just as important to have good governance between organisations as within organisations.'[18]

In their paper they argued that the following elements form the basis for collective working:

[18] A Williams and T Easterling, *Review of PCT collective working arrangements,* Office of London PCT Chief Executives Autumn 2009

- All arrangements put in place to enable collective commissioning must ultimately derive their authority from the 31 PCTs.
- Individual PCTs continue to set annual budgets, thereby determining the funds to be made available collective working (e.g. for acute commissioning and CSL).
- Governance of collective activities needs to be robust without being unduly cumbersome.
- The arrangements need to enable London PCTs to work together effectively and make timely collective decisions on key issues.
- Collective working should be undertaken by officers when the nature of the work is managerial, and it is being conducted within the framework of existing policy and delegated powers.
- PCT Non Executive Directors should be directly involved in the governance of collective activities where the work involves the exercise of delegated decision making powers on behalf of PCTs.
- Clinicians should be actively engaged in contributing to all PCT decision-making relating to services, whether these decisions are taken by individual PCTs or by PCTs working collectively.

In July 2009, PCT Boards in NW London were asked to approve the business case for the establishment of the Northwest London Commissioning Partnership to assume full responsibility for secondary care commissioning across the eight PCTs in the NW sector with Oversight by all eight PCTs to be been achieved through the monthly Business Group, attended by a Director representative from each PCT, and the Managing Director and senior directors of the partnership. The Business Group monitors performance both of the acute commissioning vehicle and of the acute contracts. The NW Joint Committee of PCTs (JCPCT) retains overall oversight.

The Joint Committee of PCTs (JCPCT) received and approved the proposed 2010/11 budgets in April 2010. The report highlights the financial and other benefits to be achieved by the partnership for the eighteen months to the end of 2010/11. Against a cost of £9.1 million savings of £57 million (£28.2m excluding demand management, for which PCTs retain delivery responsibility), were achieved or forecast.

In establishing the joint committee, the Boards of the PCTs recognised the transitional nature of this arrangement, and that it is was made with the explicit objective of delivering the operating plan for the year, enabling the transition to GP led commissioning and minimising instability at a time of change.

The Joint Committee of PCTs (”Sector Board”) was established as a joint committee of the Brent, Ealing, Hammersmith and Fulham. Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster PCTs referred to as Member PCTs:

The Sector Board is accountable to its Member PCTs who agreed a framework for assessing the performance of the Sector Board in the discharge of its delegated functions.

Each PCT is accountable through its statutory responsibilities to use its resources to improve the health of its population and retains that accountability even where functions are best achieved by working with other PCTs.

Delegated Functions were detailed as:

Strategy and planning

- approve strategic and operating plans for the sector incorporating London-wide and sector priorities, including services, finance, capital, estates and workforce
- develop and agree clinically-led service reconfiguration plans for sector, taking fully into account the changed political context
- approve the pre-consultation business case and consultation documentation for any such changes
- relate formally to any Joint Overview and Scrutiny Committees which relevant local authorities might be required to establish;
- take decisions on the issues being consulted upon, taking into account the outcome of consultation, the impact assessments and any other relevant material

Strengthening commissioning

- agree the programme for implementation of further stages of strengthening commissioning in accordance with national and NHS London guidance

Commissioning

- agree acute commissioning priorities on an annual basis and ensure that individual PCT draft operating plans can deliver key targets
- agree performance targets for sector
- monitor delivery of key targets and ensure that action is coordinated to improve sector performance
- ensure effective commissioning of acute services on PCTs' behalf in accordance with indicative budgets for acute services delegated by PCTs for the Commissioning Unit to implement on their behalf
- agree local incentives to support strengthening commissioning

Finance and budget

- approve a coordinated financial plan for the sector, within budgets set by PCTs, and monitor delivery against the plan
- approve the budget for the sector team within the funds delegated by PCTs for the purpose and ensure that it is managed effectively
- approve short to medium term prioritisation of business cases for strategic capital spend within the sector

London specialised commissioning

- appoint committee members of the London Specialised Commissioning Group (SCG) in accordance with the establishment agreement for the London SCG
- manage (on behalf of Member PCTs) the financial performance of the London SCG in order to assist it to remain within budgets set for that particular year

Business as usual

- agree hosting and business arrangements for sector

In September 2010 the JCPCT produced a paper on 'Delivering Management Costs and Managing Transition in North West London'.

The Paper recognised that NHS North West London PCTs faced a significant management cost savings target that challenged their current operating model. The paper proposed transitional arrangements for NW London which would allow the delivery of the agreed management cost savings across NW London by reducing costs by 67% from £102m in 2009/10 to £33.6m by 2012/13 as well as providing a more stable platform upon which to manage near-term finances and service performance whilst continuing to improve both quality and patient safety.

The transition arrangements set out will not continue beyond March 2013, by which time it is expected that existing PCT and sector functions will transfer to the National Commissioning Board, GP Consortia and local government / the Mayor in respect of public health functions.

The paper pointed out that 'The transitional arrangements, however, will also need to be robust and flexible enough to respond to changes that may occur following the outcome of the consultation on *Liberating the NHS*. Whilst these arrangements do not seek to prejudge the outcome of the consultation on the White Paper the senior leadership team feels it is sensible to be prepared for the changes.'

The NHS was required by the previous Government to deliver a 30% reduction in management costs. As NHS North West London's management costs were well above the national average, this created a requirement to reduce expenditure on management by 67% (£67.8m). As well as achieving the management cost savings previously set out this vision needs to be realised through a period in which the NHS in London must achieve in the region of £3-£5bn of efficiency savings to reinvest in improving quality and outcomes. Using current planning assumptions efficiency savings of between £512m and £674m will need to be delivered within NW London by 2014.

In his letter on 13th July David Nicholson described the framework for transition including:

a. requiring SHA Chief Executives to establish transition arrangements within each region;
b. taking immediate steps to split commissioner and provider functions at national and regional level and beginning the process of design of the new system;
c. setting the expectation of maintaining control of finance, performance, quality and productivity during the transition – including increasing financial control arrangements where necessary.

Partnerships with the user

The Care Quality Commission is committed to put people who use health and social care services at the very centre of what it does. It is working to make sure it captures their views, and those of the many groups who represent patients, people who use services, and carers. The Commission also says it is working with and listening to those who provide or buy care for local people, including primary care trusts and councils, and to people who buy care for members of their family, or for themselves.

The starting point for the Commission is that organisations are accountable for the quality and safety of the care they provide - the role of regulation is to reinforce that accountability to people using services and the public and to take proportionate action if organisations are not meeting their legal responsibilities.

'All stakeholders, including the patients, agree upon the need for an active patient role in the handover process. However, both patients and professionals are concerned about the amount of responsibility to be put upon patients. Family members are perceived as of great importance to

facilitate handover, both by patients and professionals…Though most professionals think they carry a shared responsibility in this respect, in practice there is no shared responsibility. '

(Report on how variations in handover processes lead to near misses and adverse outcomes, and identifying standardized elements of communication. P Bartel et al, HANDOVER programme 01-10-2010)

It is local staff and local services that deliver improved services for people. Regulation should be an enabler - the role of the regulator should be to work in a way which builds capability in organisations and which takes a lighter touch when services are performing well. The flipside of this is that the regulator needs to act swiftly and be tough when people are not getting an acceptable standard of care or are not having their rights upheld.

Over Christmas 2009 The DH launched the operating framework for the NHS for 2010-11 (Gateway 13232). Although only months away from a general election this guide set out the priorities for the NHS for the year ahead to enable them to begin their planning but needing a relentless focus on three things to make this possible.

1. improving quality whilst improving productivity, using innovation and prevention to drive and connect them.
2. having local clinicians and managers working together across boundaries to spot the opportunities and manage the change. It is simply not possible to identify from the centre the kind of quality improvements that are necessary.
3. to act now and for the long term.

'I want to stress that the policies set out in this year's NHS Operating Framework are intended to do four things – ensure a relentless focus on quality, encourage risk management across the system, bring into sharper focus the characteristics of the new system we are developing, both in terms of shape and behaviours, and encourage more creative thinking about integration'. David Nicholson

In 2010 amendments to the operating framework were issued and in a series of letter and FAQs NHS CEO, David Nicholson set out the need to continue with economies but to plan for the new commissioning and provider arrangements. These included:

Risk management

'In order to achieve the transformations required, we need to focus on how we share risk across the system and re-balance the risk between providers and commissioners. This NHS Operating Framework sought to drive this shift, not least through the changes in payment and contractual systems. But it is vital that NHS organisations do not respond by just trying to transfer risk to another organisation. We will not succeed if we have islands of success in a sea of failure.'

'We have to recognise that we have a zero sum game. If risk is transferred elsewhere in the system, it doesn't take the risk away. The people who pay are patients. They don't recognise organisational boundaries. What they recognise are services that are joined- up across the system.'

'The NHS is a system that has the potential to provide a seamless service for patients. We have a long way to go to achieve this, but our response to the swine flu pandemic shows that we can do it'

'All NHS organisations and care providers now need to be registered with the Care Quality Commission. This is an important step to provide public assurance that NHS services meet basic

quality and safety standards, but it does not absolve NHS organisations of their own responsibilities in this area. Quality and safety are at the heart of what we do, and it is the responsibility of each and every board to assure itself that the services it provides are safe and of a high quality.'

'This must be a reforming system where changes continue to be shaped locally by the dynamics of co-operation, competition and patient choice.'

A real tension in the NHS is both how effectively to deliver services across boundaries and how to manage risk. These two issues are compounded in governance terms because both controls and assurance can be weak when there is no formal line management nor reporting.

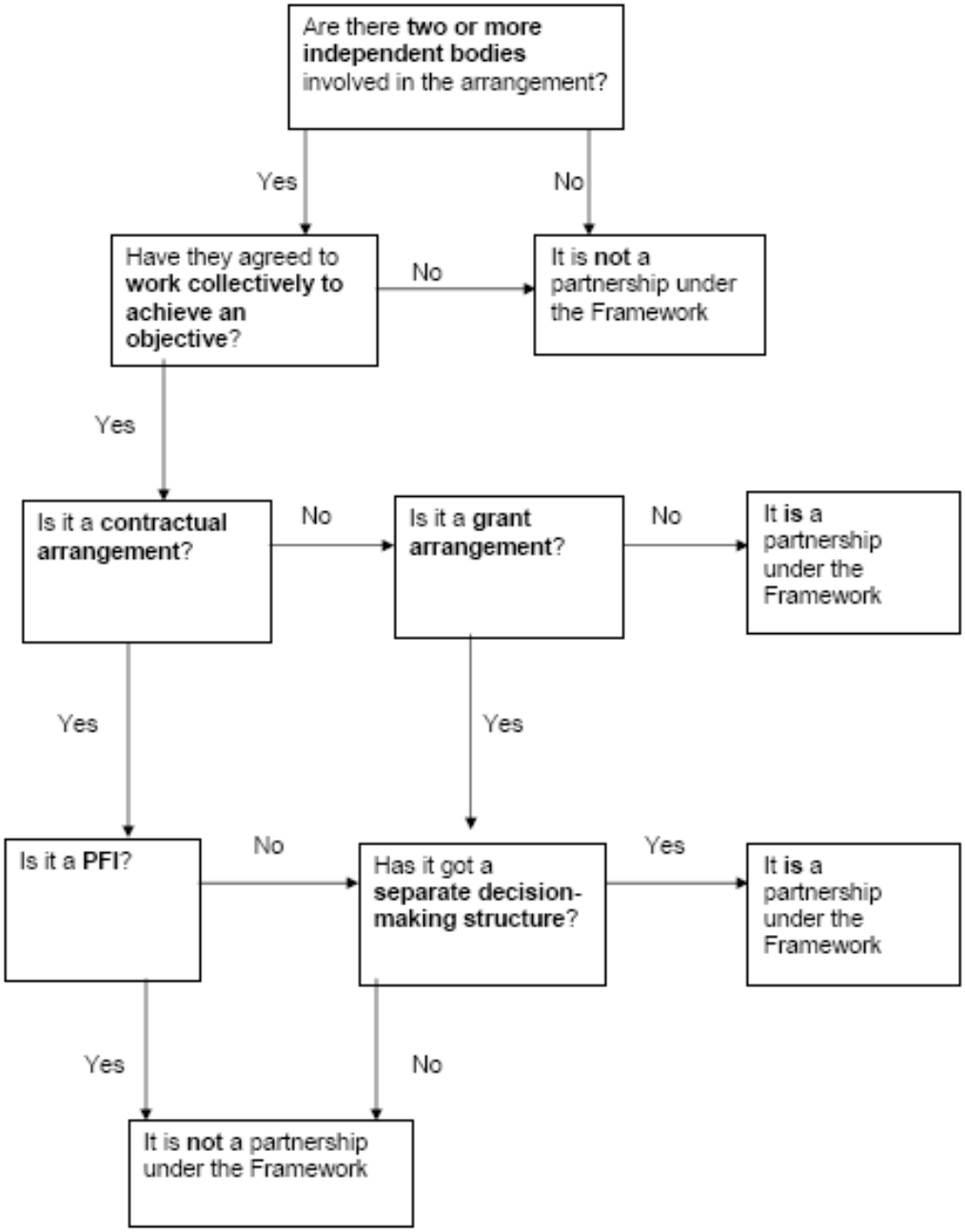
The Good Governance Institute (GGI) has been researching this particular issue from the practical standpoint of an NHS organisation asking the simple questions:

- What relationships do we have in place- what exactly are they?
- What is the purpose of the relationships?
- Is the management and governance of these fit for purpose?
- Have we adequate systems in place to fulfil our responsibilities?

To address this we have examined the literature and case studies particularly in health and social care, developed a model and examined its application in practice.

The model which emerged, is the *partnerships decision tree* which aims to both explain, test and guide improved governance.

The literature led to some interesting examples from environmental science (see Developing effective partnerships in Natural Resource Management by Peter Oliver in Social Innovations in Natural Resource Management which suggested the decision tree approach. We also found some interesting examples of local government application emerging from Hull, Birmingham and Bournemouth (see 'A practical guide to partnership working, Bournemouth Borough Council March 2006)



This idea as developed into a model that was then tested with a PCTs range of relationships from health and well being council. Joint provider and commissioning units, Safeguarding children's board to improvement networks. The model found no more than 6 distinct types of partnership, all of which could be readily identified through a series of 'killer questions'.

Killer questions

- Is the group a discrete legal entity
- Is group set up to achieve common objectives
- Does it have separate decision taking structures
- Are decisions binding on the hosts
- Do members have delegated (but limited) authority to take decisions

- Who is accountable for Health and safety of staff and visitors
- Who is accountable for counter fraud issues
- To whom should whistle blowing comments refer
- To whom do we send SUIs?
- Where are complaints sent?
- Are there competition rules issues?

The mix of responses to these questions identify which of the six partnership types we are dealing with.

- Networks - usually advisory, often clinically focussed; in England in transition as they become advisors to commissioners but with tensions over influence of provider representatives. Future status is ambiguous as new variants evolve.

- Joint Committee - decisions **are** taken by the Committee within context of agreed business plan. Under s 31 (s75 Wales) agreements the accountable body is usually the local authority. The agreement under health act flexibilities allows pooling of resources, employment of staff and integrated provision or lead commissioning and some combinations of these. The arrangement requires a written agreement which can be legally tested and is subject to audit.

- Joint Management Board - decisions are delegated to one organisation on behalf of others with single line management accountability to staff and actions but risk is shared by all partners (ie my PCT holds risk for my GP resident population).

- Advisory Board – similar to network but useful to hold as discrete type as networks evolve.

- Direct Management and Reporting- common for provider units In England set up as arms length bodies but accountability is still to host PCT. Some discrete companies owned by NHS or local government

- Contracts and SLAs - decisions will be taken by provider in respect of contract. There is a distinction between a legal contract eg with a Foundation Trust or commercial provider and an SLA with an NHS or internal provider but in the political environment of NHS, especially as we enter a mixed competition/collaboration mode the Commissioner is still accountable for the quality and safety of services/goods purchased and reputation can be compromised.

Other groupings were recognised but not considered in depth:

- Community of Practice- common in NHS but obligations if any are just to share knowledge and skills.

- Patient relationship- often referred to as a partnership rather than a contract. The NHS Constitution in England seeks to spell out rights and obligations of patients but patients do not enter into the contract as an aware customer?

Each type of partnership carries different burdens of accountability for their members and we have identified some guidance that will improve governance and confidence. Interestingly applying the framework to sets of external relationships also serves to highlight areas for improvement in internal systems.

		common obj	dec taking	d/m binding	del auth	H&S	fraud	whistle b
PCT BOARD		/	/	/		/	/	/
Network *		/	/		/			
Joint Committee		/	/	/	/	/	/	/
Joint Management Board (LA)		/	/	/	/			
Advisory Board *		/	/		/	/	/	/
Direct Management & Reporting		/	/	/	/	/	/	/
Contract			/	/	/	/	/	/
Community of Practice		/						

Key findings were that:

1. Contemporary NHS bodies operate in a multifaceted set of relationships, delegated authority and complex accountabilities. Their control over financial and other resources is stretched when others are authorised to take binding decisions.
2. Reporting accountabilities are inclined to be confused or ignored.
3. Existing systems are not robust enough to accommodate decision tracking
4. The decision tree provides a simple mechanism to codify existing relationships and provides a checklist of appropriate governance improvements.
5. Boards should review their existing and planned relationships to ensure they have proper controls, assurance, reporting and actions in place.

Background to partnership working - The NHS Act 2006

Partnership – especially between health and social services and between the NHS and patients – was one of the five challenges identified in the NHS plan (Department of Health, 2000).

The plan said in section 8. 'The NHS will work together with others to ensure a seamless service for patients'. The health and social care system must be shaped around the needs of the patient, not the other way round. The NHS will develop partnerships and co-operation at all levels of care – between patients, their carers and families and NHS staff; between the health and social care sector; between different Government departments; between the public sector, voluntary organisations and private providers in the provision of NHS services – to ensure a patient-centred service.

Barriers between services

Rigid institutional boundaries can mean the needs of individual patients come a poor second to the needs of the individual service. On one day in September last year, 5,500 patients aged 75 and over were ready to be discharged but were still in an acute hospital bed: 23% awaiting assessment; 17% waiting for social services funding to go to a care home; 25% trying to find the right care home; and 6% waiting for the right home care package to be organised. Almost three quarters were not getting the care they needed because of poor co-ordination between the NHS and other agencies. This experience is repeated daily throughout the NHS. Partnerships with local authorities have not been as close or effective as they could be. The 1948 fault line between health and social care has inhibited the development of services shaped around the needs of patients.

The National Health Service Act 2006 provided an enabling framework so that money could be pooled between health bodies and health-related local authority services, functions can be delegated, resources and management structures can be integrated. The arrangements, which have been in use since April 2000 as a result of the previous Health Act 1999, allow for the joining-up of commissioning for existing or new services and similarly for the development of provider arrangements. The arrangements were previously referred to as Section 31 Health Act flexibilities:- lead commissioning- integrated provision- pooled budgets Section 31 of the Health Act 1999 has been repealed and replaced, for England, by Section 75 of the National Health Service Act 2006, which has consolidated NHS legislation. The new provision is in exactly the same terms and existing Section 31 arrangements will continue as if made under the new powers. Any new partnership arrangements should refer to the new powers under Section 75 rather than to Section 31.Similarly, previous grant arrangements known as Section 28 A and Section 28 BB have changed as result of the NHS Act 2006 and are now known as Section 256 and 76 respectively.

Section 75 (previously S 31)

The White Paper, *'Our Health, Our Care, Our Say'* highlights the importance of partnership and emphasises use of s31 Health Act Flexibilities as a key route to cementing relationships and improving service.

The use of Health Act Flexibilities was endorsed by the Commissioning Framework for Health and Well-being (March 2007) which stated that GPs will have powers to give money to social care, and in it's appendix refers to the legal framework set out in the Health Act 1999 (see para 7.8 and 7.9).

Section 31 of the Health Act 1999 has now been repealed and replaced, for England, by section 75 of the National Health Service Act 2006, which has consolidated NHS legislation. The new provision is in exactly the same terms and existing section 31 arrangements will continue as if made under the new powers. Any new partnership arrangements should refer to the new powers rather than to section 31.

Example: *Meeting of Bristol South and West Primary Care Trust* held on Thursday, 25 November 2004

Bristol Health Services Plan Joint Decision-Making Committee – Protocol

- The Bristol Health Services Plan contains a number of proposals, each of which affects two or more NHS bodies in the Bristol, North Somerset and South Gloucestershire area. Since it is expected that all decisions on the Bristol Health Services Plan will be taken at the same time, this will require the establishment of a joint decision-making process.
- Legal advice was sought recently on the establishment and constitution of a joint decision-making committee. This advice is as follows:-
- *"Technically although PCTs and NHS Trusts have powers to act jointly this does not extend to a power to formally establish joint committees. PCTs have an express power to form joint committees to carry out their functions and can do so with other PCTs and SHAs but not NHS Trusts. The appropriate power is set out in Regulation 9 of the Primary Care Trust (Membership procedure and administration) Regulations 2000 (SI no 89 of 2000)".*

  "PCTs are of course entitled to appoint non PCT individuals to sit on their committees and this would also apply to a joint committee. Accordingly there is no objection, and indeed it seems to be eminently sensible for the PCTs to formally adopt the joint committee and appoint to that not only their own chairs but the chairs of the two Acute Trusts".

  "The NHS Trusts will need to note the report and to formally approve the appointment of their chairs to the joint committee".

  "The PCTs need to go further and formally to resolve to appoint the committee and it was suggested that it may be helpful to include in the protocol document to cover some of the remaining issues including information about meetings. It was assumed from the decision making process that the joint decision making committee will only meet once but we may want to provide for it to be meet on a review basis as issues are emerging between now and the final point of decision. At the very least we ought to provide for scope for other meetings and say how these are to be convened".

It is clear that the NHS has been experiencing a proliferation of partnerships and joint working arrangements which can cause confusion in terms of good governance.

The Audit Commission report Governing Partnerships, noted three issues about local partnerships:

- they bring risks as well as opportunities, and governance can be a problem;
- they do not guarantee value for money, so local public bodies should question whether and how they engage in partnerships; and
- partners must be accountable to one another and to the public.

Even where the accountability is clear partners and suppliers can compromise the relationship of an organization and prudent Boards should keep an eye on the controls in place to protect their resources, activity and reputation.

A literature review on partnerships was conducted by Wildridge[i]. (Wildridge V Childs S Cawthra L Madge B, How to create successful partnerships – a review of the literature, Health Information & Libraries Journal, 21, page 7, 2004) In it she cites the view that there is no universally accepted definition of partnerships and then goes on to describe the common factors found by researchers in partnerships. They include:

1 relationships (between organizations, groups, agencies, individuals or disciplines),
2 common aims (vision goals, mission or interests),
3 joint rights, resources and responsibilities,
4 new structures and processes,
5 autonomy and trust.

More helpful perhaps is Gray's classification of partnerships:

- Collaboration: Temporary and evolving forum for addressing a problem
- Co-operation: Informal arrangements to achieve reciprocity
- Co-ordination: Formal institutionalised relationships

A number of difficulties have traditionally been present when organisations work in partnership in the health and social care sectors. For example those working on criminal justice relationship have identified:

- culture clashes, ideological differences and rivalry between organisations (Drugs Prevention Advisory Service, 1999)
- difficulty maintaining continuity of care when there are multiple agencies involved (Department of Health, 2002)
- difficulties in establishing accountability arrangements when multiple organisations are involved (NHS Executive, 2000a)
- tensions between different traditions and perspectives eg a health v criminal justice (Audit Commission, 2004b).

Good practice for partnership working

A number of major studies of joint working initiatives have identified factors that influence the success of a partnership. To ensure successful joint working the partners should:

- ensure full strategic and operational commitment to collaboration (this can sometimes be

more important than organisational structures)
- be aware of agencies' differing aims and values and commit to working towards a common goal
- consult with all relevant stakeholders such as partnership members, staff, trade unions, service users and carers
- identify clear roles and responsibilities for individuals and agencies involved in joint working
- develop agreed performance targets
- be clear about what resources each agency has committed
- follow national guidance on joint working for specific issues and client groups
- ensure there are clear funding arrangements
- create systems for inter-agency collecting, sharing and analysis of data
- develop and provide joint training where appropriate
- ensure there is effective and appropriate information sharing between agencies and professionals
- set clear guidelines for reviewing partnership arrangements
- develop and review complaints protocols.

The 'Working in partnership: developing a whole systems approach: good practice guide' (NHS Executive, 2000a) also outlined the importance of services being aware of different organisational cultures between partner organisations and working towards developing a culture of learning and development. This will help services be more open to changes and developing innovative ways of working together.

A critical factor in developing and maintaining partnerships is assessing how well the partnership is performing and identifying strengths or areas for improvement. The Home Office has produced a combined self-assessment process for drug action teams and crime and disorder reduction partnerships, which is available at www.crimereduction.co.uk/selfassessment.

Other partnerships could use 'Working in partnership: developing a whole systems approach: community wide self- assessment tool' (NHS Executive, 2000b) to highlight strengths and weaknesses in their joint working.

'The (CQ) Commission is putting people who use health and social care services at the very centre of what it does. It is working hard to make sure it captures their views, and those of the many groups who represent patients, people who use services, and carers. The Commission is also working with and listening to those who provide or buy care for local people, including primary care trusts and councils, and to people who buy care for members of their family, or for themselves.' New Chairs info-pack.

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- difficulties in establishing accountability arrangements when multiple organisations are involved (NHS Executive, 2000a)
- tensions between a health perspective and a criminal justice perspective (Audit Commission, 2004b).

In Wales the Audit Commission 2004 produced a report (Aligning the levers of change Transforming health and social care in Wales) by Clive Grace and Bruce Harris that identified potential barriers to success including a scepticism that for all the promotion of partnership working there was a real concern that partnership working is not improved. It said:

'The modernisation agenda for public services in Wales and structural arrangements such as the (then) coterminosity between local authorities and local health boards offer significant potential for joint working between health and social services in Wales. The statutory requirement to form health and wellbeing partnerships should provide an impetus and allow the health agenda to be linked to wider determinants of health and wellbeing such as housing, transport, the environment and crime and disorder. But if this potential is to be realised, health and social care services will need to overcome a number of barriers that have prevented good partnership working to date:

- *A need to develop a shared vision for health and social care services based upon the desired outcomes for people who use the service.*
- *Better strategic planning and management that leads to a positive*
- *Interdependence and is manifest in shared care budgets (eg Health Act flexibility) and joint planning and commissioning activities.*
- *Integration of services so that the user experiences seamless services that are not fettered by traditional professional boundaries. The Wanless proposal for a single integrated budget for older people's services held by LHBs is an example of how this might be achieved. It does not figure in the Implementation Plan, but measures like this may prove to be essential.*
- *Better sharing of information on needs assessment, activity and performance between health and social services.*
- *A need for improved policy alignment.*
- *The need to use legislative frameworks to ensure effective partnership working.*
- *The need for better understanding between partners of each other's accountabilities and constraints.*

The report commented that such barriers 'reflect issues of control and culture within individual agencies, and demand strong political leadership to provide the intent and the cultural change needed to make partnership working happen effectively. An investment of time by prospective partners in developing a mutual understanding of each other's cultures, work pressures and priorities can be productive and help ensure more meaningful partnership working. Although to be effective such partnerships must also work within a clear and robust framework for performance management, underpinned by accurate and relevant performance information. A fundamental cornerstone in achieving this shift will be the alleviation of political pressures in the local government arena which are themselves in part based on public opinion. There is a major education process necessary through which all parties understand that modern healthcare is not based on beds and buildings but on services and access to those services. The current focus on beds and buildings, rather than access and services, and the lack of consistently effective integrated thinking at an organisational level across the public sector inhibits access to services.'

In 2008 in spite of efforts and a system predicated on partnership working.

- Improving Health in Wales - A Plan for the NHS with its Partners, 2001
- Building Strong Bridges Strengthening partnership working between the Voluntary Sector and the NHS in Wales. 2002
- Partnership working is key to the improvement of social services throughout Wales (Graham Williams, Chief Inspector for the Social Services Inspectorate for Wales (SSIW) commenting

when he published his annual report for 2001-2002 on 22 January 03

The WAO reporting on the management of chronic conditions by NHS Wales reflected (section 3.1) on the barriers that local health service planners and providers still needed to overcome in order to deliver improvements to chronic conditions management. They identified four key areas which affect the ability of NHS Wales to deliver holistic, integrated models of care and make effective use of resources:

- a lack of understanding and analysis of need and demand for services
- the reliance on short-term funding to develop services, with limited consideration or evaluation of how to mainstream successful programmes
- gaps in financial information and activity data, which limit the ability to evaluate existing services or to plan for new ones; and
- despite greater collaborative working across NHS bodies and with partner organisations, better joint working and further workforce development are still needed. across health communities.

(The management of chronic conditions by NHS Wales Dec 2008 WAO)

Scenario

The NHS is in the throes of a major transformation. The proposals devolve accountability to local commissioners and any willing provider but expect all players to work together and with users and stakeholders to achieve common goals.

Participants in a whole system event are invited to clarify their aims in relation to specific service outcome such as child obesity or diabetes; identify the current trend and service costs associated with the condition and plan innovative innovations with providers and partners that will *turn the curve* of the incidence of the condition and reduce the cost burden for patients and commissioners.

Metrics should be identified that allow progress and outcomes to be monitored.

Issues & Questions

- How much medicine does the commissioning board need to know?
- Can the commissioning board commit resources to plans extending over a 5-10 year horizon?
- What are the critical indicators the board will need to monitor progress?
- Are we clear when working in partnerships just what the entity of the partnership is and have we the right governance arrangements in place?
- When decisions are taken by others, are they tracked back to the accountable organisation?

Key Elements:	Progress Levels: NO	1: Basic level - Principle Accepted	2: Agreement of commitment and direction	3: Results being achieved	4: Maturity - comprehensive assurance in place	5: Exemplar
4. Jointly audit critical processes across the boundary (clinical, financial, information etc) at appropriate depth & frequency respective to risk	**NO**	Protocols agreed for integrated clinical/systems audit	Protocols agreed for joint audit of single provider by two interested (commissioning) organisations	Protocols agreed for interface audit across organisational boundaries	Audit covers boundary conditions	Integrated clinical/system audit plan tracks key whole pathways on regular basis as part of clinical audit spiral of improvement

3.2.1 Jointly audit critical processes across the boundary

Chris Iremonger writing in the HQIP guide to Facilitating Clinical Audit across Different Care Settings (2010) says:

'The treatment of even a simple patient condition with simply defined care requires communication and cooperation among staff members working in several large organisations. Failure to communicate about any part of the care can leave a patient compromised and unsafe, and can mean that optimum care is not provided. Staff members who provide a patient's care can be unaware of what happens at the 'interfaces' of care and that problems in delivering care happen, until a patient tells a member of staff about the patient's experience getting care.'

Clinical audits can involve more than one organisation such as another NHS organisation, primary care centre, social services and/or other providers. For example, possible audits on self harm could be carried out by a primary care team only or along with walk-in centres, minor injury units, an ambulance service, acute general hospitals or mental health services.

If more than one organisation is involved, the group needs to consider the type of collaborative audit, joint working principles, confidentiality, data exchange and information governance among the involved organisations.

Here we consider three types of collaborative audit Joint, dual and interface.

A **joint audit** is an audit on a legal entity (the auditee) by two or more auditors to produce a single audit report, thereby sharing responsibility for the audit. A typical joint audit has audit planning performed jointly and fieldwork allocated to the auditors. The auditors are typically not individuals,

but auditing firms. This work allocation may be rotated after a set number of years to mitigate the risk of over-familiarity. Work performed by each auditor is reviewed by the other, in most cases by exchanging audit summary reports. The critical issues at group level, including group consolidation, are reviewed jointly and there is joint reporting to the legal entity's management, its audit committee, a government entity, or the general public.

In 2008 **Borders NHS Board Audit Committee** reported on progress of the joint audit with Scottish **Borders** Council (SBC) on Performance Management where it was noted that discussions had taken place with the Council's Chief Internal Auditor.

A joint audit is different from a **dual audit,** where a dual audit is performed by two independent auditors issuing their own separate reports, which are then used by another auditor that ultimately reports on the entity as a whole.

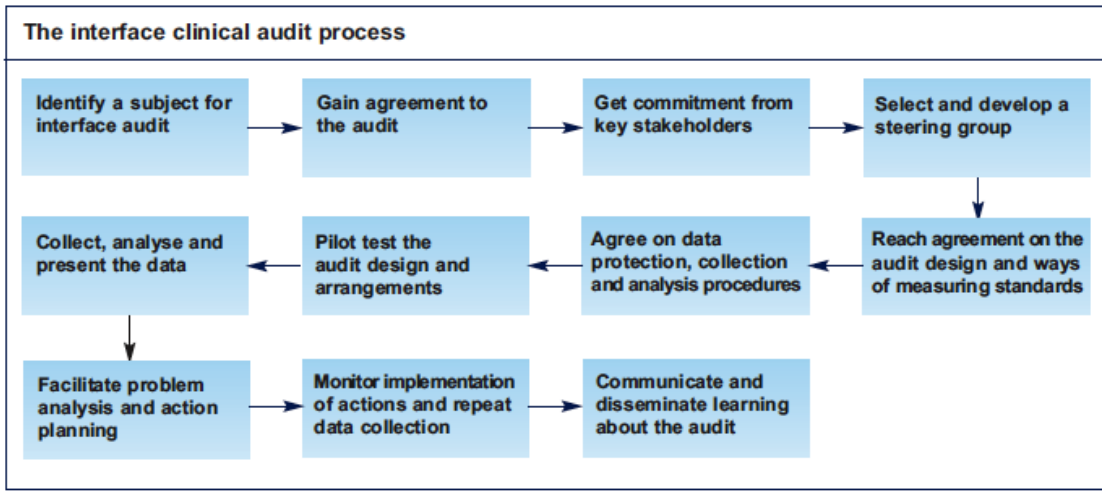
An example is provided by the Internal Audit Joint Working Protocol for Herefordshire Public Services including both NHS Herefordshire and Herefordshire Council.

The two providers will agree in advance areas of work where joint working of audit teams would be appropriate. For work undertaken at the PCT, CW Audit Services will be the lead provider with supporting resource from the Council team and for work undertaken at the Council the in house audit team will be the lead provider with supporting resource from CW Audit Services. The process for agreement of assignment briefs will follow the protocols of the lead audit provider. Audit reviews will be carried out in line with the lead audit provider's methodology, quality standards and reporting protocols. It will be the lead organisation's responsibility to ensure that these standards are complied with. When joint assignments are being conducted it is important that the timing of required resources is agreed by both internal audit providers and those resources are provided in line with the agreed timescales. Where a member of staff is assisting on a joint review which is not being led by their employer, their day to day reporting accountability will be to the lead audit provider on that specific review. Joint working will be undertaken on the basis that it is resource and cost neutral to both providers.

Note that 'Transforming Community Services: *Enabling new patterns of provision'*. (DoH 2009) required that a separate process of audit be in place for providers and commissioners to maintain internal separation.

An **interface clinical audit** is a clinical audit that is carried out by healthcare professionals in different healthcare organisations working as a single team to measure and improve the quality of patient care. An interface clinical audit follows the same overall process as any clinical audit.
*The Guide to Facilitating Clinical Audit across Different Care Settings (HQIP 2010) points out that i*t should include all of the following:

- clearly stated objectives and a robust design
- well-defined standards of good practice
- accurate collection of data on care or service in comparison with standards
- analysis and evaluation of the findings
- implementation of any changes in practice needed
- repeat data collection following the actions taken to determine if needed improvement has been achieved.



From 'Facilitating Clinical Audit across Different Care Settings' (HQIP, 2010)

Multi-disciplinary and cross-organisational working are hallmarks of good clinical audit practice and NHS Newcastle and North Tyneside Community Health encourages clinical audit undertaken jointly across professions and across organisational boundaries. Partnership working with other local and regional organisations is encouraged where improvements to the patient journey may be identified through shared clinical audit activity.

'The Trust supports collaboration on multi- professional clinical audits of interest to other parts of the local health economy, both within and outside of the NHS e.g. primary/secondary care, local authorities, social services etc.'

(NHS Newcastle and North Tyneside Community Clinical Audit Policy Health June 2010)

Audit South West working with Plymouth Hospitals Trust have successfully integrated the management of clinical audit and internal audit into one combined function. The Audit Consortium offers 'one audit service' covering both clinical audit and internal audit via one management team. This represents a significant change in the governance arrangements for audit within the trust. This development has lead to a fundamental change in the way in which aspects of clinical assurance, directly related to the Clinical Audit Team activities, are reported to the Audit Committee. The main improvement in this governance change has been around the visibility of clinical audit activities to the Non- Executive Directors who sit on the Audit Committee.

In NHS Sheffield's Clinical Audit and Effectiveness (CAE) Annual Report 2009-2010 there is reference to the **Sheffield** Priority CAE Programmes:

'A clinical effectiveness programme is agreed with each provider for 2009/10, to demonstrate compliance with NICE guidance, supported by evidence which may or may not include clinical audit. This programme is constantly updated with the publication of NICE guidance in year. Performance is detailed below.'

A separate clinical audit programme is also agreed for the year with providers which include four priority areas: national; trust; good practice; and clinical interest. The purpose of this programme is to improve clinical services, demonstrate a commitment to quality improvement and provide evidence and assurance of adherence to NICE guidance and National Service Frameworks (NSF's). Performance against each provider is recorded.

Both these programmes are monitored on quarterly basis and BRAG (blue – done/compliant, green - progressing satisfactorily, amber – some delay, red – cause for concern) rated by NHS Sheffield. Compliance with best practice and audit activity is part of the contract quality schedule for each provider. The Head of CAE meets with each provider lead and exceptions in performance are discussed at the contract quality review groups.

In 2009, the monitoring process was enhanced to include the detailed checking of progress of two projects each quarter for each provider. The actual items are chosen for each organisation via a random number generator, so that there is no selection bias. All providers have been very supportive of this approach and results have demonstrated that all statements of progress made by providers have generally been accurate. The above approach has been recognised as best practice by NICE.

Scenario

A Foundation Trust is refusing to collaborate in a joint clinical audit programme and also to release audit results and follow up actions quoting a series of issues such as patient privacy, the data protections act, intellectual property and a lack of resources. Recent external regulator reports have suggested that the Trust is particularly weak at patient handover from and to other health and social care providers,. The Commissioning Authority is a PCT handing over to a newly formed GP Consortia and wishes to engage the GPs in this issue. What timescale and assurance would the Board want of its Directors that progress is being made. What role can the PCT Chairman and NEDS play. How should the Accountable Officer designate and Consortia Chair become involved at this stage?

The HQIP/GGI document Clinical audit: A simple guide for NHS Boards & partners (2110) sets out the importance of Board engagement in clinical audit programmes.

A follow up survey by HQIP in 2010 '*Improving the quality of patient care: are NHS Boards engaging with clinical audit?* " showed a marked increase in the amount of clinical audits being carried out across the UK, and a significant increase in Board-level involvement. However, serious questions were raised regarding the quality of that interaction between management and the audit community - some 62% of respondents marked 'poor' or 'needs improvement' when asked about this interaction. (See http://hqip.org.uk/assets/Uploads/NewFolder/HQIP-Clinical-Audit-Simple-Guide-online1.pdf)

The Board should be involved in using clinical audit as assurance that strategic objectives and patient safety are supported by timely focused audits but ey als need to encourage the culture which reinforces good audit practice within and between service providers. This will include confidence that clinical audit is being managed at a senior level with sharing of data among the organisations involved and that any necessary actions in any of the organisations involved will be carried out

Questions

Is good practice in focusing and managing joint clinical audit being carried out? Does this involve:

- An important idea for clinical audit that involves another organisation
- Involvement of all the organisations responsible for care
- Clear communication channels among the organisations involved
- Leadership for the work involved in carrying out the clinical audit
- A steering group for the audit with members from all organisations
- involved

- Knowledge by the team involved of the parts of the care process and part of the process where care can be compromised
- Agreement by all concerned to data protection requirements and to having information sharing protocols in place between the organisations involved
- A well-designed clinical audit and robust data collection protocol and process

Key Elements:	Progress Levels:					
	NO	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
5. Be consistent in telling patients/carers what they are entitled to and when they or others are holding responsibility for their care	**NO**	Patients are informed of their rights and responsibilities	Commitment to informing patient/carer who is holding responsibility for their care at any time	Staff are actively encouraged/trained in informing patients/carer who is holding responsibility for their care at any time	Audit shows professionals and patient/carer knows who is holding responsibility for the care at any time	Patients and carers are clear of rights and responsibilities and evidence shows improvement in fulfilling these

Issues

- Have we considered establishing a joint clinical and system audit team?
- Have we aligned our audit programme with other stakeholders including our commissioning partners and providers?
- Does the audit consider the whole patient pathway from GP referral through secondary care to social care support as appropriate?
- How and by whom are decisions taken on whether to support a new audit and what assurance is there that the audit will deliver a return on investment in improved services delivery and cost reduction?
- Are users involved in audit prioritisation and consideration of results and actions that might follow?

A self-assessment maturity matrix is available at: www.hqip.org.uk/assets/Dev-Team-and-NJR-Uploads/HQIP-GGI-NHS-Boards-Matrix-for-CA-FINAL.pdf

3.2.2. Who holds responsibility for patient care?-Be consistent in telling patients/carers what they are entitled to and when they are holding responsibility for their own care.

One of the key partnerships in health and social care is that with the patient and their carers. It is, like most partnerships, not an equal relationship and for the patient it is a meeting that occurs at a time of strong emotions and concerns. The temper of this relationship is of course mostly controlled by the people in the room, the clinician and her patient but it is affected by the policies of the day; what entitlements do patients have, the commitment given to patients wishes and rights such as

embodied and publicised from the NHS Constitution and of course the resources available and the morale of staff providing care. The tone of the press, regulators and the ease of use of statistics and information all influence the interest and capacity of patients to share decision-taking. It should also be recognised that on the whole consumers are 'satisficers' i.e. they may want a wide range of choices but when it comes down to picking for example a new house and location they will routinely trade off ideal requirements and reach a compromise that meets some of their needs and aspirations but also accommodates price, time and effort. (see Simon 1956)) Simon, H. A. (1956). "Rational choice and the structure of the environment". Psychological Review, Vol. 63 No. 2, 129-138. **)**

Choice has been a popular phrase in recent governments but research has shown in education (Bullivant 1981) and health (Appleby *et al* 2003) that not everyone can exercise or desire the same level of choice (Bullivant, J PHD Thesis 1981)

'Individual choice may also conflict with the choices available to others. For example, where there is a fixed health care budget, allowing people to choose treatments that are not cost-effective – although they may be clinically effective for that person – may limit the choice open to others'

Appleby J, Harrison A, Devlin A (2003). *What is the Real Cost of More Patient Choice?* London: King's Fund.

The Kings Fund quoted the Healthcare Commission's most recent 'annual health check' of the NHS combined data from the national patient survey and uptake of Choose and Book to create a 'choice' target against which to measure PCT performance. They report that 70 per cent of PCTs had failed to meet this target and concluded that 'this is by far the worst level of performance for any of the existing national targets' (Healthcare Commission 2007).

The paper went on to raise concerns about the then recent government initiatives to strengthen the power of PCTs and GP practices as commissioners in relation to hospital providers include the use of tactics to intervene in the referrals between GPs and hospitals, mostly to keep the demand for hospital services within budgetary limits (Department of Health 2006d). These include the use of referral management centres, which add an extra stage to the referral process, whereby GP referrals are scrutinised by a third party for appropriateness. Choice guidance states that in these cases choice should be offered by the referral management centre clinician (Department of Health 2007a), but it is not known how effective this is or how it compares to the quality of choice being offered in the GP surgery.

Another example is the impact of practice-based commissioning (PBC) on patient choice. Practice-based commissioning was a system introduced across England by which participating GPs are given their own indicative budgets with which to purchase all their patients' care. This system provides incentives for GPs to carry out some procedures in their own surgeries that were previously undertaken in the hospital. Potential conflicts of interest have been recognised as the purchasers of services (GPs with their indicative budgets) may be the same as the providers (GPs providing, for example, an anticoagulation service in their surgery) (Audit Commission 2006), which might result in the reduction of choices on offer to patients as well as raising questions about the quality of care. (Kings Fund 2008).

The increased role of GP consortia in commissioning decisions further raises questions of 'whose choice and accountability?

The coalition white paper and subsequent documents sets out that the care of the future should be shared decision-making and informed choices:

'No decisions about me without me' a phrase coined by Harvey Picker, founder of the Picker Institute, and now adopted by Andrew Lansley as '*Shared decision-making: nothing about me without me'*

The consultation document (Gateway 014748) Liberating the NHS: An Information Revolution (DH 2010) says:

'Structured around a conversation between the patient or service user and the professional, either through face-to-face contact or remotely, such as through the care record. This will be a genuine dialogue in which each brings an important perspective to bear: the care professional brings knowledge about conditions and treatment options; the patient or service user brings individual needs, protected rights, values, 'preferences and personal circumstances. The principles, values and rights that underpin this approach are set out in the NHS Constitution[17]*.'*

Patients Know Best is a startup which aims to help patients make use of their 'Personal Health Record' They support the principle of "shared decision-making" quoting international evidence shows that involving patients in their care and treatment improves their health outcomes,[17] boosts their satisfaction with services received, and increases not just their knowledge and understanding of their health status but also their adherence to a chosen treatment.[18] It can also bring significant reductions in cost, as highlighted in the Wanless Report,[see scenario 2 below) and in evidence from various programmes to improve the management of long-term conditions.[20] This is argued also to be true of the partnership between patients and clinicians in research, where those institutions with strong participation in clinical trials tend to have better outcomes.

[13] See www.dhcarenetworks.org.uk/CAF/
[14] See http://www.connectingforhealth.nhs.uk/systemsandservices/infogov
[15] See http://www.nigb.nhs.uk/guarantee
[16] See http://www.nigb.nhs.uk/social

Liberating the NHS: An Information Revolution quotes the long term conditions model as example of this approach as one which includes a personalised care planning discussion, focused on the needs and wants of the patient. The outcome is a care plan that is personalised to the individual rather then the service provider. And goes on to say:

'There is strong evidence, both in this country and internationally, showing much better care outcomes when people are actively involved in shaping their own care. The appropriate involvement of carers in the dialogue can also be important in making a reality of shared decision-making.'

For people to be able to take increased personal responsibility and fully participate in decision-making, they need information and support that enables them to understand clearly both their own situation and the options open to them. Many clinicians and care professionals are already skilled in shared decision-making and comfortable with patients seeking information and advice outside the consultation. They will support their patients, especially those with long-term conditions, to become their own first line of healthcare. As a routine part of their practice, care professionals should support and encourage self-care, signposting patients and service users to reputable information sources such as information prescriptions[18] and other resources such as patient decision aids. They

should encourage people to explore such resources in their own time and, if they wish, with their family.

Shared decision-making is not about imposing responsibilities onto people when they feel least equipped to deal with them. Often people find that they need to make decisions about health and care at a time of anxiety and uncertainty for them and their family. Getting the right information at the right time is not just a matter of matching information to individuals or groups, it is also about communicating with sensitivity and tact, and working with people to provide the support they need to make decisions and manage their own health and care.

[17] See http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613

[18] See http://www.nhs.uk/aboutnhschoices/professionals/healthandcareprofessionals/other%20resources/pages/information-prescription-service.aspx

21 An Information Revolution: a consultation on proposals. 18 October 2010 Gateway number: 14748

Regulators too have a key role. The inability to hear the patient voice was a troubling issue in Mid Staffs and other reviews.

In the Healthcare Commission's 2007 survey of inpatients (the latest national survey available at the time of the 2008 review), the trust was in the worst 20% for 39 out of 62 questions. This was a poor result. The trust was in the worst 20% for overall standards of care and whether patients felt that they were treated with respect and dignity in the hospital.

The 2008 Healthcare Commission's review of Mid Staffs:

'Patient concerns reinforced what we found through observations, reviews of case notes, complaints and interviews – disorganisation, delays in assessment and pain relief, poor recording of important bodily functions, symptoms and requests for help ignored, and poor communication with patients and families'.

The latest CGC review in Oct 2010 says:

"Handling of complaints is another area where we expect to see significant improvements. The trust's complaints system is not effective because staff involved in complaints are not fully trained and investigations are not completed as quickly as they should be.'

The information pack for the post of Chairman of the CQC says :

(Jan 2010) 'The (CQ) Commission is putting people who use health and social care services at the very centre of what it does. It is working hard to make sure it captures their views, and those of the many groups who represent patients, people who use services, and carers. The Commission is also working with and listening to those who provide or buy care for local people, including primary care trusts and councils, and to people who buy care for members of their family, or for themselves.'

The NHS makes much of choice but struggles with users bringing their own resources to bear. The NHS has been largely a free at point of delivery service but if you don't want what's on offer you are on your own, it's not a mix and match service, except for example dentistry and physiotherapy. This

has provoked much debate when there are obvious inconsistencies between different parts of the country and accusations of post code lottery are levied. Ironically the withdrawal from NICE of authority over which drugs are to be available on the NHS will creates greater variability and probably more public angst over rationing decisions as below.

'Women seeking IVF treatment on the NHS have been told they only qualify if they are between 39.5 and 40-years of age under policies which have been condemned as "cruel and bizarre" by fertility experts.' Quoted in Daily Telegraph 27 Jun 2009

The debate over 'what am I entitled to, even if I choose to pay?' had been brewing for a while when it blew up in 2007 over the case of a a former nurse Ms M seeking to top up her treatment privately became a national issue. She was told that if she pursued the top up she would have to foot the entire £10,000 bill for her drugs and care. The Sunday Times reported (16.12.2007) that 'The threat stems from the refusal by the government to let patients pay for additional drugs that are not prescribed on the NHS. Ministers say it is unfair on patients who cannot afford such top- up drugs and that it will create a two-tier NHS. It is thought thousands of patients suffer as a result of the policy.'

The NHS Trust was reported as saying, "If a patient chooses to go private for certain drugs they elect to become a private patient for the course of their treatment for that condition. That is the trust policy. The Department of Health apparently said: "Co-payments would risk creating a two-tier health service and be in direct contravention with the principles and values of the NHS."

After much pressure the DH set up a review under Professor Mike Richards whose report set out a series of recommendations on improving access to medicines for NHS patients. It also made recommendations on the consequences for NHS patients of seeking additional private care. Professor Richards presented his report 'Improving access to medicines for NHS patients' to the Secretary of State; who accepted the recommendations in full on 4 November 2008

Richards in his letter to the Secretary of State explained that 'at the heart of the issue is the tension that exists between the principles of equity – that every person should have access to health services based on their need and not on their ability to pay – and personal autonomy – that people should be free to spend their money as they choose. This tension has existed since the NHS was founded 60 years ago, and the issue of unfunded drugs is simply its latest iteration'. He commented on the unnecessary burden of 150 PCTs debating the same issues and argued that 'there is a strong case for PCTs to work more collaboratively on making funding decisions, pooling expertise and avoiding unnecessary duplication of effort'.

He made 14 recommendations including:

Recommendation 2: The Department of Health should urgently consider how PCTs can be encouraged to work together to make proactive commissioning decisions. Consideration should be given to whether collaborative Improving access to medicines for NHS patients processes already developed, such as in the North East for cancer drugs, could be used as a model. Greater collaborative working would go some way towards addressing the high levels of concern that exist about the variations that occur in the way PCTs make funding decisions. However, it is important that PCTs should also be able to demonstrate that they are taking decisions in a transparent, rational and consistent manner.

I found that current guidance on the issue, which was not developed to deal with the complexities of modern drug treatment, is unclear. It is being interpreted in many different ways, resulting in

differing approaches for patients with the same condition who require the same drug.

Recommendation 7: The Department of Health should clarify the policy on how the NHS should handle situations where a patient wishes to purchase additional treatment. The objective should be to ensure consistency in practice across the NHS. During the course of the Review it also became apparent to me that a wide variety of different terms have been used to describe issues relating to the mixing of NHS and private treatment. These terms have often been used interchangeably and are defined in different ways by different stakeholders. I have therefore used a common framework to consider the issue. The options considered broadly range along a spectrum from ensuring the complete separation of NHS care and treatment purchased privately to encouraging complete integration. The clearest way to ensure separation between NHS and private care is to force patients to make a choice from the outset whether they wish to be a private patient or an NHS patient for the duration of their treatment for that condition. I share the view of the large majority of stakeholders that this option is unfair, as it would deny patients NHS care they would have otherwise received.

Recommendation 8: The Department of Health should make clear that no patient should lose their entitlement to NHS care they would have otherwise received, simply because they opt to purchase additional treatment for their condition

It is important to stress that every possible approach to implementing this recommendation has practical difficulties and I have tried to balance these considerations in recommending a way forward. The most integrated solution would be to introduce a system of NHS top-ups whereby patients would pay a user charge to receive additional drugs. However, I believe that this approach presents significant practical challenges and is inequitable for those NHS patients who could not afford to top up. It would also place the NHS in the perverse position of charging for treatments that have not been deemed as Improving access to medicines for NHS patients cost-effective. For these reasons I believe that the option of NHS top-ups should be rejected. My preferred option for ensuring that patients do not lose their entitlement to NHS care because they purchase additional drugs is for the government to clarify that individuals may pay for these drugs while continuing to be treated as an NHS patient for other elements of care as long as the two elements of care are provided separately. This ensures that there is a separation between NHS and private care, in line with strongly held views on the desirability of maintaining equality on NHS wards and day clinics.

Recommendation 9: The government should make clear that:

- clinicians should exhaust all reasonable avenues for securing NHS funding before a patient considers whether to purchase additional drugs;
- patients should be able to receive additional private drugs as long as these are delivered separately from the NHS elements of their care; and
- providers should establish clear clinical governance arrangements to ensure that patients who do elect to purchase additional private treatment receive good continuity of care.

Not all NHS hospitals have private facilities or a private hospital nearby. In these circumstances there may be practical difficulties in implementing the parallel arrangements. However, with goodwill, I believe these can be overcome.

Recommendation 10: Strategic Health Authorities, working where appropriate through cancer networks, should ensure that local policies are developed to ensure that any revised guidance issued by the government is implemented properly. This might include using a designated hospital with private facilities for all patients wishing to purchase additional drugs, making use of homecare

provision or designating an area of an NHS hospital for the delivery of privately funded treatments.

('Improving access to medicines for NHS patients' A report for the Secretary of State for Health by Professor Mike Richards CBE COI, November 2008)

One of the issues for patients is the time it takes to clarify these issues. The family of an injured patient in Wales were required to pay large sums for care they should have received from the health service. The patient was hospitalised in July 2006 for 10 months with severe brain injuries. He left hospital the following year but his father complained that the local health board (Carmarthenshire LHB) had failed to put in place the package of therapy recommended after an assessment of his son's needs.

The Public services ombudsman's report concluded that "a large part of the package was not provided" and the patient "did not receive sufficient physiotherapy, occupational therapy and had no speech and language therapy."

The review found that the LHB had "mishandled its response to Mr B's case" and the LHB's written decision making "was very confusing." His father also "spent large sums of money" on therapy that he should not have needed to pay out.

Public services ombudsman, Peter Tyndall said in an interview with BBC Wales: "I think the LHB failed to provide the service required in order for their son to make the best possible recovery. "He became disabled after a serious assault and the family decided to support him at home, but the services they needed in order to do that weren't provided. "He added: "Funding for continuing health care is very complex and needs to be dealt with properly. "In this instance the paperwork, the various meetings were not properly documented and, in the end, they failed to make the right decisions and failed to keep a record of the decisions they made.'

Hywel Dda Health Board, successor to Carmarthenshire Local Health Board (LHB), said it accepted the report and apologised for any distress caused.

Carmarthenshire LHB had agreed the patient qualified for continuing care and should receive physiotherapy, speech, language and occupational therapies after being discharged from hospital. But his parents had to battle for that care to be given in subsequent years, paying out of their own retirement savings for the sessions. " I think the LHB failed to provide the service required in order for their son to make the best possible recovery " Peter Tyndall, public services ombudsman. See http://news.bbc.co.uk/go/pr/fr/-/1/hi/wales/south_west/8440253.stm BBC 5 1 10

This issue threatens to continue with a series of test case struggling with the tensions Mike Richards espoused between principles of equity –access to services based on need and not ability to pay – and personal autonomy – that people should be free to spend their money as they choose. It is not limited to the Health Service.

In Jan 2010 the Times reported that Barnet Council's 'no-frills' approach to services had fallen foul of the law. The council had made headlines over its plan to provide a no-frills "easyJet" service with top-up charges but the Council has had to drop plans to allow residents to pay a fee to jump the queue with planning applications as this would flout current regulations. And, after a High Court decision, the Conservative-run council has had to rethink plans to cut the number of live-in wardens in sheltered housing. However the new council leader said he is determined to carry through proposals, which include incentives for recycling and other top-up fees. (Times 5 1 10).

In spite of the Richards review and recommendations this has felt like a 'don't go there' issue for Boards but these issues are at the heart of the Commissioner's role. Have we considered who is entitled to what? In many ways the deliberations, now well established for determining whether a particular drug can be funded are well established and the judicial review process which allows challenge on this issue is limited to comment on due process not outcome. But Boards must ask themselves if they have a consistent approach, one they can articulate and that their staff and if commissioners their providers too are clear about. As we enter a period of financial stringency this issue becomes much greater as Boards must deliberate not just which medicines but which services can be provided and where. The need for clarity and consistency becomes even greater.

Scenario 1

A patient wishes to top up their treatment by paying for additional (expensive) drugs. Other trusts/commissioners and the NHS have formally indicated that "Co-payments would risk creating a two-tier health service and be in direct contravention with the principles and values of the NHS." But the Richards review suggests otherwise.

Other trusts have worked through the issue and have a consistent policy which staff and patients are aware of and understand. Commissioners and providers there have agreed a common position. Have we?

Scenario 2

One of the three future scenarios modelled in the Derek Wanless report '*Securing our Future Health: Taking a Long-Term View*, (2002).report was a "fully engaged" scenario where patients and the public were more engaged in their health, contributing to significantly lower demands on the health service in the longer-term. (see Wanless, D., *Securing our Future Health: Taking a Long-Term View*, (2002).

This described a future with a dramatic improvement in public engagement, driven by widespread access to information – for example, through media such as the internet and digital television. In this scenario Public health improves dramatically with a sharp decline in key risk factors such as smoking and obesity, as people actively take ownership of their own health. The improvements seen in the *solid progress* scenario are achieved quickly and exceeded. People have better diets and exercise much more. Targets for obesity are met quickly and maintained. Fewer people smoke: only one in six compared to around one in four today, matching levels in California where there has been intensive smoking reduction in recent years. These reductions in risk factors are assumed to be largest where they are currently highest, among people in the most deprived areas. This contributes to further reductions in socio-economic inequalities in health. Health needs and the type of care available become more sophisticated as engagement rises.

'The service responds effectively…uptake of appropriate technology is assumed to be rapid and effective...people make one more visit to their GP each year compared to today. The very old rapidly start experiencing higher levels of hospital care than at present, because they demand more and doctors are much more likely to provide them with care based on their clinical need alone, not their age.'

- As a commissioning board or public health team what would you need to do to create a positive environment for such a scenario to become real?
- What are the implications for demand of hospital and community based services?

Questions & issues

- Is it the role of the local Board or GPC to determine these issues or should they be lobbying for consistency from the Department of Health?
- Have local commissioning boards determined their local principles for disinvestment and shared these with providers? If not are they vulnerable to criticism in a judicial review?

'Patients know best' encourage patients to ask 3 key questions of their clinician:

1. What are we doing?
2. Why are we doing it?
3. What happens if we don't do it?

Are our clinicians ready and able to answer these questions?

(PKB refs
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18 Stevenson, F.A., Cox, K., Britten, N., Dundar, Y., 'A systematic review of the research on communication between patients and health care professionals about medicines: the consequences for concordance' Health Expectations 7(3): pp. 235-45, (2004).
'The Human factor: How transforming healthcare to involve the public can save money and save lives', NESTA (2010).
Garcia-Alamino, J.M., Ward, A.M., Alonso-Coello, P., Perera, R., Bankhead, C., Fitzmaurice, D., Heneghan, C.J., 'Self-monitoring and self-management of oral anticoagulation', Cochrane Database of Systematic Reviews, Issue 4 (2010).

20 Heisler, M., Bouknight, R.R., Hayward, R.A., Smith, D.M., Kerr, E.A., 'The relative importance of physician communication, participatory decision-making, and patient understanding in diabetes self-management' *Journal of General Internal Medicine* 17(4): pp.243-52, (2002).)

6. Check our partners/suppliers have the capacity to deliver their obligations to us.

We need our partners not only to be committed to a common purpose but to have the capacity to take, often difficult, decisions and then to act to deliver. We in turn need to have trust in that commitment but also to be alert when things are going awry.

Professor Murray Stewart points out (Tackling Health Inequalities, The Cities Research Centre, September 2002) that building partnership capacity through the creation of trust cannot be done overnight and it is important that:

- new partnerships take time to assess their strengths and weaknesses,
- partners get to know one another and
- there is a clear and shared understanding of what can be achieved through partnership.

What is evident, if perhaps as yet poorly recognised, he argues 'is that partnerships take time to bed down for a host of structural, procedural and cultural reasons…vertical, functional, silo based working has characterised British public administration for nearly a century. The development of a more horizontal model which recognises the importance of territory and locality will be slow to develop, especially where central and local practices need to be realigned. If there is one lesson for systems governance and a move towards more effective partnership working, it is that ten years is the most appropriate (indeed minimum) time within which one can expect results ' Murray Stewart 2002.

Key Elements:	**GBO Progress Levels:**					
	NO	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
6. Check our partners/suppliers have the capacity to deliver their obligations to us	**NO**	Needs and joint resources have been identified and deployed	Protocol /etiquette for working together agreed with escalation / failure actions predetermined	Agreement on resource deployment between responsible organisations agreed as part of planning/commissioning cycle	Audit of process shows joint working arrangements and arbitration are working to plan and time	Routine robust check of partners resource and decision making capacity with corrective action plan

The Joseph Rowntree Trust funded '**Designing citizen-centred governance** by Marian Barnes et al, (2008) found the picture to be complex and changing with towns and cities now governed by a patchwork of special-purpose governance structures operating alongside local authorities, NHS

bodies and other government agencies.

'Clarity about the purpose of engaging people in governance arrangements is lacking. This can lead to confusion and disillusionment.' Barnes 2008

The NHS is full of examples of successful partnerships and the Institute for Innovation and improvement annually recognizes many of these through the Health and Social Care Awards; for example in 2009 Stroke Northumbria won a leadership award for its work across acute, primary and social care and with the voluntary sector to provide specialised services and ongoing support for people with stroke and their families.

The network's implementation of the latest emergency interventions, new care pathways and a collaborative, multi-disciplinary approach was found to yield impressive results. Patients had access to specialist teams and rapid assessment throughout an integrated care pathway. The quality of rehabilitation care meant that 9 out 10 people who survived stroke recovered well enough to return home.

Recognised as a High Achieving Site by the Royal College of Physicians, the team accredited their success to effective leadership and collaboration. This they claimed helped them 'overcome major challenges in providing integrated care across organisational, political and geographical boundaries'.

http://www.institute.nhs.uk/health_and_social_care_awards/national_winners_2009/national_winners_and_finalists_2009.html

Not all partnerships succeed in building the capacity to overcome the barriers to effective partnership working. A starting point is to understand the purpose of the partnership perhaps distinguishing between *transformation* (working in partnership to convince the other partner(s) of your own values and objectives), *synergy* (working to produce added value beyond what would have been achieved separately) and *budget enlargement* (achieved when partnerships generate extra resources). Macintosh (1993)

Murray Stewart who quotes this work in 'Systems Governance: Towards effective partnership working' UWE, 2002 believes that 'central to the operation of systems of governance, therefore, are issues of trust. Indeed trust is the key concept raised in all discussions about the attributes of a good partnership. It is less clear, however, whether trust is a necessary input to partnership or is an output from it. That is, can trust be assumed or does it have to be built, earned, won, or given? Stewart identifies different definitions of trust:

- 'Hardy et al 1988 believes trust is a proxy for predictability. The greater the degree of trust the more likely is it that actions will be predictable. In this sense trust underpins economic transactions, endorses the principal/agent relationship and reduces the need for binding legal and costly contracts.

- Vangen and Huxham (2000) observe that trust needs to be both formed and fulfilled to generate bilateral trust. They also remind us that trust can both be rooted in expectations (that something predictable will occur) and in experience (that something has occurred).

- Granovetter reinforces this view in commenting that trust does not arise 'when the transactors are previously unacquainted, where they are unlikely to transact again, and where information about the activities of either is unlikely to reach others with whom they might transact' (Granovetter 1985, p.496).

Trust, Stewart argues, is therefore generated by both experience and reputation. Trust also lies at the heart of two other features of partnership working, risk and power. In situations where no one partner has the will, resources, or capacity to carry through some task on his or her own, then trust in others minimises risk-taking, since the possibilities of failure or resource wastage are spread. Trust ensures that risks are genuinely shared as opposed to being off-loaded in the case of failure. Furthermore trust reduces the risks of partisan interest group activity, partner disempowerment, or leadership domination.'

All this echoes the influential Audit Commission report 'Taking it on Trust' (2009) which although focused on internal corporate governance issues has lessons for governance between organisations. It found in England significant gaps between the processes on paper and the rigour with which they are applied. 'There is much guidance in place, but as with the banking crisis in the UK…NHS board members need to understand, question and assess risk on an informed and ongoing basis.

Its main findings were:

- board assurance processes are generally in place but must be rigorously applied;
- board members are not always challenging enough; and
- the data received by boards is not always relevant, timely or fit for purpose

As Steve Bundred, then Chief Executive of the Audit Commission commented on 29 4 09:

'Our evidence suggests that, while processes are in place, many board members … are not always getting the right information that is needed to go hand-in-hand with the critical nature of work in hospitals. The NHS has, in many cases, been run on trust. But those who are charged with running our hospitals must be more challenging of the information they are given and more skeptical in their approach. Healthcare is inherently risky and complex, and assurance is not easy in the public or private sectors. To do their jobs properly, NHS board members must review their risk management arrangements so that they can be absolutely confident that their trust is providing high quality care by well-trained staff in a safe environment all of the time.'

So partnerships may be critical to successful outcomes but the nature of the partnership is also critical. Relying on a weak partners or failing to be explicit of expectations will not deliver success. Understanding their capacity and commitment to deliver joint objectives is an important precursor to trust. The Public Services Productivity Panel has issued a checklist, "Creating Successful Partnerships", for central government bodies considering sponsoring partnerships. It was designed to give an idea of some of the issues that need to be addressed during policy development to ensure that a Partnership is appropriate**:**

- Are you sure that the outcome you want cannot be delivered by existing government organisations with better cross-agency coordination?
- Are you sure that an existing partnership could not be adapted to deliver the outcome instead?
- Are you willing to wait for results while a new partnership takes several years to develop the trust, teamwork skills and capacity necessary for effective delivery?
- Are you sure the benefits outweigh the costs of creating a new partnership?

The Development Trusts Association commissioned studies by 'Partnerships online' which led to some guidelines which offer a way of deciding what sort of partnership to create, and how to make a start:

- Clarify your own aims and objectives in forming a partnership. What are you trying to achieve, and how will you explain that?
- Identify the stakeholders - the key interests who can help or hinder the project or programme - and put yourself in their shoes. Who holds the power?
- Consider who you really need as partners, and who would really want to be a partner. Some stakeholders may simply want to be consulted.
- Before approaching potential partners, make sure you have support and agreement within your own organisation about working with others.
- Make informal contact with partners to find out about their attitudes and interests before putting formal proposals.
- Communicate with your partners in language they will understand, focusing on what they may want to achieve.
- Plan the partnership process over time. For example, a new organisation may well take a year to set up.
- Use a range of methods to involve people - workshop sessions as well as formal meetings. Be sociable.
- Encourage ideas from your partners. Ownership leads to commitment.
- Be open and honest.

The GGI have published their own etiquette for partnerships and supplier relationships:

1. Be clear if it's a contract, SLA, Grant, Partnership, Network, Community of Practice (COP) Does our governance reflect this?
2. Agree common objectives, values, outcomes and measures
3. Define our emerging plans with partners and agree necessary changes in relationship and expectations
4. Log, share and track agreed decisions and ensure all parties affirm and provide assurance of delivery of performance and outcomes
5. Agree to share information which provides early warning of variance and completion of agreed actions / commitments
6. Agree and appoint an arbitrator to handle and determine partnership disputes
7. Identify and share common risks (and escalation plans) including risks of partner/supplier failure to deliver
8. Share with partners knowledge of reputational risks in timely manner
9. Clarify & update first contact point for control of each decision/agreement & escalation contacts for concerns over assurance
10. Give adequate notice of absence of key contact points or intent to withdraw specific commitment or whole partnership

(GGI Partnership Etiquette (2009)

Suppliers

Relationships with suppliers must be two way. NHS Westminster at a Board meeting (24 Nov 2009) identified the major risk in realising its Major Health Campaign (MHC) was supplier performance over the contract four- year period but the Board paper also recognised procurement polices created risks to suppliers which in turn affected the PCT. The payment mechanism associated with FESC drives and incentivises supplier performance with the approach tying payment to results. For example, NHS Westminster may deduct payments based on supplier failure to meet agreed timeframes or quality criteria associated with deliverables and milestones. The contract may be

terminated within one month due to repeated failure. A further performance charge is withheld until the end of the financial year and is only paid where the supplier has met all stretch targets. In an economic downturn cash flow becomes a critical driver for sustained business and late payments risk the viability of the enterprise. *Medicaldevice-network.com* an online procurement and reference resource decision makers within the medical device and diagnostics industry describes ' Late Payments: Public Enemy Number One': Across Europe, the public sector is notorious for failing to pay its medical device suppliers on time with Data from credit management services indicating that 60% of late payments are from the public sector webnews item 16 7 10).

A key risk identified by Bidders in the first round of FESC bids was the current challenging fiscal environment within the NHS. While not having any legal right to stage two funds, concerns were expressed that the amount of funding for stage two proposals may be reduced due to future cost constraints. Bidders identified this as high risk with a significant impact.

In the IT industry it is common to enter into benchmarking clauses which give an extended commitment (say 6 rather than 3 year contract) but require an annual review of standard industry costs so for example if the contact is based on current energy, processing or labour costs and these reduce as evidenced by agreed benchmarks then the purchaser can enjoy cost reductions as well as the supplier. These transactions make a lot of sense trading off risk against price but are fraught with issues such as competition law and company lawyers are often wary of allowing their technical staff sitting down with competitors to agree principles for fear of being accused and fined for price fixing.

March 2010 **v 2.1**	**Integrated Care Working Integrated Governance maturity matrix developed by the Good Governance Institute**					
Key Elements	**0**	**1: Basic level - Principle Accepted**	**2: Basic level agreement of commitment and direction**	**3: Early progress in development**	**6: Maturity - comprehensive assurance**	**7: Exemplar**
1. Strategy and clarity of purpose	None	Agreement on joint purpose	Shared strategies	Aligned strategies and priorities	Common performance measures	Joint review of strategy
2. Organisational structures	None	All resources committed to service area identified	Appropriate clinical advisory group engaged	Structures realigned to deliver strategy	Service delivery elements merged in single organisation	Whole pathway of care aligned in single entity or single contract to deliver
3. Ownership of financial risk	None	Clarity of financial risks and who holds	Risks Shared	Budgets shared	Joint audit	Lessons learnt from over spends etc
4. Clinical assurance	None	Assurance Framework identifies principle risks to clinical objectives	Prioritisation of clinical audits	Joint clinical/ care audit programmes in place	Gaps in independent assurance identified	Assurance is independently provided

5. Behaviours maturity self knowledge	None	Agreement on way of working/ etiquette / communications	Scenarios/ Locks ins used to practice resolving wicked issues	Resolution of disputes planned / arbitrator identified in advance	Joint planning and delivery arms operate as one entity	know how partners would react and can act on this knowledge with confidence
6. Talent/ competencies managerial development	None	Competency Needs assessment completed	Joint or aligned Development plan	Development activities in place	Succession plan in place	Recognised place to work
7. Outcomes	None	Success Criteria agreed	Joint measurement system in place	Tolerances agreed and exception reporting dashboards in place	Outcomes analysed and influence new strategy and delivery plans	Focus moving to longer term outcome improvement and sustainability

Scenario Example 1- Are our supplier relationships sufficiently robust to ensure service delivery is not disrupted?

The NHS trust is supplied by an independent firm for all dressings and wound management products and equipment. The firm has recently been taken over by an off-shore private equity firm and is experiencing both logistics and industrial relations problems and fails to deliver 50% of supplies in advance of Christmas. In January/February a number of waiting list initiatives are planned using all theatres six days a week to meet annual performance targets. The supplies contract is specific in requiring timely deliveries but the favourable terms were secured by granting an exclusive contract. The trust is entitled to compensation but may lose the theatre sessions and incur additional contracted locum/staffing costs. The trust has a business continuity plan in place that should allow for unusual activity levels to be adequately serviced. What assurance does the Bard have that services, income levels and patients expectations will be maintained. Is the issue different if the concern was blood products from the NHS blood and transplant authority?

Scenario 2

One of our partner organisations is subject to special measures due to performance failures. The interim management team have serious care delivery problems to manage within their organisation and it is possible/ probable that they are not focusing on boundary issues. What can we do to help and ensure our obligations are met?

Questions & Issues

- Are we confident of our partners/suppliers to meet our needs. Have we contingency plans in place if they fail?
- Have we introduced risk and cost through over elaborate tendering processes?
- Have we mutual aid agreements in place with fellow NHS organisations in the event of supplier failure?

3.3 Mutual aid and business continuity

Mutual Aid is defined as “An agreement between responders, within the same sector or across sectors and across boundaries to provide assistance with the additional resources during an emergency which may go beyond the resources of an individual respondent.” (DoH 2005, The NHS Emergency Planning Guidance).

Mutual aid is probably the most difficult aspect of GBO. The NHS is fabulous in a crisis but less good at both predicting and learning from longer-term strains on our systems. Swine Flu, like the Year 2000 worries, required much preparation but as things go wrong and we fix them, we need to learn the lessons and hang onto them. It is now over 10 years since ‘An Organisation with a Memory’ was published (Report of an expert group on learning from adverse events in the NHS Chaired by the Chief Medical Officer, 2000) but just how good are we at learning and holding lessons both from within our own and from other organisations. Have we overcome the ‘barriers to organisational learning’ identified in that document and can we make them work between and well as within organisations? Securing the legacy of good practice from SHAs/PCTs and their relationships with others will be critical for new GP consortia but the NHS has not had a good track record in remembering its past.

The GBO debate paper (2008) identified three key areas in terms of mutual aid governance and security which require particular focus between organisations:

1. **Longer term business continuity planning**
2. **Overall multi-sector organisational security and mutual aid aligned to planning for sustained events and incidents such as pandemics, weather and terrorism**
3. **National resilience planning**

These areas are often seen as independent of the governance process and in our experience are not fully understood or addressed by boards within NHS Trusts. The evidence also indicates that broader strategies are needed to address these elements throughout the entire public and private sector; note for example the new National Risk Register announced by Gordon Brown in March 2008. The Department of Health and the Cabinet Office published in 2007 'Pandemic flu: A national framework for responding to an influenza pandemic, and supporting guidance,(12) which describes the Government's strategic approach for responding to an influenza pandemic 'The Civil Contingencies Act 2004 and its accompanying non-legislative measures provide a single framework for civil protection, and resilience forums have been established to coordinate, develop and maintain links between partner agencies and coordinate planning at regional and local level. These forums provide an effective mechanism for developing integrated plans for all major threats, including pandemic influenza. A phased approach allows for a step-wise escalation of planning and responses, proportionate to the risk at any particular time.' In practical terms this level of planning is fundamentally undeveloped and many directors fail to understand how to implement and sustain business continuity planning as a means to avert costs or mitigate longer term risk.
The following trust report shows the far-reaching personal and financial implications of failing to take this into account:

"Business Continuity Management is a key component of the Civil Contingencies Act 2004 which has driven local efforts to be focused on preparing for civil emergencies such as localised flooding and major transport accidents. In my experience, what the NHS is getting right is emergency preparedness, in that tested plans are in place and well communicated in order to cope with an emergency. What we are not getting right is the alignment of business continuity plans with preparedness plans. We instigated our major incident plan, cancelled theatres etc in readiness for a potential (worst case scenario) influx of patients, as opposed to considering the business and financial implications of so doing. When the casualties never materialised (in part because of diversion efforts of social services/PCT) it was too late… we had lost half a million pounds of activity. The Trust failed to recognise the importance of the planning process across the locality (internally and externally) through better contacts between organisations (Police, PCT, Social Services). We could have ensured that whatever happened locally dovetailed with efforts at the hospital. It is imperative that we all share the desire to ensure any disaster or incident, natural or otherwise, has minimal effect on the economic well being of the community."

Organisations should not only test the resilience of internal structures and processes but also those of the organisations on which they rely or deliver services through. In the event of an emergency integrated planning and effective communication across organisational boundaries is critical to service continuity and community resilience. Robust and cross-organisational continuity plans ensure compliance and corporate governance by enabling adherence to the wider framework of responsibilities and expectations.

Disruptive events, such as flooding or pandemic illness, pose significant social, economic and environmental risks to local communities and to the continued delivery of vital public services. Over the last ten years for example, the attacks of 11 September 2001 in the United States increased awareness across the world of the threat from terrorism; the Indian Ocean tsunami in December 2004, Hurricane Katrina in New Orleans, 2005 and the Haiti earthquake, 2010 all highlighted the threat to people and the

environment from natural disasters, and people around the world are weathering a flu pandemic.

The Strategic command arrangements for the NHS during a major incident published in 2007 required that NHS organisations In developing arrangements for mutual aid would need to be clear:

- what aid might be required,
- what they themselves can offer and
- who their partners are.

Administrative boundaries, including national boundaries within the UK, should not be a reason for not working with organisations over those boundaries in developing mutual aid arrangements.

The purpose of the document was to provide guidance to National Health Service (NHS) organisations regarding command, control and co-ordination arrangements, required in planning, preparing and responding to emergencies. It provided a platform for all NHS organisations to undertake emergency planning. The guidance stated that if the scale of an incident escalated beyond the SHA's capacity or region, or if its duration or nature is such that wider NHS resources are required,

'The SHA will enact mutual aid protocols with neighbouring SHA(s) and, where appropriate, the devolved administrations of Scotland, Wales and Northern Ireland. For events that require mutual aid on a large scale, the Department of Health (DH), via the Department of Health Major Incident Coordination Centre (MICC), can implement national co-ordinating arrangements. '

The guidance for personal social service providers in the statutory and independent sector, November 2008, encouraged multi-agency planning, discussing the ability to share and redeploy staff within and between organisations, and across sectors whilst recognizing the prime focus for staff in each service will be to concentrate on keeping the service they are immediately responsible for running.

7. Engage with other organisations to support us in case of long term or widespread service collapse.

In July 2010 in addition to abolishing SHAs, the Government also announced its intention in principle to abolish the Government Offices for the Regions. The announcement recognised that some Government Office functions, such as arrangements for resilience and civil contingencies, would need to continue. CCS and CLG were commissioned to provide joint advice to ministers on the options for the future of the regional resilience tier and to work with Government Departments, Government Offices and other to establish and evaluate the options. Guidance should be available early in 2011. Here we rehearse the practice that has emerged to date and which GPCs and Local Authority Public Health Teams need to consider.

The NHS Emergency Planning Guidance 2005 gives the Chief Executive Officer of each NHS organisation responsibility for ensuring that their organisation has a Major Incident Plan in place that is built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public, and information sharing. The plan will link into the organisation's arrangements for ensuring business continuity as required by the CCA. Responsibility for ensuring that there are appropriate command, control and co-ordination arrangements in place forms part of that responsibility for Chief Executives of all NHS organisations. SHAs and Primary Care Organisations will need to ensure that arrangements made within their boundaries and with neighbours are adequate and appropriate to local circumstances.

Whilst it is ultimately the responsibility of the Trust Chief Executive at a local trust level, the NHS Chief Executive has final responsibility for the NHS as a whole and therefore will need to be assure that trusts (including FTs and SHAs) are suitably prepared and resilient to disruptive challenges.

The responsibility for providing this reassurance will be through the SHAs.
The purpose of the NHS Emergency Planning Guidance 2005 is therefore to describe a set of general principles to guide all NHS organisations in developing their ability within the context of the requirements of the Civil Contingencies Act 2004 (the CCA) to:

- respond to a major incident or incidents or emergency
- manage recovery whether the incident or incidents or emergency has effects locally, regionally, or nationally.

Throughout the document, the term *emergency* is used as in the CCA, i.e. to describe 'an event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK. To constitute an emergency this event or situation must require the implementation of special arrangements by one or more Category 1 responders.'

The guidance is quite explicit that responses should only be considered appropriate in the event of emergencies that comply with the definition above.

'Under no circumstances should any NHS organisation seek to initiate or adapt these in order to respond to a problem arising solely from staff shortages, waiting list pressures, management failures or other local institutional deficiency. The accompanying ethical and medico-legal endorsement that will support NHS organisations and staff in an appropriate escalation response will not be applicable in other circumstances.'

In 2009 the DH set out revised strategic command arrangements for the NHS during a major incident (DH 14 August, 2009) The purpose of this document was to provide good practice guidance to National Health Service organisations regarding command, control and co-ordination arrangements, required in planning, preparing and responding to emergencies. It was intended to provide a platform for all NHS organisations to undertake major incident and emergency planning, built on best practice and shared knowledge.

Key elements:	**GBO Progress levels**					
	NO	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
7. Engage with other organisations to support us in case of long term or widespread service collapse	**NO**	Key risks and contingency partners/suppliers identified	Escalation action plans agreed	Plans are tested for resilience and updated. Partner failure is factored in	Black Swan unknown unknowns resilience/responsiveness is tested in joint scenario exercises	Contingency plans with out of region support established

It was to be used in conjunction with the NHS Emergency Planning Guidance 2005, the purpose of which was to describe a set of general principles to guide all NHS organisations in developing their ability within the context of the Civil Contingencies Act (CCA) 2004.

The guidance covered:

- background to the subject
- SHA response and planning responsibilities
- definitions of strategic, tactical and operational roles
- requirements of a co-ordinated local response
- the role of NHS organisations
- delivery of an appropriate command support
- the formation of a Regional Civil Contingencies Committee
- the roles and responsibilities of NHS organisations in emergency planning

The web version of the guidance is available at:- www.dh.gov.uk/emergencyplanning

The guidance emphasised that:

- it is essential that there is good communication between different health care services in order to ensure that responses are structured and cohesive and reflect the needs of the whole health economy.
- the term NHS organisation includes Foundation Trusts

It was the stated intention of the guidance to:

- set out proposals for command, control and co-ordination arrangements taking into account the recent and ongoing changes to the organisation of the NHS;
- take into account the need to maintain a clear line of sight between all elements of the process;
- help maintain clarity for external partners, in the role of the various elements of the NHS.
- to provide clear guidance for NHS organisations on strategic command arrangements across the health economy to allow robust planning to take at trust level

Most emergencies and major incidents are geographically local and limited in time and are dealt with in an effective and efficient way by the emergency services and the Acute Trusts. Some events require a broader level of co-ordination, say, at a borough, county or regional level, which may necessitate the involvement of the Primary Care Organisation(s) or SHA(s). An example could be the need for a significant increase in community/intermediate bed capacity or community/intermediate support at home to enable the acute Trust to discharge patients to enhance acute capacity.
NHS organisations should ensure that all arrangements made to plan for and respond to emergencies take into account a whole system approach to healthcare and ensure reciprocity.

The emphasis has been on developing local capability to respond at primary care and community level, including public health advice and at individual hospital and ambulance service level. The NHS is now required to plan additionally for incidents of a different nature and magnitude, including incidents that may have a long-term impact on the provision of services.

At the Planning Stage the SHA must be able to assume strategic control and leadership of incidents as required. Each SHA needs to ensure that it has an overview of all major incidents and emergencies within its boundary and that appropriate arrangements are made to allow for a well co-

ordinated response. These arrangements must take into account the requirements of the CCA and therefore SHAs must take a proactive lead in guaranteeing the availability of support and practical mutual aid both within their area, and across SHA boundaries. SHAs may wish to consider designating formally one of its constituent PCOs to act as the lead NHS organisation for emergency planning on its behalf, for example nominating a 'lead PCT'. Where there is a designated Lead PCT/PCO , it is expected that the designated Lead PCT/PCO would provide links to the Local Resilience Forums (LRF) making sure that the SHA is kept aware and fully briefed on decisions agreed in the planning phase. The SHA will provide the link between NHS organisations in the region with Regional Resilience Forums. Where there is no Lead PCT/PCO arrangements, the SHAs will need to retain this role.

Chief Executives of SHAs have been responsible for ensuring that, whatever organisational model is used, the provision of strategic command arrangements during both the planning phase and the response are in place across the NHS in their region and these arrangements are resilient and robust.

In terms of Response where the designation of Lead PCTs is agreed, it must be clearly established what roles and responsibilities the Lead PCT is expected to fulfil. This could include: - leading health emergency preparedness on a strategic basis within the LRF on behalf of the wider health sector in that locality - ensuring health is engaged in the planning process and where appropriate, lead the local planning for health-related workstreams for example Mass Casualties, Human Infectious disease etc. - ensure that the health sector is a full partner in the local multi-agency command and control arrangements that would operate in an incident - under the leadership of the SHA ensure there are command arrangements across the local health sector with clear and robust lines of control - support the SHA by co-ordinating the local response to an incident including upward communications to the SHA and, depending on the scale and nature of the incident, act as the clear NHS executive lead in an incident that escalates beyond 'normal' local mechanisms.

In developing arrangements for mutual aid, NHS organisations will need to be clear what aid might be required, what they themselves can offer and who their partners are. Administrative boundaries, including national boundaries within the UK, should not be a reason for not working with organisations over those boundaries in developing mutual aid arrangements. SHAs will be responsible for ensuring robust mutual aid plans are in place across the regional NHS, and are able to provide NHS mutual aid outside of their region if necessary.

If the scale of an incident escalates beyond the SHA's capacity or region, or if its duration or nature is such that wider NHS resources are required, the SHA will enact mutual aid protocols with neighbouring SHA(s) and, where appropriate, the devolved administrations of Scotland, Wales and Northern Ireland. For events that require mutual aid on a large scale, the Department of Health (DH), via the Department of Health Major Incident Coordination Centre (MICC), can implement national co-ordinating arrangements. These arrangements are intended to support the SHAs, ensure wider NHS resources are made available and wider government assistance is accessed, as required. It will be the role of SHAs rather than of individual PCOs to contact the DH MICC.

During a major incident, the SHA(s) are responsible for notifying the DH Emergency Preparedness Division (EPD), and providing an overview and initial impact assessment of the incident on routine health care provision. In addition, in relation to an on-going response to a major incident, the SHA(s) must establish a mechanism to provide regular briefing reports at a time and pace set by DH EPD. DH EPD will then collate this, and other information, and submit a health briefing note to DH Ministers and to the Cabinet Office Civil Contingencies Committee (known as COBR) if established. With the incorporation of the Regional Directors of Public Health (RDsPH) and the Regional Public

Health Groups in the SHAs, RDsPH are the most senior public health and medical officials in the region. They are able to relate to Regional Resilience Directors at Regional Government Offices and Regional Directors from the Health Protection Agency. RDsPH should also ensure that arrangements are made for regional level communications and co-ordination during public health emergencies, and that these responses are supported by other resilience planning arrangements being made by the SHA.

SHAs should identify key staff from all sections of the organisation who are willing and able to respond out of hours to support any SHA strategic command arrangements, providing a critical link between the regions and the DH EPD.

The roles and responsibilities of NHS Organisations in Emergency Planning

The Department of Health (DH) - Emergency Preparedness Division:

Support the NHS Chief Executive, DH Permanent Secretary and Chief Medical Officer (CMO) to lead the health service response during a catastrophic incident. - advises Ministers on the development of policy;

- is accountable through the Chief Medical Officer (CMO) to Ministers; - ensures NHS and social care preparedness and contributes to the central agenda; - contributes to/leads the central Government response e.g. Cabinet Office Briefing Room (COBR) or the Civil Contingencies Committee (CCC);
- implements national and international co-ordination arrangements; - oversees and supports the response of the NHS and partners and ensure the resilience of the NHS and partner organisations;
- support the NHS CE to take command of the NHS during complex national emergencies/incident through the Major Incident Co-ordination Centre (MICC);
- contributes to the central work on communications; - issues authoritative material to media, professions, and the public as well as handling national media.

Strategic Health Authorities & Regional Directors of Public Health. (at Jan 2010)

- provide strategic leadership to the health economy during periods of disruptive challenges
- assess the impact on the health care system from a major incident - Ensure that NHS organisations plan, prepare and exercise for major incidents
- act as a central point of contact for DH EPD providing the regular incidents reports during major incidents.
- ensuring resilience in response and recovery phase of NHS organisations

As part of the SHA, Regional Directors of Public Health specific responsibilities are:

- represent the Chief Medical Officer (CMO) in the Regions
- ensure pre-planning is co-ordinated between Regional Resilience and the NHS in preparedness for infectious diseases and other public health emergencies as part of their SHA role,
- work closely with the Regional HPA Director to provide public health advice, support and leadership especially in responding to major public health incidents,
- take the lead with SHA colleagues in providing health input into the Regional Resilience Forum and associated regional communications networks working, with the Regional Director of the Health Protection Agency, the NHS, and the ambulance service(s) within the

region,
- contribute to policy formulation within the Department of Health, - ensure sign off of any public health and health protection messages to be communicated to the public,

The Health Protection Agency (at Jan 2010):

- provides expert advice to the DH on health protection policies and programmes; - is accountable through the CMO to DH at a national level;
- provides operational public health advice and support to the NHS; - provides resources to support the provision and delivery of health advice to the SCGs and RCCCs;
- cooperates with others to provide health protection advice and information to the NHS, to the media and the public;
-

The HPA also provides training and exercise support on behalf of DH.

- it has a statutory duty to protect the community against infectious disease and other dangers to health, prevent the spread of infectious disease, and provide assistance on public health issues to responders such as the NHS, other Category 1 Responders, the Devolved Administrations, and the wider general public.
- Ii will give advice on public health threats and may, where appropriate, make this advice public. While the Agency has some sampling and testing capability, this would not necessarily be deployed during an incident.

It is anticipated that the HPA will become part of the restructured Public Health Service.

In October 2010 the Cabinet office set out a paper on the Role of Local Resilience Forums: covering current guidance on The Civil Contingencies Act (2004), its associated Regulations (2005) and guidance, the National Resilience Capabilities Programme and emergency response and recovery. It recognised that new structures would mean that the guidance may be subject to change but set out a useful summary of principles.

UK Civil Contingencies, ensuring CCA compliance and developing resilience performance are built on:

- taking responsibility and managing your own and your organisations‟ performance;
- integrating resilience: into day-to-day work; and at every tier – individual, team, organisational, bi-lateral, multi-lateral, local, regional and national; supporting and challenging each other in a spirit of:
    - openness;
    - honesty;
    - diplomacy;
    - co-operation; and
    - team-working;

- taking action which is:
    - proportionate;
    - at the right tier (whether that means addressing an issue yourself, escalating it or de-escalating it); and
    - at the right time;

- continuous improvement at all four civil contingencies tiers; and
- ensuring and, where necessary, enforcing compliance with the legislation

In general, performance management and resilience should be viewed and delivered as positive if stretching experience with the aim of ensure that the UK is robustly resilient.

Figure 1: 'Summary of Performance Development Principles:

The Role of Local Resilience Forums: A reference document
The Civil Contingencies Act (2004), its associated Regulations (2005) and guidance, the National Resilience Capabilities Programme and emergency response and recovery Civil **Contingencies Secretariat Oct 2010.**

At the local level NHS Sheffield as lead PCT in South Yorkshire for Emergency Planning and Preparedness has established its **Principles of Mutual Aid.**

1. A formal request for mutual aid will only be made by a Chief Executive Officer (or an authorised officer acting on behalf of a Chief Executive Officer) to a Chief Executive Officer or delegated authorised officer.
2. A Chief Executive Officer (or authorised officer) will take the appropriate action to respond without delay to the request for mutual aid.
3. The responsibility for coordinating mutual aid, including supervisory control and financial arrangements necessary to address the emergency situation, rest with the organisation(s) receiving the support.
4. Organisations in receipt of mutual aid will reimburse reasonable financial costs incurred in relation to the aid, and will seek to do so within 28 days of the termination of the mutual aid.
5. Each organisation agrees to provide the mutual aid requested if it is able to do so within the capacity and resources of that organisation.
6. All employees working under this agreement are deemed to be acting in the course of their employment and will be covered by their employer's indemnity insurance for the duration of the mutual aid.
7. All parties to this agreement will endeavour to resolve amicably any disputes through ordinary negotiations.

Mutual aid lessons and examples

In May 2009 the DH distributed advice on heatwaves, (Gateway: 117670) maybe in light of the Met office's optimistic prediction that: 'The coming summer is 'odds on for a barbecue summer', according to long-range forecasts. Summer temperatures across the UK are likely to be warmer than average and rainfall near or below average for the three months of summer.'

Chief Meteorologist at the Met Office, Ewen McCallum, said: "' We can expect times when temperatures will be above 30 °C, something we hardly saw at all last year."
Government Services Director, Rob Varley, said: "Our long-range forecasts are proving useful to a range of people, such as emergency planners and the water industry, in order to help them plan ahead. (Met office 30 4 09)

The Plan's purpose is to enhance resilience in the event of a heatwave. It is an important component of overall emergency planning; and will become increasingly relevant in adapting to the impact of climate change. Additional guidance this year is provided for each of the heatwave levels, from one to four. This provides clarity about governance and risk management.

Strategic Health Authorities and Local Authorities therefore need to ensure:

- PCTs and Social Services Departments support primary and social care teams in:
- familiarising themselves with the Plan, and their roles in implementing it; and
- identifying individuals at particular risk, and taking steps as set out in the Plan to reduce it - this will involve collaboration with the voluntary sector and the Independent Care Home sector.
- Independent Care Homes and Hospitals are made aware of the Plan, of the specific risks associated with residents of care homes, and of the specific advice directed at Care Home Managers and Staff.
- NHS Trusts, including Mental Health Trusts, have assessed their ability to maintain their temperatures below 260C in order to reduce risk to vulnerable groups. In the French 2003 heatwave, 2,000 of the 15,000 deaths were among those already in hospital at its start.
- Local Authority Housing and Planning teams, and providers of social housing, take account of long-term measures to reduce the impact of heatwaves, especially in urban areas where temperatures become hotter. This includes increasing external and internal shading, the use of reflective paints, and using trees and green spaces to aide urban cooling.
- All local emergency plans and procedures incorporate this Plan where relevant, and those involved in their implementation, including Local Resilience Fora, are made familiar with it.

See:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099015

As this illustrates not all preparations work out as intended: In April 2009 Scottish Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon disclosed that a pandemic flu exercise – code-named 'Cauld Craw' – a four-week civil contingency exercise involving hospitals, ambulance services and other agencies designed to test the resilience of authorities to cope with a major outbreak had been due to start that day, but it was postponed because of the real threat of the swine flu outbreak.

She told the Good Morning Scotland programme that Cauld Craw - Scots for Cold Throat - had been due "by sheer coincidence" to start this morning. "Obviously that has now been suspended," April 27 2009.

A pandemic flu outbreak had been identified as one of the main risks Scotland could face along with terrorism, extreme weather and widespread utilities failure. These four risks form the priority issues which Scottish Resilience - the part of the Scottish Government that works with frontline organisations on emergency planning - is currently focussing on.

At the **NHS Scotland Health Emergency Planning Officers' Meeting in 2007 there was an attempt to** discuss the possibility of formalised mutual aid arrangements between NHS Boards to allow staff or equipment to be called upon to supplement requesting NHS board decontamination teams. It was reported that during the exercise "Cutty Sark", there was an issue of where the victims would have to go to receive aid. ' CCU could support and co-ordinate aid arrangement during an incident and Fire and Rescue Services would be first port of call if the SORT team was not available. After some discussion on the subject, the group came to the conclusion that mutual aid should be requested in the same manner between NHS Boards as for other major emergencies. It was agreed that formal arrangements could be discussed between NHS Boards on regional basis if required.

http://www.sehd.scot.nhs.uk/EmergencyPlanning/Documents/minutes/hepo_meeting_28112007.pdf

Exercise Cutty Sark in 2006 had identified problems around the police computerised messaging system and NHS boards needed to devise their own manual system as an alternative or fallback. It was said that whilst 'the JHAC was quite focused, but some NHS personnel still tended to debate issues when what was needed was an identification of the problems and options or preferably the solution brought to the table. NHS and other staff attending JHAC needed to be senior enough to make decisions and commitments on behalf of their parent organisations.' (**Health Service Emergency Planning Officers Meeting 18th May 2006).**

In 2009 Audit Scotland reported on their study of Improving civil contingencies Planning prepared for the Auditor General for Scotland and the Accounts Commission (AS, August 2009).

The study found that he Civil Contingencies Act 2004 had reinforced multi-agency working and organisations were making progress in meeting their duties, although there are a number of areas that could be improved.

Recent events in Scotland included the Glasgow airport terrorist attack (2007), the potential fuel shortage and risks to safety caused by the industrial dispute at the Grangemouth petro-chemical refinery (2008), having the first confirmed cases in the UK of the Influenza A H1N1 virus – or swine flu (2009), and numerous floods. These have all highlighted the importance of effective arrangements being in place to prepare for, respond to and recover from major emergencies. They illustrate two important features of civil contingencies planning; first, that a wide range of different events can cause significant disruption, and second, that dealing with and recovering from such events requires public sector organisations to work together, alongside the private and voluntary sectors.

Summary of key messages

- Overall, key organisations work well together, particularly through SCGs, but there are still barriers to joint working.
- The Scottish Government has taken an active role in implementing the Act and this increased priority has placed greater demands on local responders.
- Governance and accountability arrangements for multi-agency working in civil contingencies planning are unclear.
- All SCGs have produced and published a CRR but these have made a limited contribution to informing civil contingencies planning at a local or national level.
- Most Category 1 responders have a generic emergency plan in place and have been involved in developing multi-agency arrangements for their SCG area. However, planning for business continuity management and recovery are not yet well developed.
- Complex training and exercising requirements place significant demands on local responders, making participation and effective coordination difficult.
- Lessons from incidents and exercises are not shared widely or systematically put into practice.
- There is no clear information on how much is spent overall on civil contingencies planning across Scotland.
- There is potential for more collaboration between organisations to increase capacity and make more effective use of resources.

Recommendations

AS made a number of recommendations for the Scottish and UK governments and the main responding agencies in Scotland, both as individual organisations and as members of their SCGs. These identify how things can improve, and are as follows:

Working together

- The Scottish Government and SCG partners should agree a standard approach to the sharing of civil contingencies planning information across Scotland.
- SCGs should review their membership to ensure key organisations are represented appropriately, and work to maximise the benefits of effective joint working, including across SCG boundaries.
- The Scottish Government should review how it engages with those individuals who have day-to-day responsibility for civil contingencies planning, and ensure that it provides clear and consistent information.
- In consultation with SCG partners, the Scottish Government should clarify the governance and accountability arrangements for decisions made by the SCGs and for its own role during an emergency.
- Councils, police forces and fire and rescue services should ensure elected members are aware of their role in an emergency and of developments in civil contingencies planning.

Planning for a resilient Scotland

- SCG partners and the Scottish Government should work together to ensure that the full potential of CRRs in informing risk assessment and planning at local and national levels is realised.
- The UK and Scottish governments, SCGs and individual organisations should work together to improve cross-border and cross-boundary planning.
- Local responders should ensure that they have up-to-date emergency and business continuity plans and recovery arrangements, and that staff are fully aware of their roles and responsibilities.
- Local authorities must ensure they are providing business continuity management advice and assistance to local businesses and voluntary organisations. SCG partners should consider how they could add value to this process.
- Scottish Government and local responders should work together to improve public awareness of the risks we face and to ensure effective communication procedures are in place during and after an incident.

Learning lessons from training, exercises and incidents

- SCG partners and the Scottish Government should work together to ensure the effective targeting and coordination of exercises and training.
- Category 1 responders must ensure they are meeting the statutory requirement to exercise all of their emergency and business continuity plans.
- SCG partners and the Scottish and UK governments should ensure that lessons learned from training and exercising activities are systematically shared and that monitoring arrangements are in place to ensure their effective implementation.

Costs, capacity and performance

- SCG partners and the Scottish Government should work together to develop and apply a consistent framework for managing and reporting expenditure to demonstrate value for money, and seek to deliver increased efficiencies and improved resilience through further partnership working.
- Category 1 and 2 responders should develop formal mutual aid agreements. These agreements should take account of cross-border and cross-boundary arrangements, and the voluntary and private sectors.
- Local responders, SCGs and the Scottish Government should develop arrangements for managing, monitoring and reporting their performance.

In England the Government Office for the North West carried out a Salt Shortage Incident 2010 Review reporting on 20 April 2010 and noted:

- there were some concerns that having loaned salt it was often difficult for the donor authority to get it back. Some suggested that the Salt Cell delivery schedules should be adjusted to take account of loans and deliver the repayment direct to the donor authority.
- In terms of improvements, authorities have noted that using the same size salt as neighbours increases the opportunities for mutual aid. Some neighbouring authorities have already agreed to work towards this.
- The lack of confidence around the delivery schedules lead to some reduced willingness to lend salt. There were concerns that if either authority in the arrangement was let down on the supply side, they would be left short.
- One respondent suggested that neighbouring authorities should share winter maintenance plans and priorities and agree fallback options in advance.

In July 2010 Dame Deirdre Hine published an 'independent review of the UK response to the 2009 influenza pandemic' where she recorded that 'the UK has been commended by WHO for the robustness of its preparations for a pandemic and noted that this point was reinforced by the evidence of our interviewees, who repeatedly praised the preparedness of the UK and the thoroughness of its planning. She went on to say:

'No plan, however, survives intact its first contact with the enemy – and the only predictable characteristic of the flu virus is its unpredictability. The National Framework noted that 'Although an influenza virus with potential to cause a pandemic could develop anywhere, it is most likely to emerge from South East Asia, the Middle East or Africa'. In the event, the first cases emerged in Mexico. Preparations were made to combat the potential emergence of an avian H5N1 virus as a plausible source of the new pandemic, but again this did not prove to be the case. Both assumptions were and remain very reasonable planning assumptions which turned out to be false.'

She rightly said 'The point of mentioning them here is to highlight that any response has to be highly flexible to deal with changing threats'.

Scenario 7a

Do we have effective forums in place to develop links between partner agencies and to coordinate planning with escalation proportionate to the risk at that time'?

The resilience forum established under the Civil Contingencies Act (2004) has met every 6 months but it is clear that senior executives of partner organisations are beginning to lose interest and either send deputies or fail to be represented. The appointed Chairman has resigned through ill health and the planning required by this Forum is no longer up to date and escalation plans have not been developed or agreed. The Board can no longer be assured that effective mechanisms for developing and delivering integrated plans for all major threats either exist or are in timely development. This organisation takes its responsibilities seriously but the status of the resilience forum and just whom is accountability for its decisions is unclear.

Do we have a mutual aid and business continuity planning model in place for both short (1-3 days) and long term disruption (3 days to 3 months) and how are we monitoring it?

Scenario 7b

We have recently experienced severe disruption to services and communication caused by floods/storms/industrial action/fire/utility failures/ ITC failures. The services coped as services were able to resume to normal with 36 hours. It raised however the question as to how we would cope over a longer period- e.g. 3 weeks or 3 months?

Issues & Questions

The key issue at the present is the need to maintain continuity n the face of dramatic changes in structures and accountability. This is a requirement of both new organisations such as GP Consortia and Local Authority Public Health but also outgoing organisations such as SHAs and PCTs and the HPA.

Boards and auditors should be explicit in the handover of function and accountability. The need for robust systems of business continuity, resilience and agreed arrangements for mutual aid will no doubt be tested in the challenging period as new arrangements are established. Provider organisations have a major role not least in that their stability means they may need to pick up the mantle.

The US Centers for Disease Control and Prevention have prepared a checklist of questions to maintain Mental Health Resources in the event of an emergency. In addition to reveling the capacity of mental health service providers that serve the community the site recommends asking the following:

Government roles and Responsibilities in a Disaster

- What are the Federal, State, and local roles in disaster response?
- How do Federal, State, and local agencies relate to one another?
- Who would lead the response during different phases of a disaster?
- What mutual aid agreements exist?
- How can mental health services be integrated into the government agencies' disaster response?
- Do any subgroups in the community harbor any historical or political concerns that affect their trust of government?

Nongovernmental Organizations' Roles in a Disaster

- What are the roles of the American Red Cross (ARC), interfaith organizations, and other disaster relief organizations?
- What resources do nongovernment agencies offer, and how can local mental health services be integrated into their efforts?
- What mutual aid agreements exist?
- How can mental health providers collaborate with private disaster relief efforts?

Community Partnerships

- What resources and support would community and cultural/ethnic groups provide during or following a disaster?
- Do the groups hold pre-existing mutual aid agreements with any State or county agencies?
- Who are the key informants/gatekeepers of the impacted community?
- Has a directory of cultural resource groups, potential volunteers, and community informants

who have knowledge about diverse groups been developed?

- Are the community partners involved in all phases of disaster preparedness, response, and recovery operations?

3.3.1. Establish Mutual Aid Agreements and test partner forums including company secretary/Chief risk officer networks to coordinate planning with escalation proportionate to the developing risk.

Mutual Aid Agreements

Emergency Planning in Northern Ireland District Councils is co-ordinated through the Local Government Emergency Management Group (LGEMG). This group has recognized the need for a protocol whereby District Councils may give support to each other in a situation where an emergency is of such magnitude that it overwhelms the resources of one particular council. This could be as a result of a civil emergency or an emergency in a particular Council that severely affects business continuity. Mutual aid is defined in the protocol as "an agreement between organisations, within the same sectors and across boundaries, to provide assistance and additional resources during an emergency or business continuity disruption which demand resources that go beyond those of an individual organisation". The protocol is not proposed to be a legally binding contract; but rather a statement of intent which will act as a point of reference should mutual aid arrangements need to be invoked between two or more Councils.

Some further examples of Mutual Aid Agreements can be found. E.g. in England the South East Coast NHS Organisations set out the arrangements which may be implemented by any of the NHS organisations within South East Coast SHA and should be read in conjunction with the SHA Mutual Aid document.

Key Elements:	**Progress Levels:**					
	NO	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
8. Establish and test partner forums including company secretary networks to coordinate planning with escalation proportionate to the developing risk	**NO**	Risk sharing is recognised as normal business practice.	Forums for identification of new and escalating risk and advice established	Resilience planning is part of normal business practice and included in contracts/partnership agreements	Identification of new risks is reviewed against what happens; forecasting systems and plans updated	Networks in place, tested and working

1.2 Mutual Aid is defined as "An agreement between respondences, within the same sector or across sectors and across boundaries to provide assistance with the additional resources during an

emergency which may go beyond the resources of individual respondents." (DoH 2005, the NHS Emergency Planning Guidance).

1.3 Responding to a major or catastrophic incident can quickly overwhelm the initial responding NHS organisation and even a small incident confined to one PCT area requires the Acute, Ambulance, PCT and Mental Health response in the majority of cases mutual aid may be required between this local group of NHS organisations.

1.4 This mutual aid agreement sets out arrangements for 3 levels of mutual aid:

a) Mutual aid between NHS organisations within the lead PCT area
b) Mutual aid between NHS organisations across 2 lead PCT areas
c) Mutual bid between NHS organisations across SHA boundaries

Charging arrangements for Mutual Aid

12.1 The principle of 'shared risk' in the context of this agreement, recognises the fact that the risk of a major incident occurring, which results in the need for mutual aid, is equal amongst all NHS organisations.

12.2 Any mutual aid provided by NHS organisations will be on the basis of 'shared risk' and costs lie where they fall. Consequently, there will be no cross charging for mutual aid between PCTs/Trusts.

12.3 As part of the risk sharing agreement, the NHS is to collate all associated Mutual and Aid costs for audit purposes.

12.4 It is recognised that the level of resources, which NHS organisations are able to provide, will be governed by the resources that are available to it. To this extent the mutual aid provided will inevitably be time-limited and will be for discussion between the providing/receiving NHS organisations when an incident occurs.

12.5 If any NHS organisation wishes to discuss associated costs of supplying mutual aid to other NHS organisations then discussions may take place between the relevant finance directors once the major incident has been stood down.

An NHS organisation which is no longer in a position to provide support or where it needs to reduce the level of support being provided; should notify the host PCT/Trust and the Strategic Health Authority(s) as soon as reasonably possible and explain why they are no longer in a position to provide support and arrange for agreed disengagement of supporting resources.

Support Networks

One of the key recommendations in the 2006 'Integrated Governance Handbook' was the appointment of a dedicated company secretary to both guide the Board and also to be the professional adviser to the Board and directors. Governance Between Organisations is complex and may require new protocols for governance, and indeed, ways of working. We realised that to create and manage the required efficiencies (financial and otherwise) in a wider multi-organisational setting would require a special set of skills. We now believe this role might best be provided by the new role of Chief Risk Officer (CRO) as recommend by David Walker's review of corporate governance in UK banks and other financial industry entities. (July 2009)

The CRO would be well placed to extend their brief which would include 'promoting a culture of control and contingency planning' (See CRO job description in Integrated Govaerne II - A guide to risk and joining up the NHS reforms, HFMA 2011) to encourage system wide networks of support

South Yorkshire Health and Local Government Organisations have established a Mutual Aid and Staff Exchange **Memorandum of Understanding** and Statement of Intent with a specific purpose:

- To set out the reasons for enabling employees to work in different organisations in the event of an emergency situation.
- To clearly set out which organisations and employees this protocol will cover and any identified restrictions.
- To set out the principles which each participating organisation will agree to and adhere to during such an emergency situation.
- To set out the principles relating to the request for and provision of mutual aid.

The employees referred to in the document work for one or more of the participating organisations and as such have some form of contract or agreement that governs their employment with that organisation.

This includes volunteers who have an agreement or honorary contract, but not those who might offer their services during an emergency without such an agreement or contract.

Agency employees are not covered by this agreement and will be engaged separately by the participating organisations in accordance with their needs.

Participating organisations were identified as:

- NHS Sheffield and Sheffield PCT
- Sheffield Teaching Hospitals NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- Sheffield City Council
- NHS Rotherham
- Rotherham Metropolitan Borough Council
- The Rotherham NHS Foundation Trust
- NHS Barnsley
- Barnsley Hospital NHS Foundation Trust
- Barnsley Metropolitan Borough Council
- NHS Doncaster
- Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Doncaster Metropolitan Borough Council
- Yorkshire Ambulance Service

Confirmation of individual employers' agreement to this passport was deemed to be demonstrated by the inclusion of the organisation's name in this section.

Rationale for this agreement

The rationale for this agreement came from the national perspective articulated by the Department of Health in the document *Pandemic influenza – Human Resources Guidance for the NHS,* DH, 2009.

In the event of an emergency including a pandemic flu outbreak in South Yorkshire, health and social care organisations may need to take pragmatic decisions to redeploy staff. This might be on the basis of provision of mutual aid or on the basis that many employees live outside the area that they work and whilst they may not be able to travel to their usual workplace they could perform their duties from a more local organisation.

Whilst there are specialists working in both health organisations and local government organisations, it has been identified that there are some commonalities in workforce across all the participating organisations that is why a joint approach is being taken to this issue.

Provision of Mutual Aid is a specific approach to provide short-term assistance to other organisations and as such carry with it different principles. As a result this document will deal with these matters in separate sections.

Public Health Directors and the SHA must also be notified regarding these arrangements so the possible effect on business continuity can be factored in.

Principles of Staff Exchange

1. All participating organisation's have and can evidence that they follow their respective Recruitment and Selection Policies. This includes Pre Employment Checks, Post Employment Checks (where appropriate), Criminal Records Bureau disclosures, Independent Safeguarding Authority checks and any Occupational Health checks.

2. Participating organisations will require a level of CRB disclosure (usually Enhanced) for some posts involving work with children and vulnerable adults. This will restrict the use of some employees from other areas. In order to reduce risk to a minimum the following principles will be adopted:

   i. Receiving organisations will clearly indicate the level of CRB disclosure required in the respective parts of their organisation.
   ii. Providing organisations will maintain records and will give information and assurance regarding the CRB status of the staff member presenting at the receiving organisation.
   iii. Each organisation will identify a contact point from which information/assurance regarding the CRB status of the staff member working in the receiving organisation can be obtained.
   iv. Where a member of staff presents for work at an alternative organisation's base, it will be incumbent on the receiving organisation to check the CRB status of the person through the relevant contact point and assess the type of work that the person may be safely deployed to.
   v. Participating organisations will share relevant information regarding CRB requirements/policies to assist the smooth operation of this process.
   vi. Participating organisations will acknowledge that, in carrying out CRB checks on their applicants, some individuals will have had prior convictions that have been taken into account by existing employers and will have proceeded with the appointment of that individual to a post.

This is critical to the success of this protocol.

3. Any employee presenting for work at one of the participating organisations shall be deemed working under the authority of their employing organisation. As such no reimbursement for wages between participating organisations will be required, unless the redeployment extends

over one month, at which point the arrangement should be reviewed and appropriate terms agreed.

4. All employees working under this memorandum of understanding are deemed to be acting in the course of their employment and will be covered by their employer's indemnity insurance.

5. All participating organisations agree to ensure that all employees presenting for work are given tasks within their capability and professional competence (as appropriate) and take responsibility for providing appropriate supervision, induction and other relevant health and safety matters. All students should be properly supervised and professionally registered employees should be guided by their professional codes.

6. Any concerns regarding poor performance or conduct will be forwarded to the substantive employer to be dealt with according to their policies and procedure.

7. All parties to this agreement will endeavour to resolve amicably any disputes through normal communication channels.

See
www.rotherhampct.**nhs**.uk/.../Cv%20%20Board%20assurance%20Swine%20Flu%20Sept%2009%20APPENDIX

The US Health and Human Services (HHS) Secretary Kathleen Sebelius released in Jan 2010 The National Health Security Strategy, which focuses on protecting people's health during a large-scale emergency. The strategy sets priorities for government and nongovernment activities over the next four years. HHS defines national health security as preparation for, protection from, and resilience in the face of health threats or incidents with potentially negative health consequences such as bioterrorism and natural disasters. The strategy provides a framework for actions to build community resilience, strengthen and sustain health emergency response systems, and fill current gaps. The National Health Security Strategy and the accompanying interim implementation guide outline 10 objectives to achieve health security, including fostering integrated healthcare delivery systems "that can respond to a disaster of any size." The document also highlights specific actions that the nation—including individuals, communities, nongovernment organizations, and government agencies—should take to prevent, protect against, respond to, and recover from health threats. Among the initial actions for the federal government are 'conducting a review to improve the system for developing and delivering countermeasures such as medications, vaccines, supplies, and equipment for health emergencies; coordinating across government and with communities to identify and prioritize the capabilities, research, and investments needed to achieve national health security; and evaluating the impact of these investments.'

The USA National Health Security Strategy 10 objectives to achieve health security:

1. Foster informed, empowered individuals and communities
2. Develop and maintain the workforce needed for national health security
3. Ensure that situational awareness so responders are aware of changes in an emergency situation
4. Foster integrated, health care delivery systems that can respond to a disaster of any size
5. Ensure timely and effective communications
6. Promote an effective countermeasures enterprise, which is a process to develop, buy and

distribute medical countermeasures

7. Ensure prevention or mitigation of environmental and other emerging threats to health
8. Incorporate post-incident health recovery into planning and response
9. Work with cross-border and global partners to enhance national, continental, and global health security
10. Ensure that all systems that support national health security are based upon the best available science, evaluation, and quality improvement methods

An Audit Scotland study) concluded that whilst organisations usually support each other in an emergency, formal mutual aid arrangements are not in place in all sectors.

'Mutual aid agreements formally set out arrangements between organisations to provide each other with assistance through the provision of additional resources during and after an emergency. These arrangements can be within the same or different sectors and across Strategic Co-ordinating Group (SCG)* boundaries or national borders. Experience shows that organisations tend to offer each other support in the event of emergencies even without formal mutual aid agreements in place. However, these informal, reactive arrangements often rely on individual personalities and are at risk of breaking down when circumstances change (for example, when staff changes occur)'

*A Strategic Co-ordinating Group (SCG) consists of the police, local authorities, fire rescue and ambulance services, health services and environmental experts supported by regular detailed briefings from industry representatives.

Audit Scotland argued that for mutual aid agreements to add value to the civil contingencies process, staff need to be aware of them and understand how to use them. But their 2009 survey found confusion among some Category 1 responders as to whether they have mutual aid agreements in place, even among police forces and fire and rescue services who have long- standing mutual aid arrangements. Many organisations confused *mutual aid agreements* with more general memorandums of understanding (MOUs).

What are Category 1 Responders?

A category 1 responder is any body in the UK that has specific duties as determined under the Civil Contingencies Act (2004) and include for example in the Warwickshire area:

Local Authorities:

•- Warwickshire County Council
•- North Warwickshire Borough Council
•- Nuneaton & Bedworth Borough Council
•- Rugby Borough Council
•- Stratford District Council
•- Warwick District Council

Government agencies:

•- Environment Agency

Emergency Services:

•- Warwickshire Police Force
•- British Transport Police
•- Warwickshire Fire & Rescue Service
•- West Midlands Ambulance Service NHS Trust

Health Bodies:

•- Primary Care Trusts
•- Health Protection Agency
•- NHS Acute Trusts (hospitals)

Audit Scotland in their 2009 report 'Improving civil contingencies planning' suggest that developing and agreeing mutual aid agreements may highlight differences in approach to civil contingencies planning between organisations. Some local authority chief executives they reported have concerns that committing resources to another local authority area may prevent them from fulfilling their duty of care to their own citizens. There may also be complex legal and health and safety issues around organisations providing staff to support the work of other organisations during an emergency, as the duty of care for staff remains with their employer.

The Scottish Government states that a *"fundamental purpose of the* Strategic Co-ordinating Group *is responders' co-operation and preparing for and responding to emergencies. Mutual aid and support lies at the heart of that co-operation."* However, mutual aid at an Strategic Co-ordinating Group (SCG) level is not well developed. While Lothian and Borders SCG, for example, has a formally agreed regional level mutual aid agreement (January 2008), this only covers its local authorities (City of Edinburgh, East Lothian, Midlothian, Scottish Borders and West Lothian). Highlands and Islands Strategic Co-ordinating Group has taken a more multi-agency approach, agreeing mutual aid at a Strategic Co-ordinating Group level in 2005 and revising this in 2008.

A pandemic flu outbreak was identified as one of the main risks Scotland could face along with terrorism, extreme weather and widespread utilities failure. These four risks form the priority issues which Scottish Resilience - the part of the Scottish Government which works with frontline organisations on emergency planning - is focussing on.

Ironically 'Cauld Craw' (cold crow) the Scottish government's main civil contingencies exercise for 2009 designed to ensure Scotland was well prepared to deal with the consequences of any emergency had to be postponed as the 2009 swine flu epidemic surfaced. It was planned as a four week exercise, involving a range of agencies across the country, to test resilience and improve knowledge and understanding of how to handle the issues Scotland would face in the event of a pandemic.

Mutual aid has a much wider meaning than reacting to an emergency. In a speech in December 2009, Tessa Jowell MP **(Progress' autumn lecture series, in association with the Co-operative Party 15 December 2009)** set out this wider view in the form of a new mutualism that 'offers the opportunity to forge a new relationship between citizen and state and redefine the notion of public ownership. She suggested how mutuals, co-ops and social enterprises might play a much greater role in reformed public services, and the rights local communities and public sector workers should have in that process. The Minister for the Cabinet Office contrasted this progressive approach, strongly rooted in Labour's past, with the Conservatives' 'easy Government' view of the state.

She went on to establish a new, independent Commission on Ownership, chaired by Will Hutton set

up ‘to enhance our understanding of the influence that forms of ownership and management have on the governance of our country. It will seek to answer the big questions: how much does ownership matter? What is the link between fairness and ownership and how does that affect the distribution of power in our country? And what can, and should, government do about ownership?’

Mutualism has been described as a doctrine where the interdependence of social elements is the primary determinant of individual and social relations including the theory that collective effort and control governed by sentiments of brotherhood and mutual aid, will be beneficial to both the individual and society.

In particular, the focus on citizens as consumers with the right – and the ability – to exercise choice over the services provided to them has been important in driving up standards. On the demand side, therefore, there has been a loosening of the old constraints, and the habit of accepting whatever is offered is declining.

But on the supply side, maybe we need to do more than hold up the model of the relentlessly managed plc. We should look instead at other successful ways of delivering goods and services. There are important lessons to be learned from studying how the Co-op and John Lewis work, companies owned, respectively, by their customers and their staff.

Public services exist to serve, and are paid for by, the public, so it is the public that has the right to influence how those services are delivered, to build shared responsibility for them, and improve them by harnessing the efforts of both professionals and those they serve.

Indeed, can we really expect citizens to take on greater responsibility for their own health, learning, and environmental impact, if public services fail to give them the right to shape the ways in which they deliver them? We can. By bringing users, employees, and others together as mutual members of the provider organisation we can successfully get to grips with the supply side of public service.

Jowell in her speech (House of Commons. Tuesday, 15 December 2009), asked:

‘Whether it's the 390 members of the Reddish Vale Co-operative Trust taking ownership of their school; or the staff at Leicester City primary care trust who have taken over general medical and substance misuse services for homeless people; or 1.3 million members of 122 NHS foundation trusts, mutualism – the ownership of an organisation by those who work in and manage it and also, when it is sensible, by those who use its services – transforms internal culture, and helps to embed real democratic accountability and a renewed sense of community responsibility. When a public service is mutually owned, we know staff feel that they are leading the reform process, rather than having it imposed upon them. This turns them into champions of improvement and reform, enhances feelings of solidarity and responsibility and makes staff more willing to co-operate for the common goal.’

The Guardian 14 12 09 quoted Jowell ‘Of course, mutualism cannot be prescribed by government. By its very nature, it is driven by and relies on the commitment and active participation of the people involved. Communities need to be able to choose mutualism as and when they see fit. What government can do is sponsor and provide a legal framework that makes mutualism a practical proposition in the delivery of any public service ‘

As the NHS in England seems to move back from competition to collaboration, there is recognition of new forms of mutual aid, not just in exremis but as a routine of joint working. This becomes very apparent in times of financial hardship and it will be important that Chairmen/Boards seek out

opportunities to meet with partner/ boards to thrash out areas of mutual benefit. This can be trickier in what is still a market economy when competition law can be brought to bear but this does not preclude the meetings that are critical to add flesh to the rather sparse bones of a contract. The Board secretary is an important element of these discussions first meeting with their counterparts to establish the ground rules, protocols, etiquettes of the meetings but then keeping all parties honest and recording the detail of information shared which will subsequently be needed to be shared with new entrants to the relationship.

Scenario

Do we have board supports – e.g. company secretary (and company secretary/CRO networks) with established GBO protocols in place?

The health economy is working well but has never matured to the point of establishing a joint assurance framework. Our board secretary/chief Risk Officer is suggesting establishing a network of relevant governance advisors to build such a framework. This would go some way to meet the expected governance standard but there are concerns that our initiative could be misconstrued as meaning we are assuming sole responsibility. The Board secretary has sought a steer on how to develop the informal networks and relationships perhaps as precursors to Chairman and other board members of the various partners/suppliers meeting.

Issues & Questions

- Are we prepared to send staff into harms way. What are our legal obligations and responsibilities as an FT, PCT, GPC etc.
- Have we negotiated mitigation of our performance targets in the event of an emergency; when is the emergency declared?
- Have we an up to date Mutual Aid Agreement (MAA) in place? Are all the signatories still in existence, clear of role and committed to action when required?
- Does the MAA agreement cover any new boundary risks identified this year?

3.4 Assurance at the Boundary

Our **partnerships** and other relationships are well meaning but frequently ineffectual, often based on a *commitment* to change or work together efficiently but not an *agreement* to deliver. As in the EFQM business excellence model, Partnerships need to be treated *as a resource not just a relationship* with explicit purpose, etiquette, understanding of roles and responsibilities and commitment to deal with difficulties as well as opportunities. The Good Governance Institute developed with *NHS Kensington and Chelsea* and others a partnership decision tree (see ISQUA 2009) to codify our various forms of relationships with others, to then challenge if we have good governance systems in place to meet the purpose of the partnership and our ongoing obligations. If not we will change them. If we set up new groups we will design the governance as fit for the purpose and outcomes we want.

Issues are often unknown unknowns because we do not understand the environment and processes of our partners. A planning meeting in Sussex in 2000 between health and local government struggled for hours with NHS intransigent to the obvious population growth and need for retaining emergency facilities only belatedly realising that whist local government was allowed to invest for population growth the NHS based its investment on existing demand. Our failure to understand our partners will often allow our reputation to be compromised by their failings.

Reputational risk was recognised by the EPA in 2003 as the biggest concern for commercial CEOs. Janice Smith, a partner at health lawyers, Capsticks, emphasises the added component of outrage ‘‘outrage is the added dimension of the publics perception of risk, often fuelled by the media’ Peter Sandman argues ‘risk is the sum of hazard and outrage’. (EPA Journal 11/87)

In industry, the fact that the reputational risk of suppliers can land you in trouble is taken much more seriously now. But public sector bodies have tended to say, we can’t follow this into your organisation because that’s your business – even when the biggest risk to my hospital might be when someone is preparing to do something on my behalf.

> “The public regards it all as the NHS, whoever provides the service. You can’t just hope that by muddling through everything will work. Talking to colleagues in industry, they say: ‘if it’s important enough, of course I’m going to get in there and sort it. Otherwise there’s no deal.’ When catering company Gate Gourmet sacked 670 staff based at Heathrow airport the repercussions rocked British Airways. The company supplied in-flight meals to BA, and many of the airline’s staff walked out in sympathy with the sacked workers. Flights were grounded for two days and BA lost millions of pounds – as well as untold goodwill: the contractor’s problems were widely seen as the failings of BA itself. (In View, Issue 18 , July 2008, The Institute for Innovation and Improvement

The moral of BA and Gate Gourmet In 2005, the 2009 Maclaren buggy and 2010 Toyota break pedal recalls, BP and the sub-prime market are all examples of the damage to reputation caused by reliance on suppliers, partners and agents. Government is not immune and is highly sensitive to both academic and media commentary which undermines policy or public health measures which whilst intending to move the organisation forward seem to many to be a distraction from core purpose

Polly Toynbee in the Guardian (2 Jan 2010) issued a scathing attack on ‘pointless NHS reorganisations’ the creation of a ‘muddled market’ arguing ‘money and good managers are what makes the best councils, schools and hospitals’.

Some commentators say the Met Office should stop longer-term forecasting because it damages the organisation's reputation. (BBC on line news Saturday, 16 January 2010).

In April 2009 the BBC was told to rein in its commercial operations by the Commons Culture, Media and Sport Committee on the grounds that new activities undertaken by BBC Worldwide risk jeopardising the corporation's reputation.

Amidst this backdrop of criticism, the BBC Trust ordered BBC Worldwide to curb its merger and takeover activities.

(BBC Online 25 January, 2010)

With some prescience, Financial services companies back in 2005 were pushing risk management further up the corporate agenda and regarding reputational risk as the greatest threat to their market value, according to the Economist Intelligence Unit (EIU). Yet, the study ‘Uncertainty tamed? The evolution of risk management in the financial services industry’, also revealed that it is the quantifiable risks, such as credit and market risk, which still absorb the most attention amongst financial institutions.

The survey of more than 130 senior executives in financial institutions worldwide identified four reasons why risk management remains primarily focused on meeting regulatory requirements and

only secondarily on protecting and enhancing the value of the franchise:

- A culture of risk awareness has yet to emerge
- Compliance is not being turned into competitive advantage
- The importance of governance is underestimated
- Quantifiable risks are still the focus of too much attention.

"In an environment where new and potentially lethal risks can suddenly emerge, institutions need to look at the bigger picture. They need to seek to anticipate and avoid the submerged risks that can abruptly sink an enterprise and have both the crisis management processes in place and the underlying standards of behaviour that are likely to soften the impact of such risks when they do come to pass."

'Many central risk groups did not have much input into strategic decision-making. When asked in which business processes their company had a structured approach to assessing risk, only 43 percent of respondents pointed to mergers and acquisitions and only slightly more (44 percent) to forming alliances and partnerships. Just 17 percent pointed to the setting of compensation policies for directors and recruitment policies.

Reputation risk is typically associated with what insurance underwriters refer to as "sudden and accidental" events. This can be a pollution incident or a product recall due to defective goods. Recalls can attract massive media interest, for example, MacLaren's recall of one million baby strollers in the US received blanket coverage on both sides of the Atlantic.

Companies are often good at identifying such "sudden and accidental" type risks as possible causes of reputational damage. However, sometimes the build-up can be gradual, with reputation being eroded rather than broken, the experts advise.

The tarnishing of Toyota's enviable quality credentials may have been more deep seated. The Economist reported Dec 10 2009: President of Toyota Motor Corporation, 'Mr Toyoda, had been reading "How the Mighty Fall", a book by Jim Collins, an American management guru. In it, Mr Collins (best known for an earlier, more upbeat work, "Good to Great") describes the five stages through which a proud and thriving company passes on its way to becoming a basket-case. First comes hubris born of success; second, the undisciplined pursuit of more; third, denial of risk and peril; fourth, grasping for salvation; and last, capitulation to irrelevance or death.

Mr Toyoda claimed that the book described his own company's position. Toyota, he reckoned, had already passed through the first three stages of corporate decline and had reached the critical fourth. According to Mr Collins, fourth-stage companies that react frantically to their plight in the belief that salvation lies in revolutionary change usually only hasten their demise. Instead they need calmness, focus and deliberate action.'

Ministers please note.

"Many causes of reputational damage are not the result of classic insurable events, but the result of the organisation's strategy, values, culture and behaviour. Many will be taboo because they emanate from above the risk manager; and others will sit in blind spots because the organisation doesn't know how to ask the right questions."

This all starts at the top with clarity of the purpose of the organisation and the principles by which it will operate. Take for example the Principles set out in Hermes which as initially known as PosTel,.

The Hermes group was formed in 1983 from the investment management team of the Post Office Staff Superannuation Fund. Its philosophy is that their actions are always guided by their core ethos to "do the right thing".

Key Elements:	Progress Levels:					
	NO	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
9. Include reputational risks and potential failure of partners and suppliers in the Board Assurance Framework (BAF)	**NO**	Board Assurance Framework is established and embedded in organisation	Potential boundary failures and capacity of partners/suppliers is included in BAF	Independent Assurance is available for 80% of red flagged risks including partners systems	Tested systems are demonstrating our and partners ability to respond in timely manner	BAF includes reputational risk of partners/suppliers and all BAF risks are checked routinely for potential boundary failure

In 2008 they set out the Hermes principles that included:

Principle 9 'Companies should manage effectively relationships with their employees, suppliers and customers and with others who have a legitimate interest in the company's activities. Companies should behave ethically and have regard for the environment and society as a whole.'

'As a long-term diversified investor, we oppose companies behaving in a way which knowingly passes costs on to other companies or to the tax payer, and as such is socially or environmentally unacceptable, or unethical. It makes no sense if business success is achieved by creating other costs ('externalising costs') which the beneficial owners of companies will ultimately pay for.

Principle 10 'Companies should support voluntary and statutory measures which minimise the externalisation of costs to the detriment of society at large.' □
The Governance between Organisations debate paper (IHM, 2008) set out an argument for Boards to recognise the service delivery failure and reputational risk that partners and suppliers can cause. The impact is often a measure of public 'outrage' and is recognised in the reputation domain of the National Patient Safety Agency risk matrix (2008)

In practice there are events we cannot anticipate but *black swans* by definition are rare and most governance failures could have been anticipated. For the real *unknown unknowns*, we can only act promptly to make safe, and have the humility to apologise and reassure all that we have learnt, applied and shared the lessons of our failures so that we will not let them happen again.

3.4.1. Include reputational risks and potential failure of partners and suppliers in the Board Assurance Framework (BAF).

Boards need to be confident that the systems, policies and people they have put in place work together in a way that is effective, is focused on key risks and is driving the delivery of objectives. But the concept of assurance can be a source of misunderstanding and mismatched expectations. Potentially, there can be a lack of clarity within, and beyond the Board, as to what is meant exactly

by the term “assurance”. This can extend to uncertainty over the level of assurance required, where that assurance comes from and how the reporting of assurance is managed in a coordinated manner.

From 2001/2002 all NHS Chief Executives in England were required to sign a Statement on Internal Control (SIC), which formed part of the statutory accounts and annual report. It was a critical component of this Statement, Boards need to be able to demonstrate that they have been properly informed through assurances about the totality of their risks, not just those that are financial, and have arrived at their conclusions based on all the evidence presented to them.

Guidance was issued in 2002 in ‘Assurance: The Board Agenda’ (DH Gateway 2002) to help NHS Board Members meet this challenge through the consideration of abnormal organisational assurance framework.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumors Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

The Guide explained that every organisation was expected to design its own framework, related to the delivery of its own objectives within the context of an understanding of the principal risks that the organisation faces. The guide went on though to say ‘Having said that, there are generic aspects to building an assurance framework and the thinking through of associated issues.’ To support this the guide’s appendix included more specific guidance including the statement:

- The principles for achieving assurances are the same irrespective of whether clinical, financial or other areas of activity are involved. They all require systems to be evaluated for their ability to prevent or minimise error and then checked to ensure they are actually working as intended, or if not, the effect of weaknesses. This is known as the systems audit approach. It provides an assurance about the whole system and help in reducing ongoing problems. Whilst it is possible to gain some assurance through the examination of individual incidents or transactions, this can be very time-consuming and does not provide an insight into the whole system.
- Further guidance was made available in 2003 and the GGi have produced a simple rules guide with Dynamic Change in 2008 which set out 10 ‘rules’

Auditors are expected to conclude that 'the board has been appropriately engaged in developing and maintaining the assurance framework'

Board Assurance Framework: 10 Simple Rules

1. The Board Assurance Framework is the means by which we hold ourselves to account –it is our responsibility to defend our patients, visitors and staff not just to defend the institution
2. The Board is responsible for affirming assurance is in place
3. The BAF helps us to clarify what risks will compromise our strategic objectives.
4. We may have controls in place but they will weaken over time, check again
5. It's the Chief Executives responsibility to handle reputational risk
6. Reputational risk is what really compromises the board, but it will be the public outrage level that is the barometer of what is important
7. Check at the boundary too
8. We may get it wrong but we will be judged by how quickly we say sorry and act to put it right
9. Better to use the assurance we've got and quest for evidence based assurance and know the difference
10. Challenge why your board agenda and red flagged risks in the BAF are so different

In Wales the Welsh Assembly Government has been permissive on BAFs. For example, all Health Boards are required to have a risk management framework that ensures a systematic approach to internal control. Local Health Boards (LHBs) were free to choose a framework of their choice. Whichever framework is chosen, organisations must ensure that they have evidence that they deem sufficient to demonstrate they have implemented processes appropriate to their circumstances. LHBs are required to link risk management to their key organisational objectives in order that objectives and their associated risks may form an integrated part of the organisation's management activity. (see 'Supplementary Guidance for Local Health Boards (LHBs): Statement on Internal Control 2003-04' issued in Wales by the Director of NHS Finance on 8 September 2003 and NHS Wales Summarised Accounts 2006-07) Healthcare Inspectorate Wales (HIW) also expects NHS organisations to have sustainable systems outlining accountability and arrangements, including an assurance framework.

In Scotland Chief Executives of NHS Boards, as accountable officers, have responsibility for maintaining a sound system of internal control within their organisation. The Scottish Executive issued HDL (2002) 11 – "Corporate Governance: Statement on Internal Control" – in March 2002. This requires Chief Executives of NHS Bodies as Accountable Officers to sign a Statement on Internal Control (SIC) as part of the annual accounts. The SIC describes the effectiveness of the system of internal control; it is not restricted to internal financial controls and considers all aspects of the organisation's system of internal control including clinical governance, staff governance and risk management. If any aspect of the system of internal control is found to be unsatisfactory, this should be disclosed in the SIC. Guidance issued by the Scottish Executive to support HDL (2002) 11 states that NHS Boards are responsible for reviewing the effectiveness of internal control having regard to the assurances obtained from the Audit Committee and any other standing committee which covers internal control. In addition a quality assurance framework was developed by NHS Quality Improvement Scotland in 2005/6 to support NHS Boards to establish robust systems and processes in relation to the Primary Medical Services Quality and Outcomes Framework (QOF) review process, and to monitor Board performance against the core standards.

Principle Objectives may include Shared Objectives with partner organisations, the assurance of which will require a shared framework between the organisations. The Shared Objectives should clearly indicate what it is responsible for, what the shared responsibilities are and what the partner

organisation's contribution is to be. The Assurance Framework should capture the controls that the two (or more) organisations have to reduce the risks associated with the Shared Objective.

The Board must be appropriately engaged in developing and maintaining the Board Assurance Framework. Given the focus of the Board Assurance Framework upon principal objectives and the fact that it should be maintained to reflect current circumstances, it should be a key driver for the agenda of Board meetings. The Annual Plan for the Board and Audit and other Committee meetings is therefore explicitly linked to it and summary sheets for agenda papers cross-referenced to it.

It is the duty of Board members to ensure that they appropriately monitor the Trust's significant risks and the associated controls and assurances. In particular, the Board should focus upon the progress of action plans to address gaps in control and assurance. The Board (probably through its audit committee) should ensure that all systems, processes and procedures required for the Board Assurance Framework function effectively. Where elements of assurance have been delegated to subcommittees, these must complete and report on their specific responsibilities as defined.

The Trust Board must demonstrate it is in sufficient control of its activities through monitoring and reviewing Board Assurance Framework reporting, particularly at Board level. In this way the Board Assurance Framework informs the Statement on Internal Control (SIC), which is signed by the Chief Executive of the Trust on behalf of the Board.

Questions for Board members

- Does the BAF cover all activity and relationships?
- Are we recording risks and controls that are in the hands of our partners and suppliers? What assurance do we have that they will not compromise our objectives?
- What assurance do we have that independent providers and suppliers meet the standards we expect?
- Do we have clinical engagement for the reforms we are making?
- Do we have political, public and media buy-in to the changes?
- Are we (and our partners) being brave enough?
- Do we (and our partners) follow through on our decisions?

Key Elements:	Progress Levels:					
	NO	**1: Basic level - Principle Accepted**	**2: Agreement of commitment and direction**	**3: Results being achieved**	**4: Maturity - comprehensive assurance in place**	**5: Exemplar**
10. Critical reputational systems are reviewed regularly eg Apply rules for new staff (CRB checks, data handling, competence, qualifications etc) to existing and agency staff	**NO**	Systems whose failure might compromise our reputation identified	System process checks have identified critical failure points of our or others systems which might compromise our operational capacity. These reprioritised for investigation	Unsustainable systems or relationships are improved or replaced.	Systematic quality assurance system in place with automated action taking where needed	Systematic checks in place for all critical systems eg existing and newly acquired staff, premises & systems

Scenario Reputational Risks: Have we assessed our reputational risks in respect of what others might do that would compromise our reputation?

We have just been told that the details of up to 3,000 NHS patients could have been on a computer stolen from a doctors' surgery. The laptop belonging to a specialist screening service managed by the Trust contained patients' names, addresses, dates of birth and phone numbers. The laptop was coded with passwords and had three levels of protection. Police have been called in after the theft at a GP surgery. The trust is also investigating. The trust has reported that the computer did not contain any national insurance numbers or medical information, but a link to a picture of patients' retinas was stored on it. Some patients' NHS numbers were also on the computer and it was also possible that further patient records, which were due to be deleted, may still be stored on it. Our CEO reports that "The trust has no way of knowing if this is the case unless the laptop can be recovered."

The CEO has published a statement saying "I would like to offer a sincere apology to all patients affected by this theft and reassure them that there are very strong security measures on all our IT systems to prevent confidential information being accessed. This is an isolated incident and we are taking immediate action to try and ensure that it does not happen again."

What actions might the CEO be taking. Is the board assured that visiting clinicians whether conducting research or treatment understand their obligations to the Trust and comply?

3.4.2. Critical reputational systems are reviewed regularly eg Apply rules for new staff (CRB checks, data handling, competence, qualifications etc) to existing and agency staff

What early-warning systems does our enterprise use to detect emerging reputational risks?

The NHS still suffers from the lack of a formal quality framework (see 'Where is the Quality Framework for the NHS,?' ISQUA, Vancouver 2005) . Most well known industry models including EFQM and ISO have at their heart an appreciation of the key business processes at which the enterprise must excel to be safe and successful.

Some of these critical processes if underperforming will result in waste and reworking, others though are critical to maintain the reputation fo the organisation. In the NHS and industries such as extraction and transport, safety for users and staff are key reputational processes. Management of such processes can be left to suppliers but the board cannot expect to outsource its reputation. We expand here on one key process which has the potential to compromise organisational reputation- employment of staff

Although there has been a reaction to the over zealous application of Criminal Records Bureau (CRB) checks to all who come into contact with children and elderly and the vulnerable; there is a very serious point that the NHS organisation must be confident that all staff and contractors have been checked and their competence, qualifications and criminal record checks are current and defensible. This applies to both new and existing staff and boards would need assurance that staff moving to the trust had up to date compliant records

Concerns were raised in September 2009 about the safety of the NHS in Wales after it emerged many staff have not had a criminal record check. The Western Mail reported on reports by the Healthcare Inspectorate Wales (HIW) which found "inconsistent approaches" to Criminal Records Bureau checking.

It found some staff working in Wales had never had a CRB check – even though they are mandatory for all new employees.

The lack of CRB checks emerged as the independent watchdog published reports detailing how individual NHS organisations in Wales have performed against 10 of the 32 NHS standards relating to dignity and respect, child protection and vulnerable adults.

The reviews specifically focused on child protection because of the concerns emerging from the Baby Peter case in England.

Carol Lamyman-Jones, director of the Board of Community Health Councils in Wales, said: "From the findings of the HIW report it is worryingly apparent that NHS trusts are not following Welsh Assembly Government guidance on CRB checks.

"Patients and the public need to be assured that all healthcare organisations that deal with vulnerable adults and/or children are rigorous in their checking of potential and existing staff."

HIW found problems in six of Wales' eight NHS trusts, including:

- CRB checks were "not fully up to date" in North Wales NHS Trust;
- "Concerns" about CRB checks in Abertawe Bro Morgannwg NHS Trust;
- Staff working for Velindre NHS Trust for a long time have not been rechecked;
- "Some [staff] have never had a CRB check" at Cwm Taf NHS Trust;
- CRB not consistently applied at Cardiff and Vale NHS Trust.

Simon Jones, the NSPCC's policy and public affairs manager, said: "It is vital that NHS trusts have in place rigorous systems and processes to ensure that criminal checks are undertaken and are kept up to date."

And Tina Donnelly, director of the Royal College of Nursing in Wales, said: "CRB checks not only give confidence to patients but also to colleagues that the people they are working with are in a position of trust."

CRB checks were introduced in 2002 but the vetting scheme was tightened following an inquiry into the child murders by school caretaker Ian Huntley in Soham.

A spokeswoman for the Welsh Assembly Government said: "We expect NHS employers to undertake thorough and comprehensive pre and post employment recruitment checks. It is a mandatory requirement that NHS employers carry out checks on new employees and on those staff that move post."

Martin Beckford writing in the Daily Telegraph commented (10 Oct 2009):

From 12 October , anyone who works or volunteers with children or vulnerable adults regularly can be put through an Enhanced Criminal Records Bureau check that picks up all previous convictions and other information held on file by the police.

In addition, employers are being put under a legal duty to inform the controversial new vetting quango, the Independent Safeguarding Authority, if they fear a worker is unsuitable to work with the young, the elderly or the sick.

The new regulations are coming into force even though ministers have ordered a review of the scope of the scheme amid widespread criticism of its implications.

In the past financial year the CRB, a Home Office agency, carried out checks on a record 3.9million people who work or volunteer with young or vulnerable people.

Most had Standard checks that only pick up convictions and cautions but others, such as teachers and social workers who have close contact with young people, had to undergo Enhanced checks that reveal "soft intelligence" - or unproven allegations - held on them by the police.

Once the ISA becomes fully operational, an estimated 11.3m people in England, Wales and Northern Ireland will need to have Enhanced checks as part of the new system before they can work with the young or vulnerable.

CRB disclosures for doctors in training
21/05/2009

It is normally mandatory to carry out a CRB check when appointing to a post in which is exempt from the Rehabilitation of Offenders Act. This page sets out some possible exceptions for doctors in training.

There are circumstances where it is reasonable and safe for this requirement to be risk assessed. This guide provides advice on dealing with CRB Disclosure for doctors in training.

The NHS Employment Checks standards, published in March 2008, were developed by NHS employers in partnership with the Department of Health. The standards include those checks that are required by law, those that are Department of Health policy and those that are required for access to the NHS Care Record Service.

They apply to permanent staff, staff on fixed-term contracts, temporary staff, volunteers, students, trainees, contractors and highly mobile staff employed through an agency. Trusts appointing locums and agency staff will need to ensure that their providers comply with these standards.

The standards replace previous NHS Employers guidance on safer recruitment and outline the employment checks NHS organisations must carry out. The Healthcare Commission will be assessed trusts against these standards as part of their annual health check in 2008/2009. Failure to comply with these standards could potentially put the safety, and even the lives, of patients, staff and public at risk.

The following is an extract from the NHS Employment Check Standard "Criminal record checks":

- Where a doctor is appointed on an educationally-approved training rotation, a risk assessment may indicate that the CRB checking requirement can be set aside. This would only be where there is evidence of a successful disclosure to an NHS employing organisation within the previous three years and where the new post does not change the status of the check. This means that the three-yearly checking cycle is not affected by the CRB's withdrawal of their portability service for those who are under close educational supervision and who maintain an ongoing relationship with the NHS. Employers may choose to run checks more frequently, but are not required to do so.
- The exception to this principle is where a doctor is appointed to a training post that changes the status of the check, for example a post in paediatrics or other position within the scope of the Protection of Children Act (PoCA). PoCA checks are a legal requirement and therefore a new check must be carried out irrespective of the date of the previous check.

Evidence of a check having been carried out may be obtained from the doctor's own copy of a disclosure, from ESR, from the Occupational Health Smart Card database, or from other local records. To aid subsequent verification of a CRB disclosure having been obtained details of the date and reference number should always be recorded on ESR for the benefit of informing future employers conducting a risk assessment.

Further updated information on pre-employment procedures for doctors in training can be found in the NHS Employers' state of readiness checklist 2009.

An NHS Foundation trust undertook a compliance review on CRB checks in 2009 This was reported to the **Trust Board in late 2009 to** provide an update for the Board on the current position for the Trust in relation to compliance with Care Quality Commission and Monitor requirements and the Trust's Policy on Criminal Records Bureau (CRB).

The report recognised that as an employer it is important that CRB checks are carried out for all new staff entering the NHS as well as those who are employed. It allows the Trust to manage risks more effectively and reduces the risk of exposing staff with unsuitable criminal convictions to sensitive areas of the business that require a high degree of trust and autonomy. The Trust has a Policy on Criminal Convictions, which confirms that all appointments covered by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 are to have criminal record checks.

In June 2008, given the focus on the issue nationally, a report was submitted to the SDB setting out the Trust position. This detailed that there were 1289 members of staff (excluding Bank only assignments) on the Electronic Staff Record (ESR) database without a record of a completed CRB. At this stage, no figures were submitted regarding rechecking CRB disclosures that were older than 3 years.

An update was submitted to the SDB in August 2009 that the 1289 figure had been reduced to 237. Figures for Bank only assignments were also submitted, showing a reduction from 575 missing records to 122.

The SDB were also informed that there were approximately 700 CRBs that were *known* to be out of date, with an estimated 300 additional cases where they would become out of time.

The Trust ESR records were subsequently updated with the information obtained from the various strands of activity. In addition, other changes were occurring as usual due to starters, leavers, etc. The ESR records were then re-run.

At this stage, a large record keeping error was noticed. There were 1256 records where the CRB unique disclosure number was identical. This situation had not been identified by the earlier work as the work had focussed on those individual records with gaps. All of these records need to be regarded as suspect until verified.

Summary

Staff with valid CRB	1711	73.7%
Substantive Staff with out of date CRB	501	21.6%
Bank Staff with out of date CRB	109	4.7%
TOTAL	**2321**	**100%**

The Trust is holding 4065 CRB records (note the number will fluctuate due to starters and leavers). Of these 1711 show a valid CRB a further 610 staff have had a CRB check but are now out of date. This leaves a further 1744 cases where no valid record is held by the Trust. Within this number are the 1256 records above. The strong likelihood is that the majority of these have either a valid CRB check or a CRB record now out of date.

This compares to 1606 Substantive records and 138 Bank records that we are uncertain about.

1256 of these appear to be from a data corruption as they have identical CRB records – this seems to be a cut and paste error on the original CRB spreadsheet.

The Trust reviewed how they had got into this situation

Since 2002, the Trust has had a policy of vetting new employees via the Criminal Record Bureau. In 2004, a project was undertaken to ensure that all current staff who had been recruited previous to Sept 2002 were also checked via the CRB. This took place from August 2004-March 2006. The project seems to have been a relative success.

The Trust adopted a policy to recheck records every 3 years. (Policy on Using the Criminal Records Bureau Disclosure Service – version 2.0, 2004.) It was proposed that the Workforce Planning team, as part of Human Resources, would produce a report every April, detailing all those that would require rechecks for the coming year.

It appears that ***since this project, only new members of staff have been checked and no rechecks have been carried out***. There appear to be a number of reasons for this:

- Up until December 2007, all workforce information was provided under SLA. It is possible then that they were not aware of the Trust's policy surrounding rechecking.
- The Trust's first Workforce Manager was not appointed until February 2008. No clear process appears to have been carried over from the initial report and therefore this was not built into the Workforce Manager's responsibilities.
- The majority of rechecks did not need to be initially started until 2007/8 following the work in 2004-06. This rechecking work did not commence.
- There has been a relatively rapid turnover in Recruitment Managers in the past 12-18 months so this has not been identified as a priority until recently.

The potential risk implications are serious.

- The issue has been added to local and corporate risk registers.
- Compliance with the Trust's CRB policy is part of Standards for Better Health (standard C10), and will form part of the new Care Quality Commission registration requirements. The Trust's compliance with standard C10 will be discussed by the Assurance Committee at its October meeting, as part of the current self-assessment against the Standards for Better Health. The impact on the Trust's governance risk rating will be assessed as part of the Quarter 2 Compliance Report which will be submitted to the October Board meeting.
- Staff may be working within the Trust where criminal conviction status may be contrary to Trust policies regarding vulnerable individuals and so place individual service users at risk.

The Trust Board paper in November 2009 concluded: 'The next step is to continue the process to ensure that the Trust does not get exposed like this again. '

Scenario 1

A neighbouring trust has been criticised for failing to maintain up to date systems confirming staff (full time, agency, training, honorary contracts) meet current CRB, qualification, validation, health and employment requirements . A recent SUI related to communication problems involving language difficulties with a EU national. A Board director has questioned whether all staff are meeting their individual 'duty of care' obligations and that the Trust in turn discharges its own 'duty of care' for staff and patients.

Scenario 2

Some of the neighbouring XY NHS Trust consultants work in our trust on honorary contracts but informally NEDs have become aware from relatives overhearing gossip on the ward that the visiting consultants are 'arrogant, overbearing' and 'refuse to follow our Trust protocols' for example the WHO Surgical Safety Checklist. In addition the MD of the neighbouring XY Trust has lodged a complaint with our MD from two of these consultants that our staff 'do not follow orders' and appear to be 'poorly trained in theatre technique'. Is this a board issue? What assurances do Board Directors need either in corporate board or executive roles that the situation can be resolved?

- If this is a principal risk to our corporate objectives how does it get added to our board assurance framework?
- Is this an issue for Commissioners?

- How would they know?

Questions

- Have we identified our critical processes including those outsourced to suppliers or provided by partners?
- What early-warning systems does our enterprise use to detect emerging reputational risks?
- How are early warning systems rated and escalated to the Board?

4. Conclusions & Issues, which still need debate and resolution.

We believe the key point here is that whilst the organisation for which we have accountability is our primary concern we cannot ignore what happens at the boundary. We receive patients and confidential data from others and we deliver knowledge and patients to others. We may not be the accountable body for patients still in their community or once they leave our care but our reputation is at risk if we are seen to have prevented them from receiving timely care or failed to deliver them to a place of responsibility and safety. This inevitable takes us into the domain of other statutory or corporate bodies but also into the need for service users to look after their own health and welfare.

No-one says this is easy, but it is do-able. We have here expected high levels of accountability by patients and carers, clinicians and managers, boards and regulators but pushed for greater awareness of the need to hold partners, suppliers and commissioners to account both in seeking assurance that all is well and to act when things go wrong.

We also believe that in adversity there is a responsibility in society for all players in the public, private or third sectors 'to do the right thing'. Governance is maturing from 'comply or else' through 'comply or explain' to 'apply or explain' to 'apply and explain'. In 2011 the country will be seeking to manage in adversity, hopefully looking forward to a new prosperous world unburdened by debt. This applies to individual and enterprise. It is difficult to see how this can move forward without a strong sense of purpose, commitment and sharing of the burden of accountability and risk. We hope this document has helped to raise some issues and asked questions that you will want to debate and resolve.

Issues at the interface, which we believe, still need debate and resolution.

- Metrics for good governance within and between organisations
- Clarity of escalation of accountability from patient through clinician to departmental team to corporate management to partners to commissioner to government
- The authority to intervene when partners or suppliers have lapses, Interestingly the government plans to create an explicit duty, for the first time, for all arm's-length bodies to have a mechanism for resolving disputes without the Secretary of State having to act as arbiter. Perhaps all partnerships need such a formal mechanism
- The accountability to share personal information in the best interests of the patient
- Clarity for the patient of the accountability and authority that comes with responsibility for my own health (ie what can I demand and what do I lose by my condition)
- Clarity of accountability for emergency planning with the demise of Government Offices, SHAs, and PCTs
- The need for a whole system assurance framework

John Bullivant
Andrew Corbett-Nolan
November 2010

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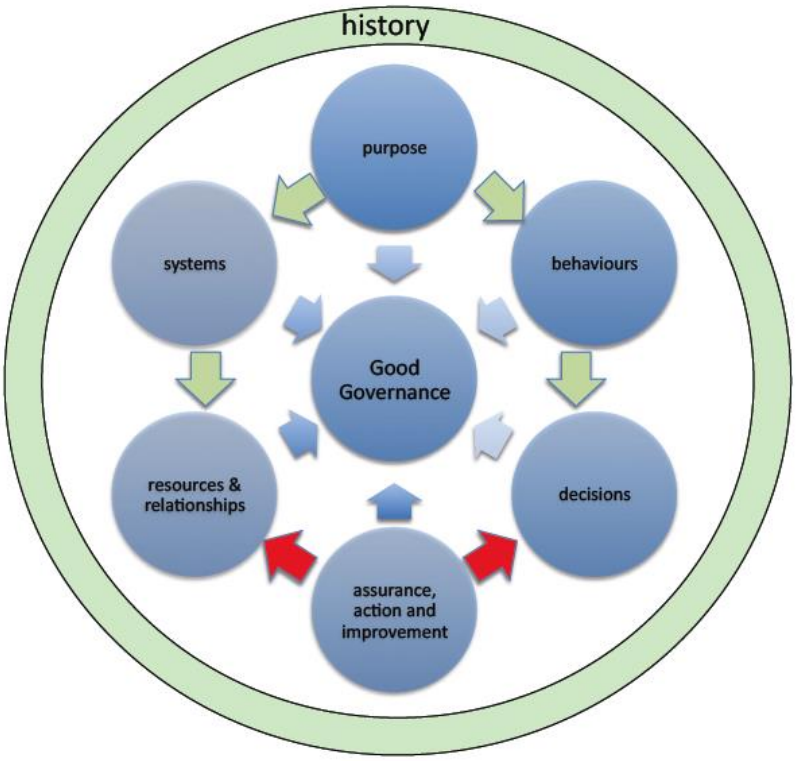
6.**Appendix**

6.1 Good Governance Institute Body of Knowledge.

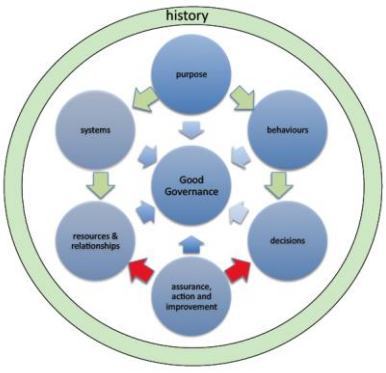
Over the last few years we have with help initially from NHS Bradford established the Good Governance Institute and begun the journey to create asocial enterprise committed to creating, developing and promoting the Good Governance Institute Body of Knowledge. This is an evolving journey but the current iteration looks like this.



The GGI Body of Knowledge

GGI Body of Knowledge

It is clear the new government does not want GP Consortia to inherit the old systems considered to be bureaucratic and slow but there is an important legacy to be maintained. The new arrangements if they work will need new ways of taking decisions but they must still be accountable for public funds. In this last section we seek to draw out some basic principles of good governance that we believe will help GP Consortia to operate in the complex world of NHS commissioning whilst maintaining their individual and collective reputations. This work is drawn from the GGI website www.good-governance.org.uk



Module 1: Concepts of Governance How governance has developed in the private, public and third sectors referencing the major reports and guidance, and identifying some of the opportunities but also ongoing tensions.

Module 2: Purpose & Strategy. Regular reviews and reflection on the purpose of the organisation as systems and behaviours will need to be amended to suit a changing purpose. Balancing strategic focus with the delivery of safe, joined up and cost effective services is the challenge.

Module 3: Decision Taking, Roles & Behaviours Recognition of the role of the Board as the ultimate decision taking body and the importance of clarity of roles and the impact that behaviours have on good governance; the board provides clarity as to where accountability rests. It is also important to draw lessons from governance failures where inappropriate behaviours have compromised the organisation.

Module 4: Resources & Relationships including partnerships, structures & supports: this module emphasises the importance of creating effective partnerships and joint working but also firmly linking this into the organisation's arrangements for risk sensitivity, compliance and assurance within and between organisations.

Module 5: Systems, Tools & Techniques focuses on the importance of creating effective systems for accessing and analysing hard and soft date to support the Board's decision taking. The Board must also have grip on probity and integrated financial and clinical audit

Module 6: Regulation, QA & Improvement: It is the Board's job to be the first line of regulation and compliance. This section rehearses good practice for the Board's role in regulation, scrutiny, audit and action for improvement. The Board should be proactive in applying and explaining its principles of good governance

Appendix 6.2 - The maturity matrix

DRAFT Version 4.1 Dec 2010	**Governance Between Organisations Maturity Matrix developed by** **Dr John Bullivant & Andrew Corbett Nolan** *To use the matrix: identify with a circle the level you believe your organisation has reached* *and then draw an arrow to the right to the level you intend to reach in the next 12 months.* ***O====→***					Good Governance Institute
Key Elements:	**Progress Levels:**					
	NO	**1:** **Basic level -** **Principle Accepted**	**2:** **Agreement of commitment and direction**	**3:** **Results being achieved**	**4:** **Maturity - comprehensive assurance in place**	**5:** **Exemplar**
Continuity of Care 1. Joint commission outcomes and connectivity of care pathways from primary through acute, diagnostics, tertiary to community & home.	**NO**	Recognition that patients expect continuity of care	Services are jointly commissioned and measured by health and social care on basis of pathway of care	Focus on Outcomes is being achieved through focus on Intelligent Funding/results based approach	Metrics and Audit shows patients are being managed along pathway of care without delay or confusion	Patient Pathways are main currency of commissioning, planning and enabling better outcomes
2. Patient handover, referral or data transfer: Take the extra step – have they arrived: What has not arrived?	**NO**	Providers have protocols for handover within organisation	Providers have protocols for handover between organisations	All patients & their data checked for arrival at next care setting	Audit shows handover is being achieved without delay or confusion	Handover procedures working well and lessons shared

3. Review and apply lessons from investigations elsewhere (NHS and other sectors) Could it happen here?	**NO**	All staff trained and updated in communication skills between professionals and with patients and carers	Failures of communication identified elsewhere in NHS and lessons reviewed	Failures of communication identified elsewhere outside NHS and lessons reviewed	Audit shows decline in communication caused untoward incidents	Lessons from internal and external reviews are learnt and applied
Partnerships & Networks 4. Jointly audit critical processes across the boundary (clinical, financial, information etc) at appropriate depth & frequency respective to risk	**NO**	Protocols agreed for integrated clinical/systems audit	Protocols agreed for joint audit of single provider by two interested (commissioning) organisations	Protocols agreed for interface audit across organisational boundaries	Audit covers boundary conditions	Integrated clinical/system audit plan tracks key whole pathways on regular basis as part of clinical audit spiral of improvement
5. Be consistent in telling patients/carers what they are entitled to and when they or others are holding responsibility for their care	**NO**	Patients are informed of their rights and responsibilities	Commitment to informing patient/carer who is holding responsibility for their care at any time	Staff are actively encouraged/trained in informing patients/carer who is holding responsibility for their care at any time	Audit shows professionals and patient/carer knows who is holding responsibility for the care at any time	Patients and carers are clear of rights and responsibilities and evidence shows improvement in fulfilling these
6. Check our partners/suppliers have the capacity to deliver their obligations to us	**NO**	Needs and joint resources have been identified and deployed	Protocol /etiquette for working together agreed with escalation / failure actions predetermined	Agreement on resource deployment between responsible organisations agreed as part of planning/commissioning cycle	Audit of process shows joint working arrangements and arbitration are working to plan and time	Routine robust check of partners resource and decision making capacity with corrective action plan

	NO	**1:** **Basic level -** **Principle Accepted**	**2:** **Agreement of commitment and direction**	**5:** **Results being achieved**	**6:** **Maturity - comprehensive assurance in place**	**7:** **Exemplar**
Mutual Aid & Business continuity 7. Engage with other organisations to support us in case of long term or widespread service collapse	**NO**	Key risks and contingency partners/suppliers identified	Escalation action plans agreed	Plans are tested for resilience and updated. Partner failure is factored in	Black Swan unknown unknowns resilience/responsiveness is tested in joint scenario exercises	Contingency plans with out of region support established
8. Establish and test partner forums including company secretary networks to coordinate planning with escalation proportionate to the developing risk	**NO**	Risk sharing is recognised as normal business practice.	Forums for identification of new and escalating risk and advice established	Resilience planning is part of normal business practice and included in contracts/partnership agreements	Identification of new risks is reviewed against what happens; forecasting systems and plans updated	Networks in place, tested and working
Assurance 9. Include reputational risks and potential failure of partners and suppliers in the Board Assurance Framework (BAF)	**NO**	Board Assurance Framework is established and embedded in organisation	Potential boundary failures and capacity of partners/suppliers is included in BAF	Independent Assurance is available for 80% of red flagged risks including partners systems	Tested systems are demonstrating our and partners ability to respond in timely manner	BAF includes reputational risk of partners/suppliers and all BAF risks are checked routinely for potential boundary failure

10. Critical reputational systems are reviewed regularly eg Apply rules for new staff (CRB checks, data handling, competence, qualifications etc) to existing and agency staff	**NO**	Systems whose failure might compromise our reputation identified	System process checks have identified critical failure points of our or others systems which might compromise our operational capacity. These reprioritised for investigation	Unsustainable systems or relationships are improved or replaced.	Systematic quality assurance system in place with automated action taking where needed	Systematic checks in place for all critical systems eg existing and newly acquired staff, premises & systems
DRAFT Version 4.1 Dec 2010	**Developed under license from the Benchmarking Institute** *To use the matrix: identify with a circle the level you believe your organisation has reached* *and then draw an arrow to the right to the level you intend to reach in the next 12 months.* ***O====→*** **'Good is only good until you find better'**					