Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Healthier Together

Memorandum of Understanding – supporting annexes 1-10

October 2021

Contents

Annex 1 – Definitions and Interpretation

The following words and phrases have the following meanings in this Memorandum:

- **BNSSG** – **Bristol, North Somerset and South Gloucestershire**: the geographic boundaries of our Partnership
- **Healthier Together Partners (or 'Partners')** – all 10 constituent organisations of the Healthier Together Partnership as currently defined in the 'Parties' section
- **HWB** – **Health and Wellbeing Board**: a statutory forum within Unitary Authority boundaries where political, clinical, professional and community leaders come together to improve the health and wellbeing of their local population and reduce health inequalities.
- **ICP – Integrated Care Partnership**: partnerships at the 'place' or 'locality' level within BNSSG, responsible for designing and delivering fully integrated preventive, proactive/anticipatory, and personalised health and care services focused on local people's health and wellbeing.
- **ICS** – **Integrated Care System**: the broad term used nationally for our Healthier Together Partnership.
- **MOU** – Memorandum of Understanding

HEALTHIER TOGETHER PARTNERSHIP BOARD
Terms of Reference

Version	Date	Author/Reviewer	Comment
0.1	05/04/2019	Gemma Self	Initial draft based upon West Yorkshire and Humber Partnership Board
0.2	09/04/2019	Gemma Self	Updates further to conversation with RW, JR and RK
0.3	09/04/2019	Gemma Self	Incorporating feedback from RW and JR
0.4	10/04/2019	Gemma Self	Incorporating feedback from RK
0.41 & 0.42	12/06/2019	Gemma Self	Incorporation of minor points from Boards & updated membership
1	25/06/2019	Gemma Self	Incorporation of recommendations as discussed at Partnership Board
1.1	June 2021	Moriah Nell	Updates to align with Healthier Together MOU

Background and Purpose

Context

1.1 Healthier Together – the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together 10 health and care organisations

- Avon and Wiltshire Mental Health Partnership NHS Trust
- Bristol City Council
- Bristol, North Somerset, South Gloucestershire Clinical Commissioning Group (CCG)
- North Bristol NHS Trust
- North Somerset Council
- OneCare
- Sirona care & health
- South Gloucestershire Council
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Bristol and Weston NHS Foundation Trust

1.2 The partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

1.3 The Partnership Board is a key element of the leadership and governance arrangements for Healthier Together (the BNSSG ICS).

Role and Responsibilities

Purpose

2.1 The Partnership Board provides the formal leadership for the Partnership. It is responsible for setting the strategic direction for the Partnership, and agreeing the vision, outcomes, and objectives. It provides leadership and oversight for all Partnership business and a forum to seek collective support for decision making to progress the delivery of the vision for the Partnership.

2.2 The Partnership Board will work by building agreement with leaders across Partner organisations to drive action around a shared vision and direction of travel.

2.3 This Board will be the forum where the Healthier Together Partners come together to seek collective support for decisions affecting the Partnership. This will include support for decisions required as the result of any shifts in authority for the system, performance monitoring or resource allocated to the system.

These Terms of Reference describe the scope, function and ways of working for the

Partnership Board.

2.4 The responsibilities of the Partnership Board are to:

i. Agree the vision, outcomes and objectives for the Partnership

ii. Provide leadership and oversight in our progress to becoming a mature Integrated Care System.

iii. Consider recommendations from the Executive Group and seek collective support for decisions on:

- The objectives, plans, and changes to priority work programmes and workstreams
- System-level planning
- The apportionment of transformation monies from national bodies
- Priorities for investment of system-level capital funds across the Partnership
- Improvement opportunities and challenges, including those highlighted through system oversight of quality and performance

iv. Act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities

v. Provide a mechanism for joint action and support for decision-making where issues are best tackled on a wider scale

vi. Develop a shared understanding of the financial resources of NHS partners, maximise the system-wide efficiencies necessary to manage within this share of the total NHS budget and pursue opportunities for creation of a single system budget over time.

vii. Support the development of Integrated Care Partnerships (ICPs) in each of our six Localities, which bring together primary care, community-based providers and local authorities, as well as voluntary and community groups, and interface with secondary care providers and commissioners to establish community-based systems of care at local level; and, support the development of Provider Collaboratives

viii. Ensure that, through partnership working in each place and across BNSSG, there is a greater focus on population health management, integration between providers of services around individual people's needs, and a focus on care provided in primary and community settings

ix. Oversee a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners

x. Reach agreement in relation to recommendations made by other

governance groups within the Partnership on the need to take action for managing collective performance, resources and the totality of population health

xi. Adopt an approach to collectively supporting decisions and resolving any disagreements, which follows the principle of subsidiarity and is in line with the shared values and behaviours of the Partnership

xii. Appointment and review of the performance of the Independent Chair for the system. The Independent Chair is responsible for the appraisal of joint executive leads, on behalf of the partnership.

Accountability and reporting

3.2 The Partnership Board has a key role within the wider governance and accountability arrangements for the BNSSG partnership.

3.3 Constituent Boards remain accountable for all aspects of their business in line with statutory frameworks; the Partnership Board has no formal delegated authority. Whilst the current landscape of statutory functions is as it is constituent Partner Organisation Boards remain accountable for all aspects of their business in line with statutory frameworks. Sovereign boards may delegate a service, budget or items for decision making to the Partnership Board in line with their statutory frameworks. Any delegation would need to be agreed by all Boards. This will happen on a case by case basis.

3.4 All members have a responsibility to ensure regular two-way communication between their Sovereign Board and the Partnership Board. The minutes, and a summary of key messages will be submitted to all Partner organisations after each meeting.

Membership

Chair and Vice Chair arrangements

4.1 The Independent Chair of the Partnership Board will chair the meeting

4.2 A Vice Chair will be agreed from among the chairs of constituent bodies

Membership

4.3

Role	Numbers
Independent Chair of the STP	1

BNSSG NHS & CIC Chairs and Chief Executives	14
BNSSG Local Authority Chief Executives	3
BNSSG Health and Wellbeing Board Chairs	3
Chair of Clinical Cabinet	1
GPs representing each area (Bristol, North Somerset, South Gloucestershire)	3
Chair or Area Manager of Healthwatch	3
One representative from NHS England / Improvement	1
Director of Public Health	1

A list of members is set out at **Annex 1**.

Deputies

It is anticipated that Members would be expected to attend all meetings, if they are unable they may send a deputy by arrangement with the Chair.

Additional attendees

Additional attendees will routinely include:

- The Healthier Together Programme Director
- The Healthier Together Finance Lead

At the discretion of the Chair, additional representatives may be requested to attend meetings to participate in discussions or report on particular issues.

Quorum

The Partnership Board will be quorate when 7 out of the 10 Partner organisations are present, including representatives of 2 out of the 3 Local Authority partners.

If a consensus decision cannot be reached, then it may be referred to the dispute resolution procedure in the Memorandum of Understanding.

Conduct and Operation

The Partnership Board will meet in public, at least four times each year. An annual schedule of meetings will be published by the secretariat.

Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days' notice will be given when calling an extraordinary meeting.

The Partnership Board may convene in private committee at the Chair and Members' discretion.

The agenda and supporting papers will be sent to Members and attendees and be made available to the public via the Healthier Together website no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

Draft minutes will be issued within 10 working days of each meeting and ratified at the following meeting.

Secretariat

The secretariat function for the Partnership Board will be provided by the Healthier Together Office. A member of the team will be responsible for arranging meetings, recording minutes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

Review

These terms of reference and the membership of the Partnership Board will be reviewed annually by Board partners. Any changes will be approved by the Board for decision by constituent agency decision making bodies. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the partnership.

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

Healthier Together Partnership Board Terms of Reference Annex One: Members

Name	Job Title	Organisation	Healthier Together Role
Jeff Farrar	Independent Chair	Healthier Together	Independent Chair
Charlotte Hitchings	Chair	Avon & Wiltshire Partnership NHS Trust	Chairs Reference Group Member
Jonathan Hayes	Clinical Chair	BNSSG CCG	Chairs Reference Group Member
Michele Romaine	Chair	North Bristol Trust	Chairs Reference Group Member
Simon Bradley	Chair	One Care	Chairs Reference Group Member
Amanda Cheesley	Chair	Sirona Care and Health	Chairs Reference Group Member
Cllr Ben Stokes	Chair	South Gloucestershire Health & Wellbeing Board	Chairs Reference Group Member
Cllr Helen Holland	Chair	Bristol Health & Wellbeing Board	Chairs Reference Group Member
Cllr Mike Bell	Chair	North Somerset Deputy Leader, Health and Wellbeing Board Chair and Executive Member for Adult Social Care and Health	Chairs Reference Group Member
Jayne Mee	Chair	University Hospitals Bristol NHS FT	Chairs Reference Group Member
Dominic Hardisty	Chief Executive	Avon & Wiltshire Partnership NHS Trust	Executive Group Member, Co-Sponsor of Mental Health programme
Mike Jackson	Chief Executive	Bristol City Council	Executive Group Member, Co-Sponsor for Integrated Care Partnerships Programme
Julia Ross	Chief Executive	BNSSG CCG	Executive Group Member, ICS Exec Lead, Co-chair of Integrated Care Steering Group, Sponsor for Integrated Care System Development

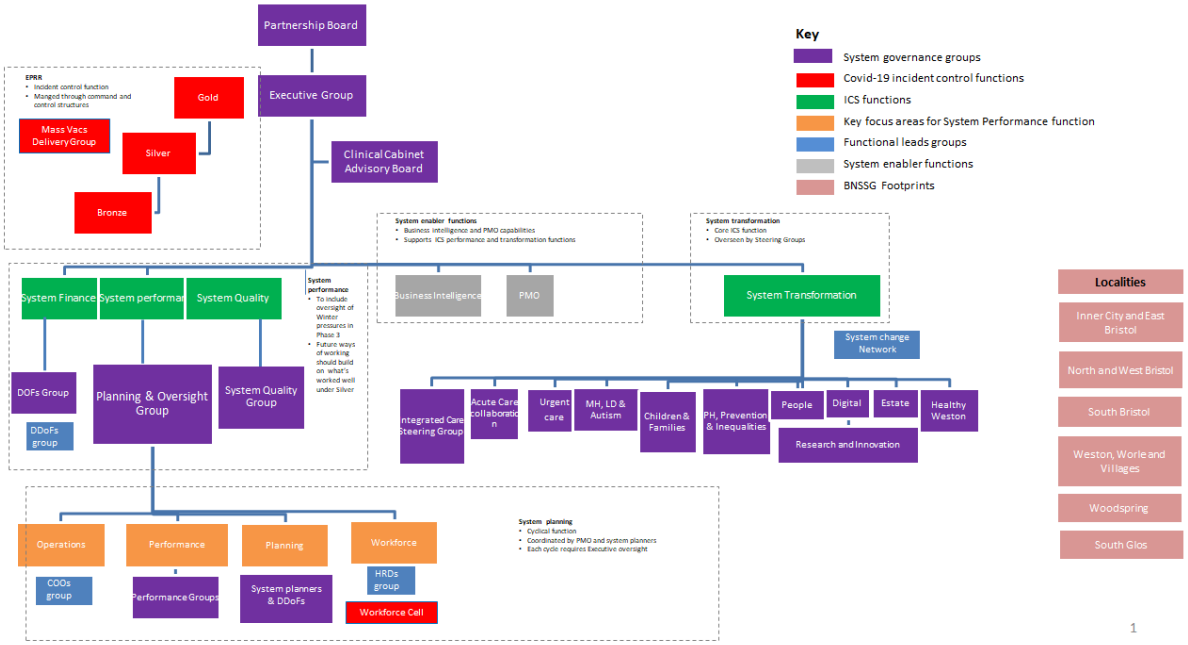
Name	Job Title	Organisation	Healthier Together Role
Maria Kane	Chief Executive	North Bristol NHS Trust	Executive Group Member, Sponsor for Acute Care Collaboration and Urgent Care Programmes
Jo Walker	Chief Executive	North Somerset Council	Executive Group Member, Co-Sponsor for Mental Health Programme
Ruth Taylor	Chief Executive	One Care	Executive Group Member, Sponsor for Primary Care Resilience & Transformation Programme
Janet Rowse	Chief Executive	Sirona Care and Health	Executive Group Member, Co-Chair of Integrated Care Steering Group, Sponsor for People and Children and Families programmes
Dave Perry	Chief Executive	South Gloucestershire Council	Executive Group Member, Sponsor for Population Health, Prevention and Inequalities
Jennifer Winslade	Executive Director of Nursing and Quality	SWAST	Executive Group Member
Robert Woolley	Chief Executive	University Hospitals Bristol and Weston NHS FT	Executive Group Member, ICS Exec Lead, Chair of Bristol Health Partners, Sponsor for Digital Programme
Peter Brindle	Medical Director	BNSSG CCG	Chair, Clinical Cabinet
To be confirmed by Localities			Locality Chair
To be confirmed by Localities			Locality Chair
To be confirmed by Localities			Locality Chair
Georgie Bigg	Chair of Trustees	Healthwatch BNSSG	
Vicky Marriott	Area Manager	Healthwatch BNSSG	
Sara Blackmore	Director of	South Gloucestershire	Executive Group

Name	Job Title	Organisation	Healthier Together Role
	Public Health	Council	Member, Sponsor for Prevention, SRO for Population Health Management
Sue Doheny	Regional Chief Nurse	NHS England / Improvement Regional Office	

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Healthier Together Partnership Board Terms of Reference Annex Two: Governance Structure



HEALTHIER TOGETHER EXECUTIVE GROUP
Terms of Reference

1 Purpose

1.1 To oversee the business of the Bristol, North Somerset and South Gloucestershire (BNSSG) ICS on behalf of the ICS Partnership Board.

1.2 To oversee the delivery of the ICS vision and objectives, providing support for system-wide decisions, providing guidance and support to the ICS workstreams & programmes, and securing the resources to deliver the BNSSG ICS priorities. To seek assurance for the ICS programmes and projects to ensure achievement against agreed deliverables and outcomes.

1.3 The group shall be the key leadership forum for in-depth discussion of key strategic system issues

2 Role and Responsibilities

2.1 The Executives Group's responsibilities are:

2.1.1 To provide the overall programme "Executive Group" function for the ICS portfolio

2.1.2 To provide strategic decision making guidance to the Partnership Board and steering groups on direction, pace, resourcing, risk management and variance against plan / benefit outcomes

2.1.3 To supervise the development of a set of system wide strategies which are fit to deliver the ICS objectives, for approval by the Partnership Board

2.1.4 To approve or delegate authority to Steering Groups to define the Workstream boundaries in terms of time, cost, scope and quality

2.1.5 To agree the overall system configuration, design and collaborative planning processes (including delegated authority) and agree changes as this develops. The Executive Group will make recommendations to the Partnership Board, Individual Governing Bodies, and regulators, as appropriate.

2.1.6 To agree the level of programme management support for each programme

2.1.7 To review and agree the ICS programme and PMO budget, for approval by the Partnership Board

2.1.8 To recommend decisions as appropriate to the Partnership Board, NHS England and NHS Improvement

2.1.9 To provide the leadership and co-ordination for workstreams / programmes requiring a system response.

2.1.10 To receive assurances from its Workstreams, Design Authority & appropriate System Assurance Groups

2.1.11 To monitor delivery of the BNSSG system plan at the strategic level and agree corrective measures & proposals from Workstreams and working groups

2.1.12 To delegate tasks to Workstreams

2.1.13 To approve the Terms of Reference for other system groups

3 Accountability and reporting

3.1 Formal minutes of meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Executive Group.

3.2 The Executive Group will report to the Partnership Board on the performance of its duties as reflected within these Terms of Reference.

4 Membership and attendance

Membership

4.1 The membership of the Executive Group shall include:

- ICS Lead Chief Executives(s) (Chair)
- BNSSG NHS & CIC Chief Executives
- BNSSG Local Authority Chief Executives
- ICS Programme Director

4.2 Members may nominate a deputy. Where the member represents a group, the deputy must come from the same group.

Quorum

4.3 The quorum necessary for the transaction of business will be three quarters of the membership present at the meeting, one of whom must be the ICS Senior Responsible Officer or Programme Director.

Attendance

4.4 Meetings of the Executive Group shall normally be attended by:

- PMO Administrator (minutes)

4.5 The Executive Group may invite other persons to attend a meeting so as to assist in deliberations. The Chair shall be notified of this prior to the meeting.

5 Conduct and Operation

5.1 The Executive Group shall be supported administratively by the Healthier Together Programme Management Office, whose duties in this respect will include:

- Agreement of agendas with the Chair and attendees; and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward within an action log.
- Advising the Group on pertinent issues/areas

- Provision of a highlight report of the key business undertaken to the governing bodies or boards of the partner organisations following each meeting.

Frequency

5.2 A minimum of bi-monthly two to three hour meetings, held in alternating weeks to the Partnership Board.

Notice of meetings

5.3 An agenda of items to be discussed will be forwarded to each member of the Executive Group and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to members and to other attendees as appropriate, at the same time.

5.4 An annual schedule of meetings will be produced and circulated to all members.

5.5 Emergency meetings can be arranged if this is approved and evidenced as such, by the majority of the members of the Executive Group.

Annex 4 – ICS Outcomes Framework

1. Purpose

The aim of the Healthier Together ICS Population Health Outcomes Framework is to articulate the change we, as Healthier Together Partners, are aiming to achieve for our population and to provide a framework to hold members of the partnership to account for delivery of the outcomes. The Outcomes Framework will enable the system to make a radical culture shift towards prevention and also provides a platform to oversee key outcomes and transformation metrics across the Partnership using peer ICS and national benchmarks.

2. Development of the framework

The Healthier Together Five Year Plan 2019-2024 sets out strategic outcomes and high level goals which were collaboratively developed based on population data and insight.

Healthier Together system ambition

"Our ambition is to build an integrated health and care system where the community becomes the default setting of care, 24/7, where high quality hospital services are used only when needed, and where people can maximise their health, independence and be active in their own wellbeing. We want to increase the number of years people in BNSSG live in good health; reduce inequality in health outcomes between social groups; and help to create communities that are healthy, safe and positive places to live. In redesigning our system, we also want to make it easier for staff to work productively together and develop a healthy and fulfilled workforce."

Healthier Together stated in our five year plan that our system goals are to:

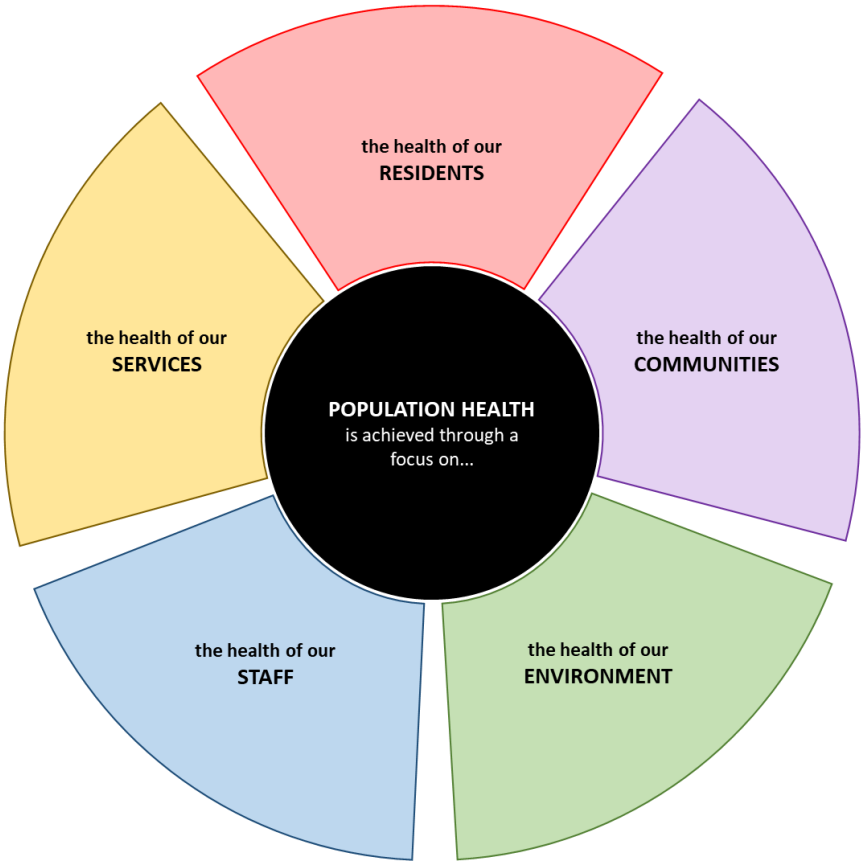
- Increase the number of years people in BNSSG live in good health
- Reduce the inequality in how many years people in BNSSG live in good health, particularly improving healthy life expectancy for those with the poorest outcomes
- Become a place where health and care services fit with people's lives and makes sense to the people engaging with it
- Make it easy for people working in health and care to work with each other
- Our workforce is healthy and fulfilled
- Reduce our adverse environmental impact in energy, travel, waste, water, food, biodiversity and land use
- Our communities are healthy, safe and positive places to live

These system goals have been taken into account when developing the Outcomes Framework. As well as setting clear ambitions as a system to improve the population health of the residents we serve and reduce inequalities, the aim is also to highlight areas where action should be taken, deploy improvement support where required and also celebrate success in health and care improvements.

The outcomes framework has been developed by the Healthier Together Population Health, Prevention and Inequalities Steering Group in partnership with stakeholders across the system. Engagement was undertaken between March and May on the **strategic outcomes.** This included presentations at Healthier Together Steering Groups and discussions with Programme Leads; presentations and discussion with individual BNSSG Health and Wellbeing Boards as well as at the joint BNSSG Health and Wellbeing Board; and presentations at Clinical Cabinet and Healthier Together Executive as well as with the Population Health, Prevention and Inequalities Steering Group.

For the Outcomes Framework to be a success and truly have impact for our population, all Healthier Together partners will need to agree common datasets and dashboards for system improvement and transformation management. This is a key next step in our system development.

Figure 1: Our framework to deliver population health



3. Our Healthier Together ICS Outcomes Framework

The health of our population will be improved through a focus on…	Our Outcomes
The health our RESIDENTS	1. We will increase population healthy life expectancy across BNSSG and narrow the gap between different population groups 2. We will reduce early deaths from preventable causes - cardiovascular and respiratory conditions, liver disease and cancers - in the communities which currently have the poorest outcomes 3. We will lower the burden of infectious disease in all population groups 4. We will reduce the proportion of people in BNSSG who smoke 5. We will improve self-reported mental wellbeing 6. We will increase the proportion of children who achieve a good level of education attainment
The health of our SERVICES	1. We will increase the proportion of our residents who report that they are able to find information about health and care services easily 2. We will increase the proportion of our residents who report that they are able to access the services they need, when they need it 3. We will increase the proportion of our residents who report that their health and care is delivered through joined up services
The health of our STAFF	1. We will increase the proportion of our health and care staff who report being able to deliver high value care 2. We will reduce sickness absence rates across all our ICS partner organisations 3. We will improve self-reported health and wellbeing amongst our staff 4. We will improve Equality and Diversity workforce measures in all ICS Partner organisations
The health of our COMMUNITIES	1. We will reduce the number and proportion of people living in fuel poverty 2. We will reduce the number of people living in poor housing conditions 3. We will reduce levels of domestic violence and abuse 4. We will reduce levels of child poverty 5. We will increase the number of BNSSG residents describing their community as a healthy, safe and positive place to live
The health and wellbeing of our ENVIRONMENT	1. We will increase the proportion of energy used by the estates of our ICS partner organisations from renewable sources 2. We will reduce the total carbon footprint generated through travel of patients using our services 3. We will increase use of active travel, public transport and other sustainable transport by our staff, service users and communities

Annex 5 – ICS Outcomes-Driven Performance and Quality Framework

1. Introduction and background

1.1. Through the development of our BNSSG ICS, we agree on the need for safe, sustainable and high performing health and care services to support our population.

1.2. We expect our ICS to be increasingly involved the oversight and assurance of these services across the system, including of constituent organisations, place-based partnerships, and provider collaboratives.

1.3. Our ambition is to establish a performance and quality approach that addresses system oversight and quality assurance requirements, and extends beyond to continuously improve and achieve our target outcomes for the people we serve.

2. Our shared vision for outcomes-driven performance and quality

2.1. To achieve our Healthier Together vision and goals (see MOU section 3), we have developed a set of population-level outcomes measures that can be monitored in order to assess the progress we are making in achieving our system goals (see appendix 4: ICS outcomes framework).

2.2. We have also established system-wide forums for managing performance and quality:

2.2.1. The Planning and Oversight Group oversees matters relating to the operational, planning, finance and performance aspects of the ICS

2.2.2. The System Quality Group is aimed at system-wide sharing of early intelligence and strategic developments.

2.3. We believe the system goals and outcomes should drive what we focus on with respect to our service quality and system performance. In considering what a high quality, high performing, outcomes-driven integrated care system looks like for the people we serve, we have agreed in principle to the following paradigm shifts in our system performance and quality:

2.3.1. **Person-centred**: we shift our thinking to engage, listen to, and consider the impact and experience of the people we serve

2.3.2. **Outcomes-driven**: the outcomes we want to achieve for the people of BNSSG drives how we deliver and measure success

2.3.3. **Proactively improvement-driven**: we anticipate potential issues and dedicate clinical and professional resources across the system to investigate pressurized pathways, applying good quality improvement methodology and investigating the whole pathway by default

2.3.4. **Self-regulating**: we take a ‘system first’/‘system-by-default’ approach to escalation and regulatory intervention

2.3.5. **Collective responsibility:** we connect constituent organisation's performance to system performance and take responsibility for addressing risks and issues together

2.3.6. **Learning culture and peer review**: we provide ongoing transparency and sharing to check and challenge one-another and drive excellence and improvement

3. Taking this forward together

3.1. Focusing on outcomes-driven performance and quality improvement is a complex challenge, which will require adaptive management and evolve over time.

3.2. We will build on the system relationships and infrastructure established to-date to design an optimal architecture in line with these paradigm shifts, and evolve our ways of working together over time.

Annex 6 – ICS Strategic Commissioning

1. Introduction

1.1. What is Value?

1.1.1. Value Based Health and Care, also referred to simply as *Value* is an international approach to improving our health and care systems.

1.2. What does Value mean to BNSSG?

1.2.1. Meeting the goals of Population Health; improving physical and mental health outcomes, promoting wellbeing and reducing health inequalities, for the whole population and not just those who present to services through a focus on achieving the outcomes that matter to people and making best use of our common resources.

1.2.2. The Value approach underpins the development of our integrated care system (ICS) in service of the four fundamental purposes of an ICS:

- improving population health and healthcare
- tackling unequal outcomes and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development

1.3. Culture

1.3.1. Culture is arguably the most important factor for improving value, with 'stewardship' proposed as the dominant force, where we take collective care for our common resources.

1.4. Value Objectives

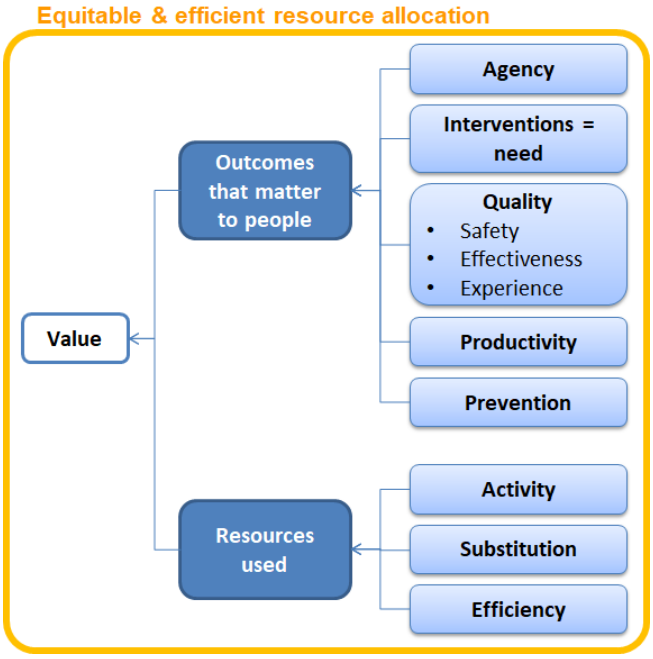
1.4.1. Our ICS Value programme has three high level objectives

1) Allocating resources efficiently across our system so that we achieve the overall best possible outcomes
2) Identifying and improving the outcomes and experience that matter to people
3) Commissioning and delivering effective services that avoiding overuse of low value interventions (unwanted or not cost-effective) and underuse of high value interventions (deemed cost-effective but not taken up by those who would benefit)

2. Our Value Improvement Framework

2.1. Our Value improvement framework (see Figure 1) has been developed with stakeholders including clinicians, public health specialists and commissioners as a way to start developing a common language and common approach to describing, analysing and improving it.

Figure 1: BNSSG Value Improvement Framework



2.2. Our Value Improvement Framework explained

2.2.1. **The wrapper**: decisions on where to use resources (including people, money) should be based on a balanced view of equity (what is fair) and allocative efficiency (what service mix will lead to the best overall outcomes for the resources available)

2.2.2. **Value**: as defined above, can be improved by improving outcomes that matter to people and/or reducing the resources needed to achieve those outcomes

2.2.3. **Outcomes that matter to people** can be improved by

2.2.3.1.1. Optimising individual agency, that is "the ability to take action or to choose what action to take" to achieve what matters to them. An important measure to consider here is the Patient Activation Measure (PAM). Important interventions to consider are Care and Support Planning (CSP) and Shared Decision-Making (SDM)

2.2.3.1.2. Matching evidence-informed, cost-effective interventions to need is critical to improving outcomes at a population level. An important area to consider is current unmet need, which is that where someone would like to improve their health AND has the potential to benefit from something currently provided that they are not currently benefiting from

2.2.3.1.3. Improving the quality of current services, which could be one or all three of the elements of quality; safety, effectiveness (whether the intervention does what it is supposed to) and experience. In some contexts the experience of care may considered an outcome in its own right

2.2.3.1.4. Improving productivity means increasing the output/activity from a particular resource or set of resources, such as the number of operations per hour of surgeon-time. Productivity should not pursued to the detriment of effectiveness and could have a

negative effect on efficiency, although this may be considered worth the trade-off

2.2.3.1.5. Prevention of poor health is generally one of the best ways to maintain health and promote wellbeing

2.2.4. **Resources used** can be improved by

2.2.4.1.1. Reducing activity and ideally **reducing low value activity,** which is activity that is either unwanted by a person (related to improving agency) or unwarranted such as an intervention that has been shown to be of no benefit, e.g. using mirtazapine with other antidepressants for treatment-resistant depression. A significant reduction in activity could also be achieved by addressing failure demand, which is "demand caused by a failure to do something, or to do something right, for a service user", which results in the service user needing to make another demand on the service.

2.2.4.1.2. The **substitution** of products or services that are less resource intense but give similar benefit, such as non-medical interventions for mild-moderate depression, or the use of 'off-patent' pharmaceuticals

2.2.4.1.3. Improving **efficiency**, which is when an output such as GP severe mental illness health checks is being achieved at the lowest possible average total costs. This is related to, but not the same as, productivity.

3. The Tragedy of the Commons

3.1. This concept comes from grazing sheep on common land. If one person adds one sheep to their flock they gain a lot, but the impact on everyone else is minimal. However, everyone then does it and so the commons is over-grazed and the tragedy is that everyone loses out. In a health and care system, there are many examples of where a part of the whole may slightly overreach and deplete our collective pot, resulting in a failure to deliver true Value-Based Health and Care.

3.2. Elinor Ostrom identified 10 principles to solve the problem through building the commons; she was the first woman to win the Nobel Prize for her work on this, in 2009.

Figure 3: Elinor Ostrom's principles for managing a commons

Leading the commons
1. Commons need leadership with moral authority
Defining the commons
2. Commons need clear boundaries
3. Commons need clear aims
Organising the commons
4. Commons need the right to organise themselves
5. Everyone who makes use of the resources should have a role in decision making
6. Commons often work within nested networks
Managing the commons
7. Rules for resource use should match local context
8. The use of resources and adherence to rules should be monitored
9. Failure to meet the rules leads to graduated sanctions
10. Unresolved conflicts need an easy means of resolution

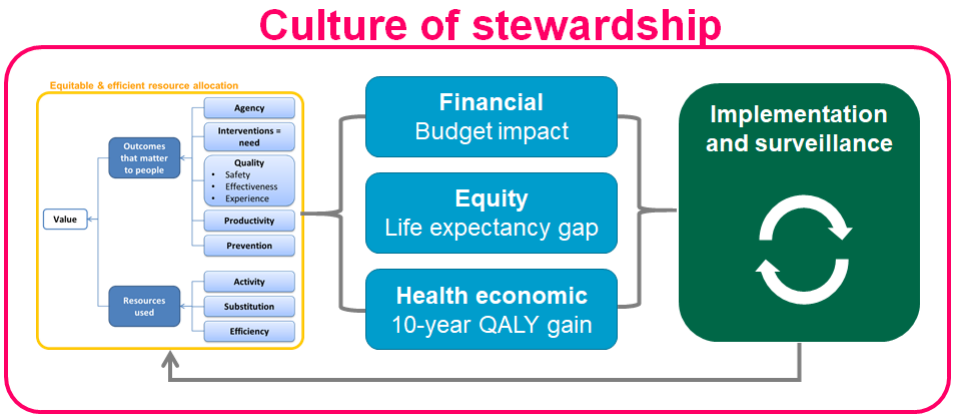
3.3. These principles can help guide our approach in achieving Value for our population as a system. We have a great opportunity to build a culture of stewardship of our common resources towards a collective set of aims through the ICS – building the commons.

4. Our Value Improvement Framework in context

4.1. The Value Improvement Framework should be used as a starting point for understanding our current services and system or describing how a proposed change might affect the overall Value of our system. It does not however lead to a decision on how decisions should be made about how resources are allocated. Our ICS must make decisions on investment and disinvestment, including for single and multi-option scenarios, for example a decision on whether to invest in a whole service reconfiguration or in a new device or medical product.

4.2. The Value Improvement Framework provides a structured way to think about the case being made, and then needs to follow a process in order to arrive at a decision, leveraging the Ostrom Principles. A model for how this could work in Strategic Commissioning is presented in Figure 2.

Figure 2: Strategic Commissioning Cycle



4.3. In this model for Strategic Commissioning, proposed investment or disinvestment decisions, articulated according to the language and structure of the improvement framework are considered according to their financial (in-year cost-implication), equity (impact on health inequalities) and health economic (gain in utility for the resources invested - noting this could be cost saving) consequences. The resulting impacts of the decision are then continuously surveyed so that an assessment of real-world value being delivered can be made, allowing for course correction as needed.

Annex 7 – ICS Financial Framework

Contents

1. Overview & Purpose

1.1 The fundamental purpose in creating our joint financial framework is to establish and define a set of principles and processes that help establish the collaborative ways of working, a culture of financial transparency, and the governance arrangements that support delivery of the ICS vision, and improve the health outcomes for the population of BNSSG in a financially sustainable way.

1.2 All Healthier Together Partners are ready to work together and support each other when required. The Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

1.3 The financial framework will:

- describe the **collaborative behaviours** expected of the parties
- enable a focus on **value** for the system
- require **open book accounting** and **financial transparency** between the parties
- describe **processes for reaching consensus and resolving disputes** about how best to use financial and other resources available to the ICS
- set out a mechanism for management of the aggregate financial position of the parties to achieve and **maintain the system financial improvement trajectory for the ICS**.

1.4 The financial framework is structured to cover the following seven domains. Annex 1 outlines the applicability of these Financial Framework elements to each Healthier Together Partner.

	Financial Framework Domains	Document Section
1.	Understanding the cost of health & care services to enable value based decisions	Section 2
2.	Process for revenue & capital resource allocation	Section 3
3.	Approach to joint financial planning	Section 4
4.	Management of risk	Section 5
5.	Contracting principles & payment mechanisms	Section 6
6.	System reporting, financial management & control mechanisms	Section 7
7.	Finance staff training & development	Section 8

a) Healthier Together Joint Financial Principles

1.5 In support of the above, Healthier Together Directors of Finance have agreed the following set of over-arching principles that will help guide decision making and that provide a foundation for the assessment of financial issues, and when proposing actions to manage the associated risks and opportunities;

- We will act in the best interests of our patients and population; and will create financial flows and incentives to promote this

- Our decisions will be based on the costs and benefits at a system level; and we will resolve the impact of that for organisations
- We will maximise new & existing resources into our system
- We will minimise the flow of resources out of our system
- We will cease activities that shift only financial problems between organisations within the system
- We will minimise the cost of growth and other new activities
- We will commit system resources to our highest system priorities (funding, people etc…)
- We will be open and transparent regarding our financial risk & opportunities
- The system will review and agree the growth levels across the system
- We will strive to be the best finance function to support our system priorities

b) A focus on 'Value'

1.6 To Healthier Together Partner organisations, Value Based Health and Care (VBHC) is an approach to meeting the aims of Population Health – improving physical and mental health outcomes, promoting wellbeing and reduce health inequalities for our whole population – through a focus on outcomes and experience that matter to people and making best use of resources. VBHC has three major goals:

- Allocating resources efficiently across our system so that we achieve the overall best possible outcomes
- Identifying and improving the outcomes and experience that matter to people
- Commissioning and delivering effective services that avoiding overuse of low value interventions (unwanted or not cost-effective) and underuse of high value interventions (deemed cost-effective, but not taken up by those who would benefit)

1.7 Professor Michael Porter and colleagues have defined Value for individuals using the following equation, but the concept of Value can also be applied to pathways, services and systems.

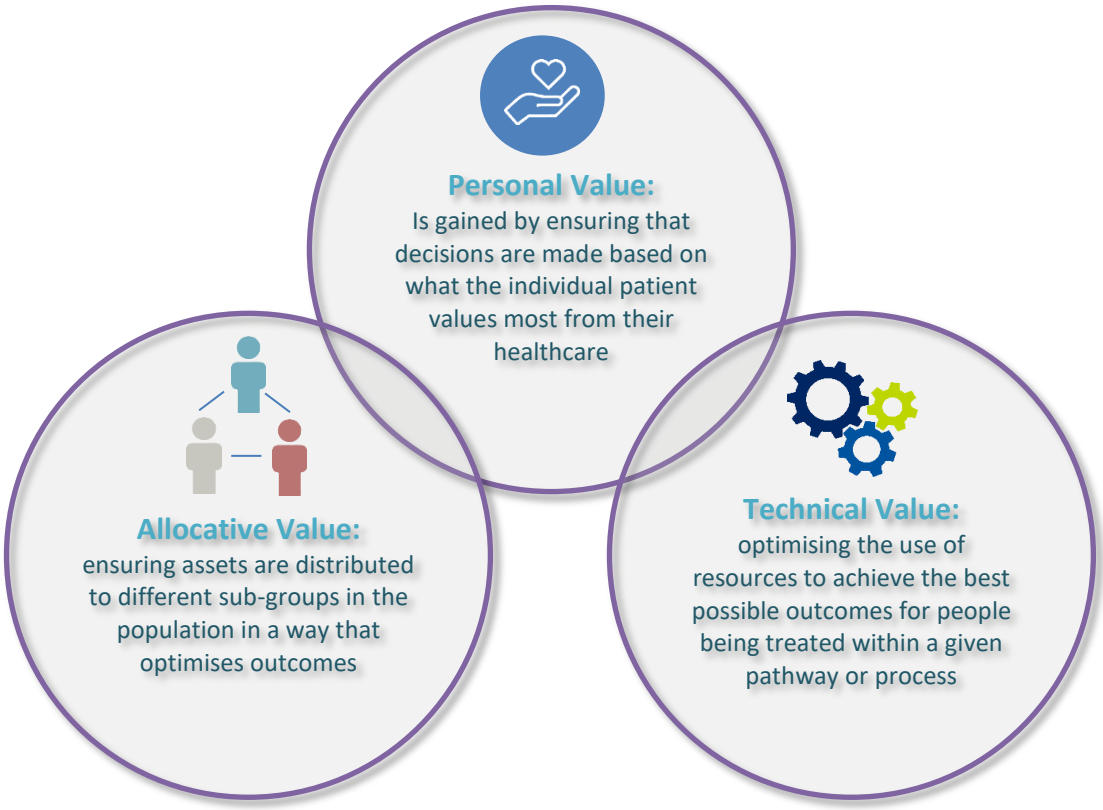
$$\text{Value} = \frac{\text{The set of outcomes that matter for the condition}}{\text{The total costs of delivering these outcomes over the full care cycle}}$$

1.8 Sir Muir Gray's "triple value healthcare model" which has been implemented in the NHS England RightCare programme to face the challenges of sustainability, equity and innovation in universal healthcare systems, addresses value in the three following levels:

- Personal Value
- Allocative Value
- Technical Value

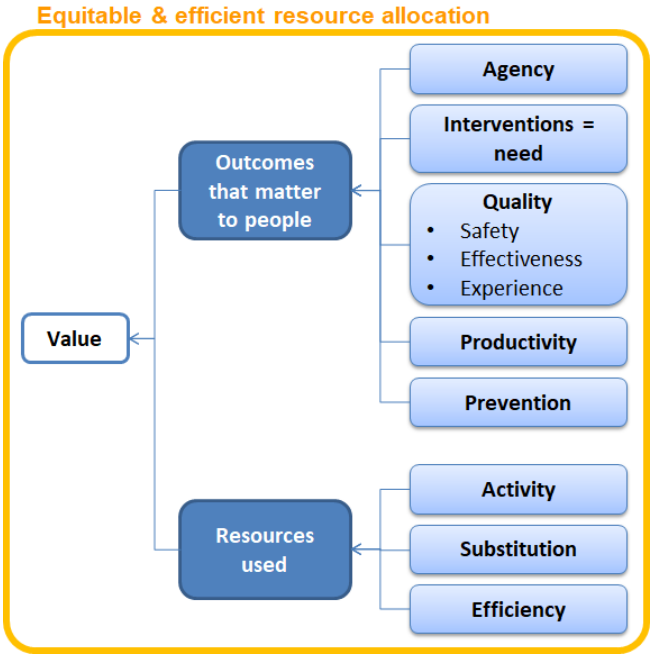
c) Triple Value Healthcare Model:

Figure 1: Triple Value Model



1.9 It is the system aspiration to use Value Based Health and Care to be the primary method by which we prioritise resources to improve population health and healthcare. When using the Value Based Health and Care framework it is important to recognise that other drivers and factors may need to be considered when making a decision to allocate resources, for example, reducing heath inequalities, meeting NHS performance targets & objectives, meeting CQC improvement objectives, managing within a fixed budget. Careful consideration needs to be taken at the outset about how to factor these other variables into decision making processes.

Figure 2: BNSSG Value Improvement Framework



2. Understanding the cost of health & care services to enable value based decisions

2.1 Partners are committed to using linked data to understand costs and demand pressures as a system, rather than as a number of discrete organisations, and using a Population Health Management (PHM) approach to develop an understanding of system cost across clinical pathways to identify system wide productivity opportunities, and enable better decision making.

2.2 The Population Health Management Finance Group will lead on developing a consistent, transparent approach to coding, counting and costing activity, allowing costing information to be analysed alongside data on needs and outcomes, to support continuous improvements in efficiency and the effectiveness of resource utilisation.

3. Process for revenue & capital resource allocation

a) Developing a Resource Allocation Framework

Aims

- To describe an evidence-based methodology to enable collective resource decisions by the Healthier Together Partners.
- The resource allocation framework needs to support delivery of the vision and goals of our ICS as described in the Outcomes Framework.
- The resource allocation framework should transparently support the delivery of improved value for the people of BNSSG. It will also need to take into account national priorities and fulfil any agreed conditions placed on particular funds e.g. Service Development Funding.

b) Resource Allocation Principles

- We have to live within the resources allocated for the population of BNSSG and the wider population we serve
- We will maximise new & existing resources into our system acting as advocates for our population
- We will minimise the flow of resources out of our system
- We will minimise the cost of growth and other new activities
- We have to plan to achieve the national rules as set out in the operational planning guidance e.g. Mental Health Investment standard
- We need to identify and allow for recognised system pre-commitments e.g. stroke business case
- We will use existing Governance structures to support decision making
- Resource allocation will be a function of the ICS but will be guided by Integrated Care Partnership (ICP) leaders.
- Revenue and capital resource will be seen as linked, not separate.
- Resource allocation will seek to reduce identified risks
- We will recognise the fixed costs in the system

c) Allocation of Service Development Funding (SDF)

3.1 The Partners intend that any transformation funds made available to the Partnership will be delegated to Healthier Together Steering Groups. Funds will be allocated based on alignment to national priority areas.

3.2 In 2020/21, the system has had confirmation of a total SDF allocation (H1) of £15.3m, with a further indicative allocation in H2 of £13.6m (£29.4m total). Funding has been delegated to Healthier Together steering groups as set out in the table below:

Healthier Together Steering Group	Confirmed Allocation Q1	Confirmed AllocationQ2	Conditional AllocationQ2	H1 Allocation	H2 Indicative Allocation	Total H1 & H2 SDF 2021/22
HT Executive	£115			£115	£115	£229
Acute Care Collaboration	£4,029			£4,029	£4,029	£8,057
Integrated Care	£2,983	£2,021	£324	£5,328	£3,348	£8,675
Urgent Care	£141			£141	£0	£141
MH, LD and Autism	£5,225			£5,225	£5,655	£11,310
Children & Families	£467			£467	£467	£933
Total	**£12,959**	**£2,021**	**£324**	**£15,304**	**£13,612**	**£29,346**

d) Allocation of ICS Capital

Gross capital expenditure	**AWP**	**NBT**	**UHBW**	**System**

Property, land and buildings	£2,260	£10,067	£64,861	£77,188
Plant and equipment	£100	£6,100	£12,976	£19,176
IT	£500	£5,492	£6,906	£12,898
Other	£3,540	£0	£0	£3,540
Gross capital expenditure	**£6,400**	**£21,659**	**£84,743**	**£112,802**
Disposals/other deductions	£0		£0	£0
Charge after additions/deductions	**£6,400**	**£21,659**	**£84,743**	**£112,802**
Less donations and grants	£0	-£600	-£18,057	-£18,657
Less PFI capital (IFRIC12)	-£921	-£567	£0	-£1,488
Plus PFI residual interest	£820	£9,240	£0	£10,060
Purchase of financial assets	£0	£0	£0	£0
Sale of financial assets	£0	£0	£0	£0
Prior period adjustments (PPAs)	£0	£0	£0	£0
Total Planned Capital Expenditure	**£6,299**	**£29,732**	**£66,686**	**£102,717**

Funding sources				
Self-Financed - Depreciation less PFI/Finance Lease payments	£3,802	£18,341	£32,042	£54,185
Self-Financed - other internal capital cash	£0	-£825	£27,436	£26,611
Capital loan repayments (net of Capital Refinancing PDC)	£0	£0	-£5,834	-£5,834
Sub total: Net Internal Sources	**£3,802**	**£17,516**	**£53,644**	**£74,962**
Interim Support Capital PDC - To Be Approved	£0	£2,592	£2,500	£5,092
Sub total: Loan Sources	**£0**	**£2,592**	**£2,500**	**£5,092**
Diagnostics (National)	£0	£384	£649	£1,033
Sub total: Total National Sources	**£0**	**£384**	**£649**	**£1,033**
Total Charge against Capital Allocation	**£3,802**	**£20,492**	**£56,793**	**£81,087**
Provider Digitisation - (HSLI) Health System Led Investment	£0	£0	£2,500	£2,500
STP Wave 3	£1,677	£0	£0	£1,677
Urgent & Emergency Care Capital	£0	£0	£7,393	£7,393
Residual Interest	£820	£9,240	£0	£10,060
Total Funding Sources	**£6,299**	**£29,732**	**£66,686**	**£102,717**

4. Approach to joint financial planning

4.1 Clarity of underlying position. Due to the interim national finance regime, the underlying positon of organisations (and in some cases, associated financial recovery) is no longer clear, and we will undertake and share analysis to establish the level of financial challenge faced by the system in returning to system financial improvement trajectories set out in the Long-Term Plan.

4.2 Subject to compliance with confidentiality and legal requirements around competition, sensitive information and information security, the Partners agree to adopt an open-book approach to financial planning and identification of financial risk, leading to the agreement of fully aligned operational plans.

4.3 Partners will be convened at the outset of all planning processes to ensure triangulated plans covering revenue, capital, activity and workforce are underpinned by common financial planning assumptions on inflation, growth, income and expenditure between providers and commissioners (including NHS England Specialist & Direct Commissioning), and on other issues that have a material impact on the availability of system financial incentives (e.g. Financial Recovery Funds).

4.4 NHS Partner Plans will be peer reviewed to ensure consistent assumptions and interpretation of financial policies and guidance which affect all partner organisations, for example, impact of national pay award funding.

4.5 The approach to planning will identify an overall system wide efficiency target for the system, and partners will work together to identify an appropriate balance of collaborative efficiency schemes and individual plans.

4.6 Responsibility for consolidating organisational plans will be led by the Healthier Together Finance lead, co-ordinated through the Healthier Together Deputy Directors of Finance Group to ensure system-level impact is understood. This will include a consolidated schedule of financial risk and mitigations.

5. Management of risk

5.1 Healthier Together Partners are committed to a shared approach to managing all risks (strategic, clinical, financial, and operational), taking collective responsibility for driving necessary change while mitigating the risks of those changes for individual organisations and the people we serve. This includes:

- Honest identification and sharing of risks
- Maintaining a system-wide risk register to consistently track system risks and document mitigation plans
- Clear ownership of the risk and expected mitigations
- Clear escalation procedures for when a risk starts crystallising
- Explicit discussion about financial risk appetite to determine the level of contingency to be held across the system
- Shift toward a collective focus on how system risks will be mitigated by the system, and each organisation's role in supporting this

5.2 Our system approach to risk management recognises that there will still be a need for constituent organisations to manage organisational risk. Where appropriate, we will strive for consistency of risk management coordination across organisations to allow more seamless risk management coordination across the Partnership.

6. Contracting principles & payment mechanisms

6.1 The NHS Long Term Plan outlines a commitment for payment reform, with a focus on blended payments. NHS Partners are committed to considering the adoption of payment models which are better suited to whole system collaborative working (such as Aligned Incentive Contracting), and help support delivery of system wide objectives.

6.2 The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs, provide shared incentives for reducing avoidable or low value activity and redirecting resources to higher value interventions, properly reimbursing these, and seek to reduce unnecessary transactions and free up administrative resource.

6.3 Adoption of new contract models can see risk transfer between organisations, and therefore the transition to adoption of new contracting models will ensure this is well understood, and managed in a way to ensure there is no destabilisation of system Partners, and that no individual organisations financial sustainability is compromised.

6.4 Contracts within the system will include some of the same, or similar, objectives in order to promote a culture of collaboration that enables all organisations to meet their targets, whilst promoting the ICS vision and objectives.

6.5 Our approach is based on the following principles:

- A movement away from annual contracting rounds based on 'current income plus growth', towards a more developed form of blended payment across the whole system
- Fixed elements set based on improved cost data (see Section 4) and more accurate activity forecasts aligned to plans
- Variable elements set based on understanding of costs of activity above/below plan
- All services are funded at the level of efficient cost
- A proportion of payment will be linked to patient / population outcomes
- A reduction in unnecessary transactions, to ensure efficient use of finance team resources, and a reduce transaction costs

7. Finance Staff Training & Development

7.1 The ways of working in this financial framework represent a significant shift in thinking from the previous ways of working that many of our staff have grown accustomed to. This requires a shift of mind-set and some focussed development to ensure staff have the necessary skills to support the transformation that we need to deliver in the system.
Currently we are undertaking some baselining work to understand:

- Current finance staff development activity in place across the system.

- Approaches to professional development
- Approaches to apprenticeships

7.2 Once we have an understanding of the baseline position we will be getting to an aligned position across the system and opening up finance training opportunities to all in the system not just within organisations. We will then scope further the different skills that are needed for the finance staff of the future taking the opportunity to drive innovation in current practice to modernise approaches to reporting to free up time that can be spent on supporting clinical services to develop.

7.3 We expect this to be through an increased focus on costing to support the value agenda and business case development to enable new pathways to be described taking a population health management approach. Much of these new skills require excellent people skills, managing relationships with different professional groups, being able to challenge in an effective manner. This will be a focus of our skills development going forward.

7.4 We recognise we have more to do to make NHS finance in BNSSG more representative of the population we serve and we will be looking to build into our approach to recruitment and training a focus that allows this to be addressed.

7.5 The finance staff development leads are coming together to carry out this initial piece of work with the DOF group with the expectation that a BNSSG finance conference will be held in Autumn 2021 to kick start this work.

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

FINANCIAL FRAMEWORK APPENDIX 1 – Applicability of Financial Framework Elements

	BNSSG Clinical Commissioning Group (CCG)	North Bristol NHS Trust	University Hospitals Bristol and Weston NHS Foundation Trust	Avon and Wiltshire Mental Health Partnership NHS Trust	Sirona Care & Health	Bristol City Council	North Somerset Council	South Gloucestershire Council	South Western Ambulance Service NHS Foundation Trust	One Care
1) Overview & Purpose	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
- Healthier Together Joint Financial Principles	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
- Focus on Value	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2) Understanding the cost of health & care services to enable value based decisions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3) Process for revenue & capital resource allocation	☐	☐	☐	☐	☐					
4) Approach to joint financial planning	☐	☐	☐	☐	☐	☐ (partial)	☐ (partial)	☐ (partial)		
5) Management of risk	☐	☐	☐	☐						
6) Contracting principles & payment mechanisms	☐	☐	☐	☐						
7) System reporting, financial management & control mechanisms	☐	☐	☐	☐	☐	☐	☐	☐		
8) Finance staff training & development	☐	☐	☐	☐	☐	☐	☐	☐		

Annex 8 – ICS Communications and Engagement Framework

1. Purpose

The purpose of this framework is to formalise the Healthier Together Partnership's approach to delivering communications and engagement activity for the benefit of the population of BNSSG as we move towards statutory Integrated Care System (ICS) status.

2. Principles

Five principles underpin the way we work and will continue to work together, as set out below. These further build on and complement the core principles set out in the ICS Memorandum of Understanding (MOU), which are: *Individuals at the Centre, Subsidiarity, Collaboration, Mutual accountability and equality, and Transparency.*

These principles have been shaped by the whole-system Strategic Communications Group (SCG) which includes representation from every Healthier Together partner organisation. A similarly networked approach will be taken to Insights and Public Engagement, ensuring that we make best use of our collective strengths, expertise and experience at system-level in pursuit of our strategic goals.

Alongside each principle is an exposition of how we intend to live up to it, with 20 key points forming the basis of our approach to transition and ICS from April 2022. This includes both work currently in train and that yet to commence. We start from the clear position that Healthier Together Partner organisation communications and engagement teams will be retained, and that there is a strong appetite among communications teams and the Healthier Together leadership to further progress our collaboration for the benefit of the people we serve.

1. Our approach will be evolutionary and 'lock-in' ways of working success	1. **Flexibility and agility have been hallmarks of our joint work to date**, and this feature will be retained as we progress our collaboration toward and beyond statutory ICS status. The SCG will continue to work together to ensure clarity and consistency of message at ICS (1) level, and the ability to flex resource in response to need. 2. **Due to the dynamic and variable nature of the communications and engagement landscape,** we will continue to ensure regular touchpoints for key groups (e.g. 3x a week tactical calls, 2x a week strategic calls plus ad-hoc and project-specific approaches); as well as strategic relationship management with NHS England and Improvement. This approach is designed to ensure comprehensive yet agile oversight. 3. **The success of the Communications Delivery Unit (CDU) model,** highlighted as an exemplar in ICS communications practice, will be further built on to encompass whole-system implementation sub-groups for key strands of communications and engagement delivery, including restoration of services. The CDU's work will be guided by the SCG.

	4. **A whole-system approach to strategic communications** will be further embedded with the establishment of a Healthier Together planning tool and grid which will allow executive and programme team oversight of activity and priorities. Clear Terms of Reference (ToR) and a protocol for issues, crisis and reputation management will be developed, building on established processes and recent case examples of successful and integrated handling (e.g. Weston Hospital closure, led by UHBW comms and with wraparound system support including stakeholder cascade). 5. **The SCG approach will be replicated in Insights and Engagement** to secure an equivalent forum for whole-system and aligned leadership among practitioners. This group will be the driving force behind the spread of people-centred design and a co-production ethos across our system. The establishment and sustainability of this forum is a priority for development. 6. **Further mapping will be undertaken during this transition year** to better understand Healthier Together Partner organisation capacity, areas of duplication, and shared systems and processes**.** This will provide a baseline and pointers for further evolutionary change which can increase our collective impact and effectiveness – for example, adopting a single ICS (1) approach to procurement of media monitoring services or graphic design. This is a forerunner to broader strategy development (see point 13).
2. People and their experiences are our core purpose, our most compelling story and our strongest offer to the wider system	7. **We will prioritise the embedding of a people-centred design approach,** including working with the Design Council and emerging Integrated Care Partnerships (ICPs) (6) to ensure that service design starts and ends with what matters most to people. We will capture and share examples, accelerating the spread of improvement within our own system and more widely; and, working with other teams, evolve mechanisms to embed experience and insights measures in the evaluation of effective integration. We will create a People and Communities Charter which will detail how we collect and undertake community insight, engagement, and co-production and how we will ensure we engage with hard to reach and marginalised groups. 8. **A system-wide intelligence dashboard will be created**, harnessing our existing citizen insight and experience sources, and complementing the PHM linked dataset. This will enable a more holistic understanding of experience and the generation of actionable insight to add value at all levels of decision-making (1, 3, 6). 9. **Building on our work through the pandemic, we will centre storytelling approaches in our public communications,** creating engaging content with and for our diverse communities, humanising the transformation of health and care, and facilitating positive behaviour change. This accelerates the approaches taken to both the 2020 system flu campaign and Covid-19 vaccination, where use of insight and co-production of content have been significant factors in success. 10**. It's important that the wider system understands what strategic communications and engagement can do for them** (and just as importantly, what it can't). Through transition, we will develop a

	toolkit for system teams, steering groups etc. setting out our offer and approach, signposting to support and highlighting clear routes for contact and escalation of issues. This will support effective horizon scanning and issues management by the SCG.
3. Our activity will increasingly meet three conditions: strategically aligned, driven by insight and underpinned by evaluation	11. **The SCG is identifying opportunities to prioritise communications activity** that will achieve the greatest population impacts in line with system 5 Year Plan goals (a value-based approach). These opportunities, and the ability to respond to them, are likely to increase as our collaboration develops. We are putting a series of mechanisms in place to support this, including: • **Pursuing academic evaluation partners to support impact measurement and improved understanding of communications interventions.** This will allow us to optimise our approach to audience segmentation, message optimisation, A/B testing and citizen engagement; including the use of deliberative and creative approaches. • **Formalising SCG alignment to Healthier Together steering groups and the six ICPs,** with the relative value of each (in relation to our resourcing), being assessed and tested currently. • **Ensuring full SCG alignment to the development of the system shared insights and experience dashboard (point 8), which will allow us to respond in real-time to trends and issues.** While the dashboard will meet a wider system need, it will be imperative to ensure an integrated communications route for understanding signals in the data and using this to refine activity and priorities. 12. **Taking these steps will leave us better positioned to make a significant impact on the health inequalities agenda**; improving population health literacy, championing and elevating community voices, building trust among marginalised groups, breaking down barriers to access and ensuring that citizen voice and experience informs everything we do. 13. **A co-created Communications and Engagement strategy** will be designed and agreed, detailing aims, objectives, audiences, activity and costs. This will include recommendations on our approach to brand and digital communications.
4. Subsidiarity is a critical lens we will apply to all priorities and projects	14. **As a group, we understand the wider system principle of subsidiarity** which holds that decisions taken closer to the communities they affect are likely to lead to better outcomes. While it is not yet clear or settled as to the optimal balance of communications and engagement resourcing required at each level (1, 3, 6) in order to drive effective change for our population, we will be applying this principle as a critical lens through transition to help reach a view. 15. **Work is currently underway to establish a communications and engagement plan to support Integrated Care Partnership development**, including potential alignment or embedding of some system communications professionals at ICP (6) level. This is further complemented by the people-centred design programme (point 7). Ensuring that a 'golden thread' of communications and engagement

	good practice runs through every level of the system is a priority for transition and next year, and scoping is currently being undertaken on specific requirements within General Practice. 16. **We will develop two small-scale test-and-learn approaches to behaviour change communications**, working with ICPs as pilot sites**.** These will build on learning garnered through our 111 First insights work, flu and Covid-19 vaccinations. We would like these to be the focus of the evaluation partnership (point 11).
5. Seamless communication fast-tracks trust, transformation and collaboration	17. **The new structures will necessitate a refresh of our system/internal and corporate communications.** Undertaking system-level stakeholder/audience mapping and ensuring that channels/updates are fit for the future is a key priority for pre-transition and as the new ICS structures bed in. 18. **Work is already underway to align strategic communications advice** and support to the system people and workforce group as a priority, recognising this as a critical area where effective communications can drive an impact – particularly in times of change. 19**. During transition, we will be further scoping the requirements for an internal/system communications approach to clinical leadership** (including Clinical Cabinet) and the spread of system learning, including that generated from serious incidents. 20. **Building on work undertaken throughout the pandemic, we will be making recommendations to the Healthier Together Executive Group on a refreshed system approach to political engagement.** This is likely to include more joint-briefings and improved corporate communication flows, particularly to Councillors.

3. Delivering the programme

To bring the framework to life, we will take a programme approach to delivery, which will encompass the following as overarching strands. The 20 points above all fit beneath one of these programme areas:

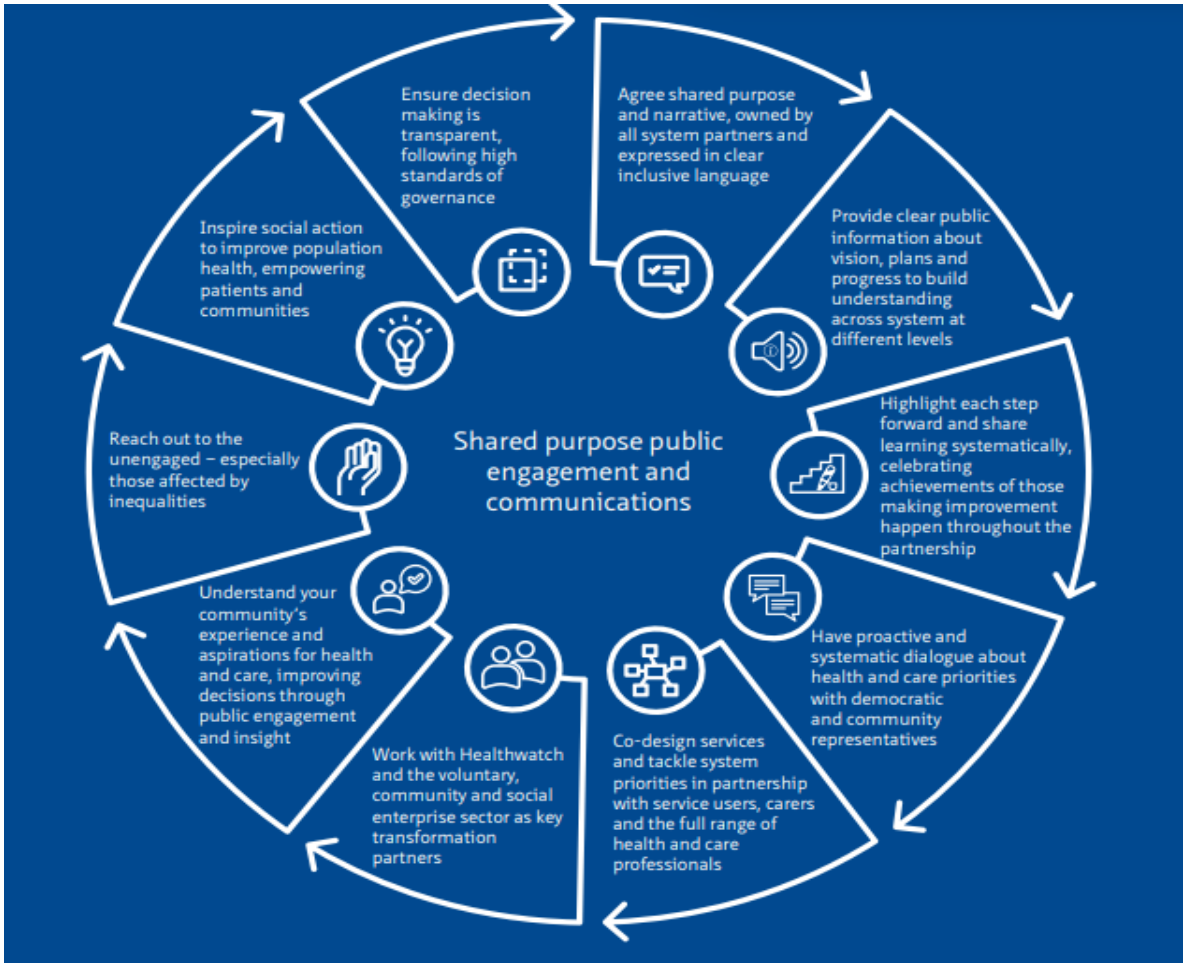
Project	**Timeline**
Corporate and system communications refresh	Q3 21/22
Political engagement strategy	Q3 21/22
Embedding People-Centred Design	Q4 21/22
Communications and Engagement strategy development	Q2 22/23
System-wide intelligence dashboard	22/23 TBC

Delivery is contingent on PMO support and budget, and the next step would be to develop and bring forward business cases that relate to the strands of activity.

4. Our approach to forward planning, assessing progress and managing risk

We are testing the appetite for quarterly forward planning and progress assessment cycles for the SCG, to be undertaken in the form of practical half-day workshops (similar to those used to design and agree this framework). These must remain purposeful, timely and high-value (reflecting principle 1, point 1).

The SCG will be in a position to report our progress against the relevant ICS strategic goals from April 2022, and outline system communications risks and mitigations. We are currently using the NHS Confederation's Common Purpose wheel to assess our maturity and guide development. This is copied below.



Annex 9 – ICS Organisational Development Plan

Contents

1. What OD is, and why it matters

Organisational development is a planned, comprehensive and systematic process for applying behavioural principles and practices to increase individual, organisational and system effectiveness, creating the conditions and culture to enable people to perform at their best. CIPD www.cipd.co.uk

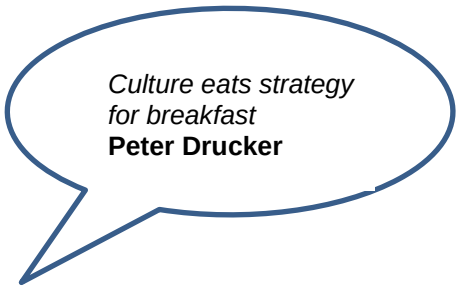
The conditions and culture our leaders create can help or hinder the achievement of our system goals. Failure to address cultural issues, particularly at times of significant change, can result in low morale, poor working relationships, inability to meet targets, absenteeism or high staff turnover.

Integration and innovation: working together to improve health and social care for all sets out an ambitious vision for system change, which will impact on every team in BNSSG, and it has never been more important to pay attention to our people and culture. This OD plan is intended to help our ICS to achieve our vision, mission and goals, and will support the delivery of our MOU. It is intended to build on the great work already achieved within BNSSG through the People Programme.

In order to make our ICS successful, and to deliver on our MOU, we need to pay attention to our culture. This means we need to ensure that we understand what our desired end states are in terms of culture and leadership. We will draw on the Johnson and Scholes OD Model, and use OD tools to undertake a gap analysis.

Our MOU sets out five principles:

- **Individuals @ Centre**
- **Subsidiarity**
- **Collaboration**
- **Mutual Accountability & Equality**
- **Transparency**



As the quote from Peter Drucker explains, a powerful and empowering culture is an important part of delivering on strategic success.

2. Links with the People Programme and the ICP OD Plan

This work is not a separate entity but is fully integrated into our System People Plan.

The focus of the **People Programme** is in attracting, retaining, developing and supporting our staff, establishing common systems, terms and conditions and sharing resources. The **OD Framework and Plan** is primarily about culture and leadership, and how we support the transition to a legal ICS. The People Programme is delivered by and through the People Steering Group, but the culture and leadership changes need to be delivered through and by the Senior Leadership of the Integrated Care System. These both also link with the **ICP OD**, and their joint endeavour should help create and promote total inclusivity, be a powerful common thread to promote improved equality and diversity within our health economy and community, connected through the common thread of equality and diversity.

3. Organisational Development Framework

The core of our OD Framework and Plan has three components:

1. **Culture, Identity and Belonging**
2. **Systems Leadership**
3. **ICS Transition**

For each of these three areas, in the following section, we have identified where we would want to be, the actions required, and how we will measure our success.

3.1 Culture, Identity and Belonging

One of the key goals in organisational development…..has been to find a way of creating cultures that are flexible and innovative and where individuals take responsibility for results – moving away from bureaucratic silos where formulaic approaches dominate.
www.managementcentre.co.uk

Where we are:

- Our partner organisations each have their own cultures and subcultures, and whilst we have established a track record in some areas for collaborative working, we have a significant journey for staff to also have a sense of belonging and identity in relation to our ICS. Many of our new models of care will require different staff from different teams to work together and organisational identity can be a barrier to

people working effectively together. We need to break down these organisational barriers.

Where we want to be:

- Our culture places **individuals at the heart**, recognising the **power of collaboration**, as we work together, as **one health and care system**
- We have an **outward mindset, focussed** on collective results, enabling us to have difficult conversations about resource allocation, and allowing us to see new possibilities for solutions.
- Our enabling culture will give our talented, dedicated workforce permission to be creative and innovative.
- We have a culture where we can work together and learn together across sectors and teams.
- Our overarching shared passion and compassion for delivering excellent patient centred care is in the very core of our collective DNA.

What we will do:

- **Improve the experience of working and living** in the health and care system and create and support a sense of **belonging and identity** for the whole ICS workforce
- Develop a system approach to **listen, hear, respect and act upon** the lived experience of staff and patients to improve health inequalities
- Establish a culture through our Learning Academy where **learning and continuing development** of all staff across the system is actively encouraged, and barriers are identified and removed
- As part of our diagnosis phase, we will undertake a **cultural audit** so that we understand the gap between the culture we have and what we aspire to, including feedback from staff and our leaders, and an analysis of the things we value and reward as a system, and where key barriers are, so we can address them together.
- Deliver a community focussed Equality, Diversity and Inclusion (EDI) Strategy promoting inclusivity across all inputs and outputs

Measured by:

- Staff engagement scores, pulse survey data, reduced leaver rates, exit data, reduced sickness absence, evaluation from our OD programme, diversity

3.2 Systems Leadership

Where we are:

- We have delivered some successful systems leadership programmes, such as Peloton and Arbinger
- However, we need to maximise our impact, address the lack of diversity among our leaders evidenced through our WRES data and support our leaders through the new and significantly different challenges to lead through the transition during 2021/22.

Where we want to be:

- **Collaboration and systems leadership** underpin our ways of working and leaders **listen to staff** and find ways to involve them in decision making

- Leaders are **clear on how they need to behave** to perform effectively and deliver our system vision
- Our future leaders are able to **grow talent, coach and lead** across diverse, cross organisational, multi professional teams and we have a diverse pipeline of future leaders
- Leaders ensure that their organisations **leverage their role as anchor institutions** to promote local social and economic growth in the wider community, address inequalities at the heart of poor health and improve health outcomes for the population.

What we will do:

- Ensure leadership standards are **embedded in place-based practices**: recruitment, performance, appraisal, conduct and development
- Hold senior leaders to account for the delivery of the **People Promise**
- Find new and more cost-effective approaches to **maximise the benefits** of our investments in our Peloton and Arbinger systems leadership programmes for example, Train the Trainer, and building alumni task forces
- Build the **"Outward" mindset** across our leaders and teams, utilising an agreed model and framework for maximum impact.
- Use Peloton Alumni to work on working groups to achieve ICS goals

Measured by:

- Significant numbers of managers trained and working differently as a result, sustainable and consistent leadership development, diverse talent pipelines established, leaders more representative of the communities they serve, extent to which our ICS MOU principles are being delivered, positive employee engagement scores.

3.3 ICS Transition

Where we are:

2020/21 is a key transitional year, with changes and challenges ahead which include:

- Implementation of new partnership governance
- New approaches to subsidiarity including the establishment of Provider Collaboratives, ICPs and a new, legally constituted ICS
- The transfer of CCG functions and staff to different organisations, working in different ways

Where we want to be:

- New governance structures are established, and there is clarity about the respective roles and functions of organisation, place and ICS
- CCG transition has taken place in line with system wide agreed approaches with transparent and equitable processes, and staff feel engaged and well supported

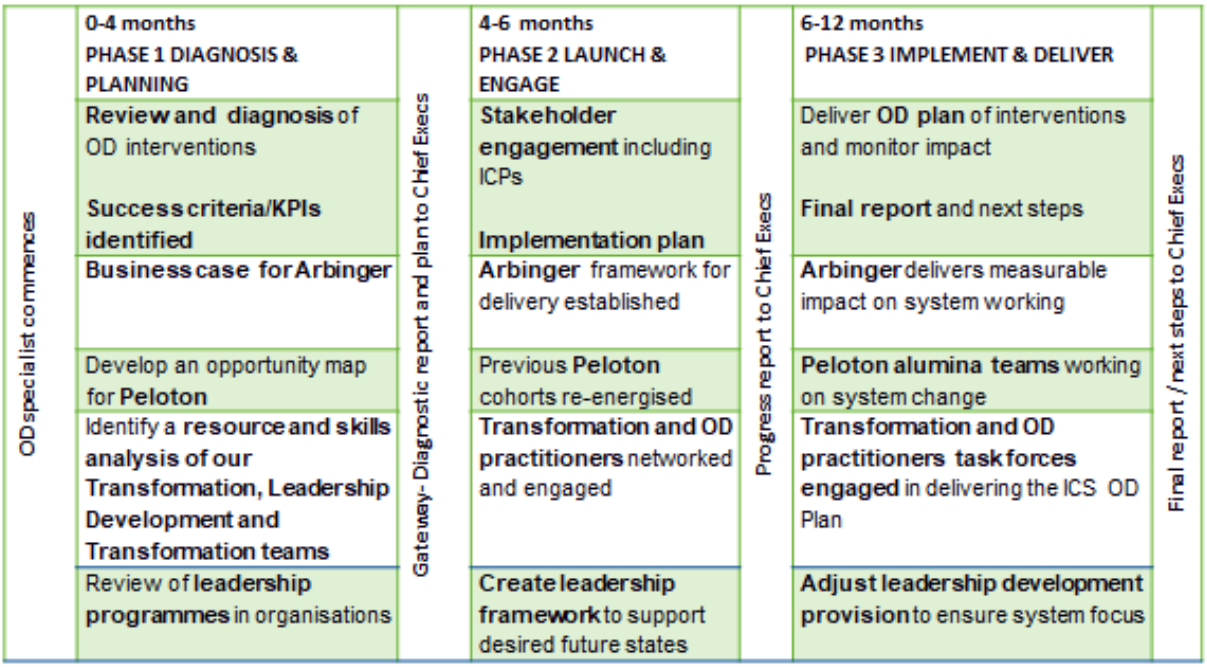
What we will do:

- Ensure that the agreed approaches to governance are reflected in, and supported by our system wide OD plan
- Offer advice and guidance on system wide approaches to managing workforce change in the context of national guidance and local organisational policies and systems

Measured by:

- Retention in the system of skilled, staff currently working in the CCG, Equality Impact Assessment showing positive impact on diversity, staff feedback and engagement scores, flourishing ICS and delivering on our MOU and supporting frameworks

4. Implementation Plan



4.1 Phase 1: Diagnosis and gap analysis

Objective: To identify and articulate what we need to improve in order to achieve our desired future culture, leadership and behaviours, through a robust analysis process, using evidence-based tools

Our Diagnosis process will include the following three steps:

- **Step 1**: Identify our desired future end states as an ICS, linked to the principles in our MOU, our Vision, Mission and Purpose, and the *NHSI/E 9 outcomes-focussed people functions*
- **Step 2:** Using evidence based diagnostic tools such as the *Johnson and Scholes Cultural Web and Birke Litwin model (see appendix),* analyse the gap between our desired future states and the current position
- **Step 3**: Develop plans to address areas of weakness and identify metrics such as staff survey feedback, pulse surveys, leaver/ recruitment data, sickness absence, diversity data to act as a baseline and to monitor our progress. A business case and dissemination approach to deliver an "outward mindset" will be developed as part of this phase including a "train the trainer" model.

4.2 Phase 2 - Engagement

Objective: To engage with stakeholders to foster commitment to our OD plan and create networks to deliver, thereby maximising our leverage and impact

This phase will be focussed on building, engaging and motivating networks and stakeholders which will include:

- **3 cohorts of Peloton**
  - **Step 1**: alumina event to re-energise, re-connect and refresh tools
  - **Step 2:** task and finish groups on relevant, common system transformation priorities or issues– these tasks will be assigned by a "Think Tank"

- **OD, Leadership Development and Transformation practitioners**
  - **Step 1:** mapping of practitioners – skills, remit and opportunity
  - **Step 2:** system event and harnessing to refocus on the system OD plan
  - **Step 3:** using existing organisational programmes to deliver an Outward mind-set/collaborative working

- **ICP stakeholders**
  Continue to support and offer advice to ensure consistency, enabling collaboration and not competition for scarce skills, and working in partnership with shadow ICPs to enable consistency of approaches to OD across the ICS and ICP stakeholders.

4.3 Phase 3: Implementation

Objective: To implement our OD plan, designed to address the key areas identified in our diagnostic phase, using collaborative resources across our teams, harnessed through our engagement phase

Actions to implement our OD plan will be identified as part of the diagnosis but may include:

1. **Culture, Identity and Belonging**
   - Utilising OD/Transformation networks and "**Task forces" to expedite system change** and build and embed a new cultural identity for the ICS
   - **Building the "Outward" mindset** across our leaders and teams, utilising an agreed model and framework for maximum impact
   - **Work with the People Programme to revise the Workforce Strategy** to support the *NHSI/E 9 outcomes-focussed people functions* to align our People Operating Model with the needs of our ICS

2. **System Leadership**
   - **Maximising the benefits of our previous investments in Peloton,** releasing future benefits through multi-organisational groups working together to achieve system transformation
   - **Ensuring our approach to leadership development and our talent pipeline** enables greater diversity of future leaders

3. **ICS Transition**
   - **Supporting our ICS transition,** enabling people across teams and organisations to work together in new and different ways

- **Providing advice and support on ICS and ICP transition** to align with cross organisational processes
- **Support CCG and system transition to** ensure alignment with agreed system wide processes

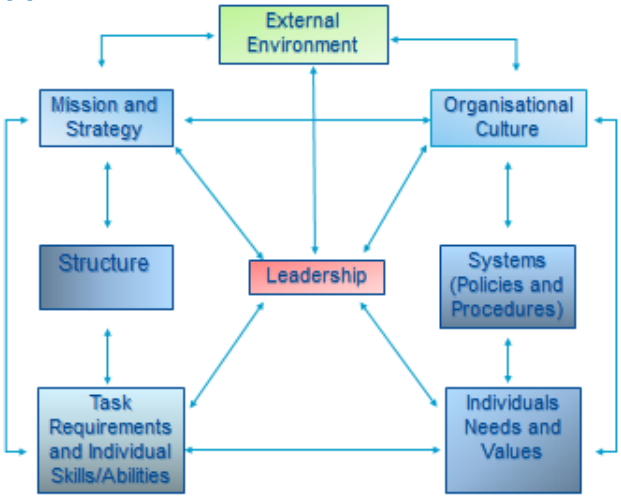
OD PLAN APPENDIX 1: *OD Models to underpin our OD Plan*

Appendix 1.1 Johnson and Scholes Cultural Web

Gerry Johnson and Kevan Scholes, 1992

- **Stories** – The stories we tell provide an insight into what we value and what we regard as great behaviour.
- **Rituals and Routines** – The daily behaviour and actions of people that signal acceptable behaviour. This determines what is expected to happen in given situations, and what is valued.
- **Symbols** – The visual representations including logos, our paperwork and where we have our meetings.
- **Organizational Structure** – This includes both the formal structure and the unwritten lines of power and influence that indicate whose contributions are most valued.
- **Control Systems** – These include financial systems, quality systems, and rewards (including the way they are measured and distributed within the system).
- **Power Structures** – The pockets of real power may involve one or two key senior executives or a whole group of executives. The key is that these people have the greatest amount of influence on decisions, operations, and strategic direction.

Appendix 1.2 Burke Litwin OD Model



Annex 10 – ICS Clinical and Care Professional Leadership Principles

1. Introduction and background

1.1. Clinical and care professional leaders play a key role within our ICS in improving outcomes for the people of BNSSG and delivering consistent clinical and care standards. To achieve our vision, we must cultivate such leadership across the system, and develop a culture that actively encourages clinical and care professional leaders to thrive and lead patient and population focussed change.

1.2. Clinical and care professionals reflect a rich diversity of professions across the partnership, including health, social care, and the VCSE sectors. Clinical and care professional leaders are distributed across every organisation and level of the system, from directors of medicine, nursing, and social care to front-line staff that interact with people in the community.

1.3. Clinical and care professionals play a central role in setting and implementing ICS strategy. We shape and make system decisions together, alongside colleagues in leadership, operations, and finance.

2. Clinical and care professional leadership principles

2.1. To enabling a thriving integrated care system for the people we serve, clinical and care professionals are committed to working together and abiding by the following principles:

How we work together across our ICS	1. We **engage, listen to, and consider the impact and experience of the people we serve and those who work in our services**; we communicate with the public with credibility and authenticity 2. We actively shift the thinking upstream to focus on **prevention, earlier intervention, and the reduction of health inequalities** 3. We **prioritise investments based on value,** ensuring equitable and efficient stewardship of system resources, and we take shared ownership in driving this 4. We act on insights from **pooled information and intelligence to reduce unwarranted variation and improve standards** 5. We are committed to working together as an **equal partnership**
Our culture and role as clinical and care professionals in the ICS	6. Across the system, we **do the right thing for the patients we serve**, even when it is challenging for us or our individual organisations 7. We **continuously improve –** we will try things together, learn, evaluate, and make changes to improve; we are actively promote evidence-informed innovation and learning across the system 8. We work in partnership with system executives and managers to drive clear and **transparent decision-making** 9. We actively shape the agenda of the ICS; **we understand how to engage to drive change and our role in it** 10. We engage in honest, respectful, and open dialogue amongst clinical and care professional leaders, and we strive to build

	confidence that we can **trust** one another's patient assessments and recommendations 11. We identify and develop clinical and care professionals at all levels in an **inclusive manner**
How we manage quality and risk	12. We are **committed to quality improvement** across all clinical and care professionals, and we embed this across the system (e.g., performance) 13. We manage quality at the right level (e.g., neighbourhood, place, provider collaboratives, system) to improve the health and wellbeing of the local population, following the principle of **subsidiarity** and acknowledging one-another's statutory responsibilities 14. We **collectively own, share and take accountability for managing risks**, particularly when serious quality issues arise 15. We **establish a just safety and learning culture**, enabling system-wide learning from serious incident, never events, and safeguarding issues

3. Taking this forward together

We are committed to ongoing improvements to our clinical and care professional leadership as we develop as an ICS. We will build on our system-wide working relationships and evolve our current working arrangements based on input from across our system and through peer review from clinical and care professional colleagues from other ICSs.