



Perspectives

Effective Joint Governance

Within Clinical Commissioning Groups
and Joint Strategic Needs Assessments

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Moving from “we to us” and from “compliance to governance”

Commissioning in the NHS is weak, ineffective and passive, this according to the House of Commons Committee in March 2010, which concluded that commissioners have failed to bring about significant shifts in activity from the acute sector, made little progress in dampening demand and have not succeeded in redressing the imbalance of power between commissioners and providers.

This backdrop and the many billions that are sunk into the NHS every year has forced government to think radically about healthcare commissioning. The emergence of GP led consortia (Clinical Commissioning Groups – “CCGs”) that promise to redefine the link between state healthcare and patient choice and redress the power imbalance towards clinically led commissioning, is yet to be proved. Whether these will be more effective than previous incarnations of commissioning will depend on a multitude of factors, ranging from whether GPs will be equipped with the necessary skills to whether the various elements of the wider governance system operates as intended.

CCGs will be responsible for approximately 60% of the NHS spend from 2013 onwards. This is a significant responsibility for relatively new organisations and inexperienced leaders of what will be publicly accountable bodies. Good governance will need to be at the heart of CCGs.

By April 2011	<ul style="list-style-type: none"> ✓ <i>A wide spread of Pathfinders and connections with Early Implementers</i> ✓ <i>GP Consortia engagement in PCT Operational and Commissioning planning demonstrated</i>
20011/12	<ul style="list-style-type: none"> ✓ <i>Preparation of GP Consortia, ready for authorisation</i> ✓ <i>PCT Clusters and single executive teams in place by June 2011</i> ✓ <i>Development of Commissioning Support Units (CSUs)</i> ✓ <i>Arrangements agreed for Health and Wellbeing Boards by LAs and GPCs</i> ✓ <i>Agreement of plans for the public health transfer between LAs and PCTs</i>
2012/13	<ul style="list-style-type: none"> ✓ <i>GPCs start to be authorised and take on more delegated responsibilities</i> ✓ <i>GPCs decide whether to contract with CSUs or not</i> ✓ <i>Health and Wellbeing Boards operating in shadow form</i> ✓ <i>HealthWatch arrangements funded by local authorities</i> ✓ <i>Public Health arrangements in shadow form, HR implications addressed</i>
April 2013	<ul style="list-style-type: none"> ✓ <i>PCTs abolished, accountability transfers to GPCs, LAs and NHS Commissioning Board (NHSCB)</i> ✓ <i>GPCs responsible for NHS Commissioning with some services commissioned nationally</i> ✓ <i>Commissioning Support Units become social enterprises/joint ventures</i> ✓ <i>Public Health becomes the responsibility of local authorities</i>



- ✓ *Local authorities commission NHS complaints advocacy*
- ✓ *Health and Wellbeing Boards go live*

The experience from the authorisation process for foundation trusts has raised the awareness of good governance within the NHS. Good Joint Governance will need to be at the heart of the relationship between CCGs, Local Authorities and Health and Wellbeing boards (HWB).

The underlying idea that commissioning must be driven by clinical assessment is self evident, however how this will translate at the macro level, where decisions need to be taken which encompass more than just the clinical assessment is unclear.

GPs appear to have acknowledged that they neither have the skills or the desire to manage the commissioning elements of healthcare. Most have spent their entire careers within the bureaucratic boundaries of the NHS, most have not had to worry about budgets and almost none have had to consider wider elements of governance. Difficult commissioning decisions could always be deflected towards the local PCT trust and NICE.

In this new environment, the GP Consortia need to engage the local population to assess and prioritise “needs”, work proactively with local authorities to deliver an integrated programme that attempts to address the underlying problems of healthcare (housing, diet, stress, environment etc), rebalance those resources and effort put towards prevention rather than just cure. All this must be done under the scrutiny of central government, local authorities, health watch dogs, local patients and sceptical politicians.

However, unless the root cause of ineffective commissioning is addressed, this new transformation may actually do more damage than good – to patients, to GPs and to the political masters pushing this new vision.

Poor Joint Governance and Relationship Management at the heart of poor commissioning

The Government’s ambitions for health and wellbeing envisage clinical commissioning groups (CCGs) and local authorities jointly leading the local health and care system, through Health and Wellbeing Boards (HWBs) and in collaboration with their communities. New relationships between councillors, directors of public health and clinicians will be absolutely vital to the success of the reforms.

In complex multi-party structures, one must recognise the intractability that most organisations work to their own agendas, make the best use of their own resources and perform to standards and self set targets which inhibit joint working.

Most partnerships and collaborations fail to achieve their objectives – fact! Most organisations enter into partnership (akin to a marriage) with the best of intentions, assuming that they will remain in a permanent and happy union. Unfortunately, it is not always the case that relationships work out as planned. Relationships are organic living things that grow up between individuals and organisations



over time. Like any living thing, relationships can be healthy and live a long life, or they can get sickly and die.

The reasons for the joint working relationship to breakdown are multiple and varied, but usually include several, if not all, of the below factors:

1. Multiple goals and different expectations of the various stakeholders driving the partners in different directions;
2. Scale and complexity of the interaction means there is little real oversight and even less insight into what is happening on the ground;
3. Lack of motivation towards the achievement of the vision means strategies and policies never get translated into action and outcomes;
4. Misunderstanding and communication breakdowns, which may be due to the use of inappropriate communications channels or ineffective communicators;
5. Diverse interests and incentives means there is little collaboration or knowledge sharing and greater conflict - most of the time conflicts are not based on misunderstandings but rather on real differences in values;
6. A programme or project management approach is used to manage the new initiative, which usually means the partners persevere to the end, even if it is the wrong end;
7. A technical focus, without strategic insight drives the focus on action rather than outcome;
8. Cultural differences between the different parties at the table mean that there is usually a real lack of trust - although these partners may not be allowed to divorce, they usually lose respect and develop contempt for the other; and
9. Disruptive behaviours - once contempt sets in, the partnership is on shaky ground. Feelings of contempt are a powerful predictor of relationship breakdown, no matter how subtly they are displayed. Contempt doesn't have to be expressed openly for it to be hard at work rotting the foundations of the partnership.

Good joint governance counters these tendencies of fragmentation and disconnectedness and requires a shift both in the vertical relationships between centre, region, locality and neighbourhood and in the horizontal linkages between organisations at different levels of the governance system.

Governance in this sense is used more widely, and more accurately I might add, than the simple definition of governance just being about compliance and accountability.

Good governance must be proactive, must balance compliance and conformance with performance and passion. It must integrate strategy, action and mindsets to the enduring vision that is provided by those that “govern”. It must integrate systems, structures, strategy, silos and styles of behaviour.



Good Joint governance must balance the principle of conformance with the principles of performance with principles of stakeholder engagement

Clinical Commission Groups (CCGs) formal line of accountability is to the NHS Commissioning Board. As a public body they are also accountable to their local population. Their strategic alignment with their local health and wellbeing board will facilitate this, but CCGs will also be expected to demonstrate public and patient involvement in their decision-making. There is also a mutual accountability between the CCG governing body and its member practices. The governing body will need to hold practices to account for individual commissioning decisions, while the governing body will need to demonstrate to member practices that it is adhering to the common purpose and values in its deployment of resources and operations.

CCG governing bodies and their member practices will need to be transparent in their decision-making. Health and wellbeing boards are at the heart of commissioning decision making. Leaders from across the local community will come together in health and wellbeing boards. They will have a collective focus – to improve services for the whole community.

The two core responsibilities for Health and Wellbeing boards include:

1. Preparing Joint Strategic Needs Assessments (JSNAs) - JSNAs will be the means by which local leaders work together to understand and agree the needs of all local people; and
2. Joint Health and Wellbeing Strategies (JHWS). The joint health and wellbeing strategy will provide local partners including CCGs with a jointly-agreed and locally determined set of priorities on which to base their commissioning plans.

Decisions about health and care will be made on the basis of clinical expertise, evidence from the JSNA, with input from locally elected councillors and wider engagement with the community. This strengthened role of JSNAs and JHWS will enable Local Councillors, GPs and Directors of Public Health, Adult and Children's services to sit at the heart of local commissioning decisions.

The JSNA and JHWS need to be the foundations upon which health and wellbeing boards exercise their shared leadership across the wider determinants that influence improved health and wellbeing, such as housing and education.

Health and Wellbeing Boards (HWB) must seek to engage their communities in the development of the health and wellbeing strategies, so that they are one of the key stakeholders in the joint governance structures, which should also include service providers, commissioners, district and borough councils and local voluntary and community organisations.

Outcome-based commissioning

Conventional health and wellbeing commissioning and contracting have been preoccupied with activity, such as the number of contracts with patients or service users, whether waiting times are met, the number of complaints received and the hours services offered. Although many of these



indicators are important, they do not answer the most meaningful question of all, which is what is achieved for service users.

Outcome-based commissioning means putting in place a set of arrangements whereby a service is defined and paid for on the basis of a set of agreed outcomes. It means shifting the basis on which services are purchased and resources allocated from units of service provision (hours, days or weeks of a given activity) for pre-defined needs to what is needed to ensure that the outcomes desired by service users are met.

The development of commissioning for quality and outcomes, with payment linked to work done, was a vision of the Commissioning framework for health and wellbeing, published in 2007. The 2010 White Paper on healthcare and GP commissioning has refocused this aim, outlining how the current performance regime will be replaced by frameworks for outcomes covering the NHS, public health and social care, with local authorities given the responsibility to determine how best to secure the objectives identified.

Outcome based commissioning, with an accompanying emphasis on individual choice, is now to be the focus for future social care commissioning across all relevant sectors. The distinction between outcomes, outputs and inputs needs to be considered carefully and understood by commissioners.

Outcomes are perceived as more difficult to measure and monitor in some areas of health and wellbeing so the response is likely to be to tighten up on compliance, with processes and regulations to ensure that a service will perform.

Outcomes can be categorised into: Individual outcomes, Service level outcomes or Strategic outcomes.



Fundamental questions for good governance within CCGs and HWBs

1. **Vision:** What is the vision of the Health and Wellbeing Board? How will that vision guide and bound the JHWS? What are the most pressing needs locally? What are the most important indicators of need? Do you take normative need as seriously as expressed need? How do you incorporate anticipated but unknown needs of relatively silent groups in the population?
2. **Priorities and Trade-offs:** What influences and evidence will be used to help set priorities for the development of the JHWS? Decisions must have a combination of factual data evidence and intelligence from the various stakeholders – how will the board combine quantitative and qualitative evidence, how will various options be appraised robustly? How will future anticipated needs flow into decisions today? Do you have a risk model that helps guide your options selections?
3. **Insight not oversight:** What does success look like and how will you measure it? How will you know you are progressing towards success, when board members may not have the skills and capabilities to wade through data and analysis? What mechanisms will be used to ensure that the board has a shared understanding of the evidence and analysis?
4. **Relationships governance:** Decision making in a group context requires an in-depth understanding of where partners are coming from, what their expectations are and what their expertise is. Good relationship governance must migrate from shared understanding towards shared commitment. How will this be nurtured, managed and guaranteed?
5. **Rationality:** All decisions must demonstrate a clear line of sight between the intelligence available, the current situation, options presented, priorities agreed and risks inherent and mitigated. As well as representatives of the public being on the board and contributing to the strategy, there will need to be wider stakeholder engagement and intelligence gathering. How will the board demonstrate that it is taking rational risk managed decisions, deliver transparency and auditability and provide evidence of how stakeholder intelligence has been used to arrive at decisions?
6. **Homogenous and inclusive strategy:** The JHWS has to recognise and be cognisant of partner strategies. The JHWS must integrate these possible diverse strategies and develop a homogenous strategy. Where are the greatest gaps in services? What constitutes a successful service? What is the relationship between social inequality and health inequality? How will different perceptions, biases and views be managed to drive consensus and choice of the optimum strategies?
7. **Accountability and action:** The JHWS must align all commissioning and strategic health and wellbeing initiatives – then it must transform initiatives to actions and outcomes. The implementation of the strategy must be actively monitored, performance assured and any risks and impediments identified and managed. How will this happen in practice? How will resources be managed to ensure effective and efficient implementation, whilst providing the governing board oversight and insight of progress, risks and workloads?



Checklist of actions for CCGs, HWBs and Local Authorities

Joint Commissioning

- Do you have the joint commissioning structures in place that include local government and NHS commissioners?
- Have you agreed a risk mitigation strategy to enable these to operate through the transition period ahead of the changes in April 2013?

Health and Wellbeing Boards

- Has a timetable and supporting plan been agreed between the local authority and its counterpart PCTs to enable the HWB to be in place in shadow form by 2012/13?
- Has an approach been developed to promote engagement between elected members and officers of the local authority with the emerging local GP consortia?
- Have Local NHS, independent and voluntary sector providers been engaged in the thinking around the development of the HWB?
- Have local partnerships been reviewed to identify how they will operate after April 2013?
- Has a plan been developed to enable the new HWB to assume its statutory responsibilities with GP Consortia involvement?
- Have arrangements for producing the JSNA been reviewed including the engagement of emerging GP commissioners?
- Have the implications of developing a Joint Health and Wellbeing Strategy been identified and factored into local plans to develop HWB and GP consortia?

Place based working and efficiencies

- Is there is a process in hand for identifying the opportunities and benefits to be gained from a place based approach and an outcome based approach to investment and service delivery?
- Have you agreed a joint plan and vision for realising efficiencies for cross-sectoral services?
- Has an evaluation been undertaken to assess the asset and estates across the sectors and have any opportunities been identifies for the shared use of these to improve service delivery and the potential to achieve efficiencies?
- Has an evaluation been undertaken to assess the scope for sharing back office functions to achieve efficiencies?



- Have you developed a joint approach to risk and reward linking funding decisions to identified efficiency gains between local government and NHS partners?

Planning, finance and workforce

- Has a process been developed to align the budget planning cycles between local government and the NHS?
- Have you established a process for the impact assessment and evaluation of investment or service change requests from one sector, to services provided by other sectors as part of your decision making process?
- Have you established a shared risk management plan and dispute management process to deal with financial and service issues that are cross-sectoral?
- Has a joint workforce plan been developed that covers both the transition of NHS staff to local authority employment, where relevant, and the development of new skills and approaches to the workforce where services are provided by both sectors to local residents;

Involvement of service users and carers

- Have you instilled a process to align the approaches on personalisation within social care and the commissioning of NHS services, including the development of personal health budgets?
- Have made assessments to streamlined patient contact with services which are provided by different agencies?
- Have you made arrangements and do you have the systems required for citizen involvement and engagement in Health and Wellbeing Boards?



This perspective has been written by Dr Bharat Vagadia of Op2i – its purpose is to challenge current thinking, stimulate debate and start a dialogue towards a better understanding of Good Joint Governance within the reformed NHS.

We are keen to hear different view, perspectives and thoughts from those involved with or have an interest in the formation of CCGs and HWBs.

We will be running a series of roundtables based around this perspective, to facilitate knowledge and experience sharing amongst practitioners in the area of good governance and the NHS.

If you would like to comment or share your own perspectives or would like to be kept informed of the round tables around Good Joint Governance, please do email me.

Yours humbly,

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