NHS
North Cumbria
Clinical Commissioning Group

NHS North Cumbria CCG Governing Body	Agenda Item
5 April 2017	09

Taking Forward Accountable Care in West North & East Cumbria

Purpose of the Report
This paper sets out the proposals toward accountable care and a population health approach across West North & East Cumbria (WNEC). It specifically it details proposed arrangements for the establishment of integrated commissioning, and for Provider Alliance working.

Outcome Required:	Approve	X	Ratify		For Discussion		For Information	

Assurance Framework Reference:

Commission services that ensure the delivery of high quality and safe care for patients in a manner that is sustainable for the whole health economy.

Recommendation(s):

The Governing Body is asked to:

Recommendation 1: Approve the formation of the Integrated Commissioning Group, as set out in the attached paper.

Recommendation 2: Note the development of the high level plans to take forward Accountable care including the arrangements for the Provider Alliance Memorandum of Understanding

Executive Summary:

Key Issues:

The proposals described in the attached paper build on those considered and endorsed by the Boards of Cumbria Partnership NHS Foundation Trust (CPFT), North Cumbria University Hospitals NHS Trust (NCUH) and the NHS Cumbria Clinical Commissioning Group (CCG) Governing Body (GB) in January 2017. Taking into account comments from Boards/GB to date

this paper is brought to Boards/GB and Cumbria County Council (CCC) Corporate Management Team for consideration of:

- arrangements for integrated commissioning
- formal arrangements including an agreed Memorandum of Understanding (MoU) for Provider Alliance working
- summary bilateral arrangements between CPFT and NCUH (for note by other bodies)
- high-level risks associated with proposals
- other clinical interdependencies
- High level timetable and workplan for the system; and
- Regulator support

It is expected that the system would have at its heart the eight constituent place-based Integrated Care Communities (ICCs), with both system-wide organisation and clinical networks where economies of scale and strategic leadership are needed. Care delivered through integrated teams including a focus on early intervention and prevention, complex case management and integration of urgent care will be key.

Over time and as the system moves as expected towards "Accountable Care", key provider elements will be developed both through the Provider Alliance Group (PAG), as well as through bilateral arrangements between Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NSH Trust including arrangements for the three principal objectives of:

- Integrated care delivery – with a common operating model, pooled budgets and delegated authority
- Shared leadership arrangements, governance and accountability
- A common platform for back office functions

To enable the Provider Alliance Group to take on an increasingly formal role over time, a memorandum of Understanding (MoU) has been developed. This sets out the shared commitment to the ACO, what it means for organisations that want to be part of the ACO construct and what it means for non-member providers.

Closer joint working between Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NSH Trust has been achieved over recent months, and this will be formalised from 1st April 2017 through a Bilateral MoU, entirely separate to the PAG MoU, providing the framework within which future structural form changes between the trusts can be

developed and formally proposed as the system matures, and as and when these are deemed desirable.

NHSE Cumbria & North East Senior Management Team (SMT) is supportive of local ACO work and it is considered likely that WNEC will be granted '*vanguard*' status to take forward ACO proposals.

Key Risks:

In order to fully identify and mitigate risks, and to ensure appropriate challenge and assurance through the process, three gateways have been locally described to monitor progress and provide an opportunity for participants to sense-check objectives.

- Gateway 1: From *(not on)* 1st April 2017 – introduction of more formalised arrangements for closer working
- Gateway 2: From October 2017 – formation of an Executive Board of the full Accountable Care Organisation to run in shadow form
- Gateway 3: From 1st April 2018 – full establishment of the Accountable Care Organisation (ACO)

Some high level objectives against these Gateways have been identified at Appendix 5.

A number of current services require a critical mass to be operationally viable, or require specialist leadership and expertise; some of these are currently delivered on a county-wide footprint. In order to ensure stability for these services in advance of any subsequently agreed changes they will continue to be delivered from the CPFT governance platform across the county. Clinical networks beyond Cumbria are expected to play a significantly increased role in plans for local accountable care, and Commissioners and WNEC providers are actively developing closer network arrangements with North East and other partners, in particular Newcastle Upon Tyne Hospitals NHS Foundation Trust.

Implications/Actions for Public and Patient Engagement:

Full staff communications were issued across the health economy, including to CCG staff, in relation to this proposal 27 March. A media briefing was also issued by all the partner organisations on 27 March.

Going forward a full stakeholder and communication plan will need to be developed to ensure effective public involvement.

Financial Impact on the CCG:

The proposals include two key areas relating to commissioning. The first is working towards more integrated and outcome-based strategic commissioning between the Local Authority and the NHS through an Integrated Commissioning Group (ICG). This will be responsible for progression of the three identified components of co-ordinated, collaborative and integrated

commissioning arrangements for WNEC has now been established, and Terms of Reference and an initial Integrated Commissioning Workplan and deliverables identified.

The second is the integration of tactical commissioning and provision for our population under a single capitated budget and contract. A West, North and East Cumbria ACO (as locally defined) is expected to bring together local providers under formal agreement to take collective responsibility under single capitated contract arrangements for the cost and quality of care for the WNEC population, although it is as yet too early to be specific in relation to end-state delivery vehicles, and legal structures. However, it is expected to take on certain 'tactical' commissioning responsibilities (as agreed), sharing financial risk, managing clinical quality, reducing inefficiency and waste, and to be accountable to strategic commissioners for achievement of pre-agreed quality outcomes.

At this stage no formal delegations or changes in responsibility are proposed. Any such change would require the approval of the Governing Body. As such there is no immediate financial impact on the CCG, though the strengthening of integration should act as a positive enabler to delivering the existing clinical strategies including the financial implications.

Strategic Objective(s) supported by this paper:	**Please select (X)**
Support quality improvement within existing services including General Practice	
Commission a range of health services appropriate to Cumbria's Needs	
Develop our system leadership role and our effectiveness as a partner	X
Improve our organisation and support our staff to excel	

Impact assessment: (Including Health, Equality, Diversity and Human Rights)	**N/A**

Conflicts of Interest Describe any possible Conflicts of interest associated with this paper, and how they will be managed	No conficts of interest have been identified associate with this paper.

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Presented By	Chief Operating Officer
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Date Report Written	29 March 2017

TAKING FORWARD ACCOUNTABLE CARE IN WEST NORTH & EAST CUMBRIA

Executive Summary

This paper sets out for approval by local statutory bodies the proposals for taking forward a move toward accountable care and a population health approach across West North & East Cumbria (WNEC): specifically it details proposed arrangements for the establishment of integrated commissioning, and for Provider Alliance working.

The proposals described build on those considered and endorsed by the Boards of Cumbria Partnership NHS Foundation Trust (CPFT), North Cumbria University Hospitals NHS Trust (NCUH) and the Clinical Commissioning Group (CCG) Governing Body (GB) in January 2017. Taking into account comments from Boards/GB to date this paper is brought to Boards/GB and Cumbria County Council (CCC) Corporate Management Team for consideration of:

- arrangements for integrated commissioning
- formal arrangements including an agreed Memorandum of Understanding (MoU) for Provider Alliance working
- summary bilateral arrangements between CPFT and NCUH (for note by other bodies)
- high-level risks associated with proposals
- other clinical interdependencies
- High level timetable and workplan for the system; and
- Regulator support

Local leaders have collectively considered how future organisational arrangements can best support delivery of agreed Sustainability and Transformation Plans (STPs), and have committed to work together to enable a rapid move towards 'integrated'/'accountable' care. The key components identified in this shift to a population health approach are:

- integrated and outcome-based strategic commissioning between the Local Authority & NHS,
- integration of tactical commissioning and provision for our population under a single capitated budget and contract, *and*
- multidisciplinary/multiagency frontline delivery with our communities and third sector

A WNEC ACO (as locally defined) is expected to bring together local providers under formal agreement to take collective responsibility under single capitated contract arrangements for the cost and quality of care for the WNEC population, although it is as yet too early to be specific in relation to end-state delivery vehicles, and legal

structures. However, it is expected to take on certain 'tactical' commissioning responsibilities (as agreed), sharing financial risk, managing clinical quality, reducing inefficiency and waste, and to be accountable to strategic commissioners for achievement of pre-agreed quality outcomes.

It is expected that the system would have at its heart the eight constituent place-based Integrated Care Communities (ICCs), with both system-wide organisation and clinical networks where economies of scale and strategic leadership are needed. Care delivered through integrated teams including a focus on early intervention and prevention, complex case management and integration of urgent care will be key.

An Integrated Commissioning Group (ICG) responsible for progression of the three identified components of co-ordinated, collaborative and integrated commissioning arrangements for WNEC has now been established, and Terms of Reference and an initial Integrated Commissioning Workplan and deliverables identified.

Over time and as the system moves as expected towards "Accountable Care", key provider elements will be developed both through the Provider Alliance Group (PAG), as well as through bilateral arrangements between CPFT and NCUH including arrangements for the three principal objectives of:

- Integrated care delivery – with a common operating model, pooled budgets, delegated authority etc
- Shared leadership arrangements, governance and accountability
- A common platform for back office functions

To enable PAG to take on an increasingly formal role over time, supporting ongoing work towards the establishment of a WNEC ACO, a memorandum of Understanding (MoU) has been developed. This sets out PAG shared commitment to the ACO, what it means for organisations that want to be part of the ACO construct and what it means for non-member providers.

Closer joint working between CPFT and NCUH has been achieved over recent months, and this will be formalised from 1st April 2017 through a Bilateral MoU, entirely separate to the PAG MoU, providing the framework within which future structural form changes between the trusts can be developed and formally proposed as the system matures, and as and when these are deemed desirable.

A generic '*Case for Structural Change'* for use by CPFT and NCUH Trusts has been drafted document, and can be adapted for wider WNEC use to consider changes that may be proposed over time.

A number of current services require a critical mass to be operationally viable, or require specialist leadership and expertise; some of these are currently delivered on a county-wide footprint. In order to ensure stability for these services in advance of any subsequently agreed changes they will continue to be delivered from the CPFT governance platform across the county. Clinical networks beyond Cumbria are expected to play a significantly increased role in plans for local accountable care, and Commissioners and WNEC providers are actively developing closer network arrangements with North East and other partners, in particular NUTH.

Three gateways have been locally described to monitor progress and provide an opportunity for participants to sense-check objectives.

- Gateway 1: From *(not on)* 1st April 2017 – introduction of more formalised arrangements for closer working
- Gateway 2: From October 2017 – formation of an Executive Board of the full Accountable Care Organisation to run in shadow form
- Gateway 3: From 1st April 2018 – full establishment of the Accountable Care Organisation (ACO)

Some high level objectives against these Gateways have been identified at Appendix 5.

NHSE Cumbria & North East Senior Management Team (SMT) is supportive of local ACO work and it is considered likely that WNEC will be granted '*vanguard'* status to take forward ACO proposals.

It is noted that as work progresses a discrete ACO Programme Team will be needed: requirements for this will be developed in light of feedback on this paper and agreed next steps.

TAKING FORWARD ACCOUNTABLE CARE IN WEST NORTH & EAST CUMBRIA

1.0 Purpose & Overview

This paper sets out for approval by local statutory bodies the proposals for taking forward a move toward accountable care and a population health approach across West North & East Cumbria (WNEC): specifically it details proposed arrangements for the establishment of integrated commissioning, and for Provider Alliance working.

The proposals described build on those considered and endorsed by the Boards of Cumbria Partnership NHS Foundation Trust (CPFT), North Cumbria University Hospitals NHS Trust (NCUH) and the Cumbria Clinical Commissioning Group (CCG) Governing Body (GB) in January 2017. Taking into account comments from Boards/GB to date this paper is brought to Boards/GB and Cumbria County Council (CCC) Corporate Management Team for consideration of:

- arrangements for integrated commissioning;
- formal arrangements including an agreed Memorandum of Understanding (MoU) for Provider Alliance working;
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- high-level risks associated with proposals;
- other clinical interdependencies;
- High level timetable and workplan for the system; and
- Regulator support.

2.0 Local Commitment to WNEC Accountable Care

2.1 Key Components

The Five Year Forward View published in October 2014 sets out a clear goal that "*the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care*."

Local leaders have collectively considered how future organisational arrangements can best support delivery of agreed Sustainability and Transformation Plans (STPs), and have committed to work together to enable a rapid move towards 'integrated'/'accountable' care.

The key components identified in this shift to a population health approach are:

- ✓ integrated and outcome-based strategic commissioning between the Local Authority & NHS,

- ✓ integration of tactical commissioning and provision for our population under a single capitated budget and contract, *and*
- ✓ multidisciplinary/multiagency frontline delivery with our communities and third sector

2.2 Local Definition of an Accountable Care Organisation

WNEC core partners have confirmed commitment to move towards the establishment of an accountable care organisation (ACO) for WNEC, defined in these local circumstances as "***an organisation or organisations accountable for care delivered for a given population through cross-system integrated working with other providers held accountable for achieving a set of pre-agreed quality outcomes within a given budget****".*

A WNEC ACO is expected to bring together local providers under formal agreement to take collective responsibility under single capitated contract arrangements for the cost and quality of care for the WNEC population, although it is as yet too early to be specific in relation to end-state delivery vehicles, and legal structures. However, it is expected to take on certain 'tactical' commissioning responsibilities (as agreed), sharing financial risk, managing clinical quality, reducing inefficiency and waste, and to be accountable to strategic commissioners for achievement of pre-agreed quality outcomes.

For Local Authority services, integrated provision arrangements may include aspects of public health, children's services and adult social care; for the latter this may include assessment and care management services. The scope and details of how these arrangements could work within the ACO will need to be considered and defined by County Council colleagues and partners at a future time appropriate to the Authority.

2.3 A New Partnership with General Practice

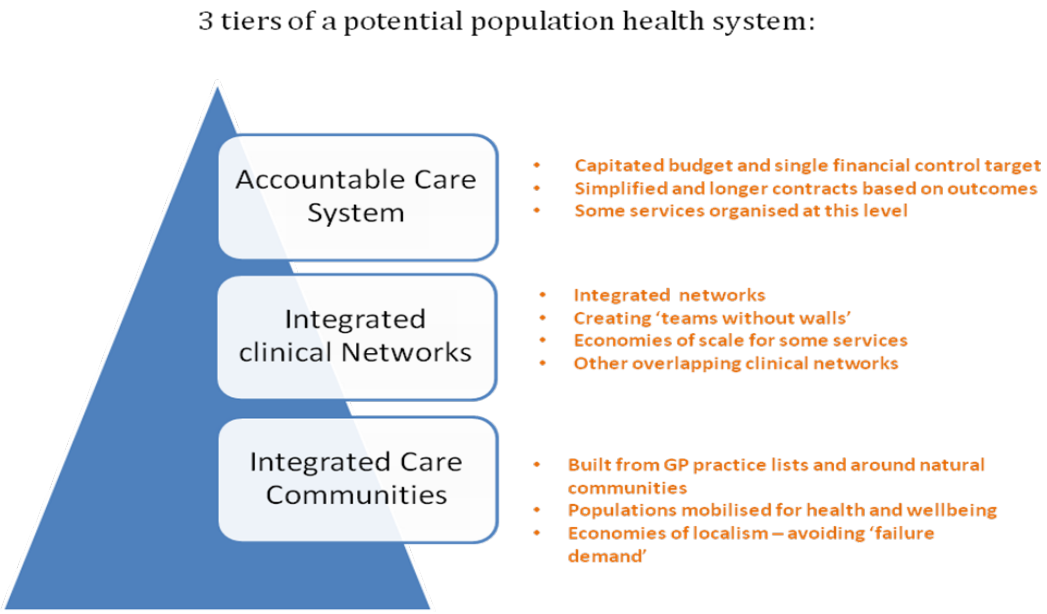
Critical within the ACO proposal will be a 'reset' of our partnership with general practice. The challenges facing primary care, the various options available to them as independent contractors, and their critical triple roles as providers for the bulk of health care contacts, service gatekeepers and system leaders must be fully acknowledged in considering future WNEC form.

The ACO arrangements will cover all WNEC general practices and their registered lists, creating a new partnership with primary care which will likely include an 'offer' for those practices that wish to become salaried, and equally, close partnership with those remaining as independent contractors. Without pre-empting discussions within primary care, it is expected to support therefore a likely desire from primary care for a mixed economy in relation to future GMS/PMS provision.

2.4 Three-Tier System for Population Health

It is expected that the system would have at its heart the eight constituent place-based Integrated Care Communities (ICCs), with both system-wide organisation and clinical networks where economies of scale and strategic leadership are needed. Care delivered through integrated teams will include specific focus on early intervention and prevention, complex case management and integration of urgent care.

The model for an ACO working within the wider Accountable Care System is anticipated to be built around three discrete tiers:



2.5 Partner Reflections & Feedback

Whilst the Boards/Governing Body of CCG, CPFT and NCUH have in January 2017 broadly endorsed the direction of travel towards accountable care as above, they have identified a number of issues of note:

- The need to develop a culture across the system which encourages and supports continuous service improvement, and which places the client/patient at the centre of all that we do;
- the importance of ensuring an inclusive approach such that emerging implementation plans are not inappropriately NHS or acute-centric;
- the need to support the rebuilding of an increasingly fragile primary care system;
- A desire for an incremental approach with transitional arrangements to allow development of arrangements over time;
- Concrete options to operationalise changes in leadership, accountability and governance to be developed as early priorities;

- A need for clear articulation of the anticipated benefits from any change proposals, and in particular their ability to address current challenges;
- The need to ensure that any changes to structural form do not jeopardise existing well-functioning arrangements or individual organisation's good governance;
- The sense in aligning where possible similar work in south Cumbria
- Recognition of the importance of wider clinical networks and in particular expected clinical partnership with Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH);
- The requirement for a clear narrative on the future provision of Mental Health, Learning Disability, Children & Families and other county-wide services.

(It is noted that CCC Cabinet has previously given their senior officers a mandate to participate in the work, and as such has not provided formal feedback to date.)

2.6 Taking Forward Proposals

Over the past six months WNEC system leaders have made good progress in taking forward these proposals for accountable care, and in particular have spent time in developing the formal governance arrangements within which commissioning and delivery of integrated care can take place. Whilst no end-stage has as yet been determined there is strong consensus for the value of increasingly integrated organisational working arrangements over time.

The Provider Alliance governance arrangements proposed in this paper provide a flexible framework to achieve this, and are now brought to Trust Boards for formal approval. In addition CCG GB and CCC Corporate Management Team are asked to approve proposals for integrated commissioning, initial workplans and other associated work.

3.0 Commissioner Integration

3.1 Integrated Commissioning Group

As part of the WNEC STP governance arrangements, an Integrated Commissioning Group (ICG) will be established in April 2017. The ICG will include membership from each of:

- Cumbria County Council
- NHS England
- NHS North Cumbria Clinical Commissioning Group

It is planned to hold a development session in March 2017 to consider the terms of reference and work plan for the Integrated Commissioning group. The outline,

provisional terms of reference are provided as Appendix 1, and an initial indication of the work programme is provided as Appendix 2.

The intended functions of the Group are to:

- Planning and Strategy: to agree the collective shaping of strategic commissioning intentions, based on the JSNA, national and local policy considerations, and the collective strategy derived from the Pre-Consultation Business Case
- Joint Commissioning: to oversee the delivery of agreed areas of co-ordinated, collaborative, and integrated commissioning
- Performance Management and Quality Improvement: to ensure collective arrangements for performance management of the Provider sector, including the delivery of NHS constitutional standards
- Organisational Form: to oversee the development of, and transition to, any agreed revisions to organisational form for commissioning and to ensure a strong commissioning voice in determining Provider organisational forms. Also, to inform the agreement on any transfer to the Provider Alliance Group or other future organisational form for any tactical commissioning functions (see below).

3.2 Cumbria Joint Commissioning Group

The Cumbria Joint Commissioning Group (JCB) will continue to govern pan-Cumbria responsibilities. From April 2017 it will include representatives from each of:

- Cumbria County Council
- NHS Morecambe bay Clinical Commissioning Group
- NHS North Cumbria Clinical Commissioning Group

The Group will provide the formal governance for each of:

- Better Care Fund
- The Learning Disabilities Pooled Fund
- Any Cumbria wide Section 75 arrangement developed in the future
- Where appropriate supporting the Cumbria Health & Wellbeing Board including ensuring the production of the Cumbria Joint Strategic needs Assessment

3.3 Strategic and Tactical Commissioning

In relation to WNEC, neither the CCC nor CCG have currently agreed to any formal delegation of commissioning responsibilities to any other organisation: such delegation would require formal approval from the respective organisation. However, there is broad agreement that over time both Cumbria County Council and NHS North Cumbria CCG will increasingly:

- focus on population level outcomes and the overarching deployment of resources (which may be described as strategic commissioning), and
- fully encourage service providers to collaboratively utilise their collective resources to determine optimal care pathways and ways of delivering population health outcomes (which may be described as tactical commissioning), *and*
- support the delegation of decision making on the use of resources as close to the delivery of care as possible (in support of a clear framework for ICCs)

A more precise, shared description of the delineation of 'strategic' and 'tactical' commissioning functions, and any proposals on the delegation of any formal functions, will be progressed in the first half of the 2017/18 financial year.

4.0 Provider Alliance Memorandum Of Understanding

4.1 Provider Alliance Group Functioning

The role of PAG is to enable integrated delivery of health and care services for the footprint of WNE Cumbria. The Group is intended to complement statutory organisations by providing a "system" based body for inter-related provider issues to be planned, agreed and monitored. PAG enables partners to work together effectively on all aspects of the pre/during/post STP implementation programme.

In due course, PAG is expected to take responsibility for number of 'tactical' commissioning functions, in addition to current provider issues. This would be in response to commissioning intentions approved by the ICG (see section 3).

Over time and as the system moves as expected towards "Accountable Care", key provider elements will be developed both through PAG, as well as through bilateral arrangements between CPFT and NCUH including arrangements for the three principal objectives of:

- Integrated care delivery – with a common operating model, pooled budgets, delegated authority etc
- Shared leadership arrangements, governance and accountability, *and*
- A common platform for back office functions

The Provider Alliance Group, chaired by the STP Lead, is now firmly established; it has developed a system of regular review of key work areas and routine exception reporting via its Group workplan.

4.2 MoU Purpose

To enable PAG to take on an increasingly formal role over time, supporting ongoing work towards the establishment of a WNEC ACO, a Memorandum of Understanding (MoU) has been developed. This sets out PAG shared commitment to the ACO, what it means for organisations that want to be part of the ACO construct and what it means for non-member providers.

It provides a formal framework for provider partners across the WNEC system, and allows formally delegated authorities to be added over time where agreed beneficial.

4.3 Delegated Authority

Within the MoU, the PAG does not initially have any delegated functions from the Boards/Governing Bodies of the parties which remain separate statutory organisations: PAG members may only make decisions within the scope of their individual authority. This is also made clear within the current PAG Terms of Reference. However over time and as the system progresses the approach to the ACO, parties may formally agree to certain delegated or shared authorities, risk-sharing or other arrangements. These will be added as specific schedules to the MoU as and when formally agreed by the relevant parties.

4.4 Legal Status

The MoU is not legally binding with the exception of clauses relating to confidentiality, costs, and liabilities, establishment of joint venture or other partnerships and submission to English law. It is noted that additional Schedules added over time may in themselves be legally binding.

4.5 Additional Supporting Documents

Additional supporting documents are to be developed to manage conflicts of interest and sharing of information between parties in more detail.

4.6 Parties to the MoU

Primary Care providers do not currently have governance structures that would support the sign-up of constituent general practices to the MoU. The three GP ICCs Leads are proposed as parties to the MoU on behalf of their eight GP ICC lead colleagues, with a specific role for them in acting as conduit with their wider primary care colleagues. They are not however mandated representatives of general practice, and cannot make binding decisions on their behalves. Once governance structures are identified this position will be reviewed.

Cumbria County Council are not party to the MoU; it is recognised that a new administration will be in place after 4th May 2017 and the inclusion of the County Council will be considered beyond that date.

Third sector representatives are not party to the MoU but may be considered as other ACO providers within this agreement.

A final draft MoU is provided at Appendix 3. Subject to approval and any final revisions parties will be asked to sign from April 2017.

5.0 Bilateral Arrangements between NCUH and CPFT

5.1 Bilateral Memorandum of Understanding

Whilst clearly a matter for the two trusts, their joint working arrangements form an important part of the system shift to accountable care so are briefly described here. Arrangements which have already seen closer joint working between the trusts over recent months are intended to be formalised from 1st April 2017, enabling further realisation of benefits of closer collaboration and common working within existing statutory organisational arrangements (as opposed to wholesale organisational form change).

A Bilateral MoU, for the most part non-legally binding in the first instance, and entirely separate to the PAG MoU provides the framework within which future structural form changes between the Trusts can be developed and formally proposed as the system matures, and as and when these are deemed desirable.

5.2 Joint Group Board

The MoU sets out arrangements for a Joint Group Board operating through a 'Committees in Common arrangement' which will allow future delegated authority from the two existing trust Boards. This simple approach delegates authority to two discrete Trust Committees meeting simultaneously as the Joint Group Board. Any decisions made would be either within the remit of the individual constituent members or within the delegated authority of the respective Committees.

The intention is to enable well-governed co-operation, alignment, collaboration, convergence and synergy to support the ongoing transformation within the overall system and to secure the cohesion and stability needed as two core NHS statutory providers.

The MoU does not mandate any move to a merger or acquisition and does not cross the line into areas where a referral to the national cooperation and competition panel would need to be made.

These arrangements and key elements for focus strongly complement those described for PAG. It is expected that in the short to medium-term other provider partners may wish to become part to some or all of the above arrangements, and facility is made within both MoUs for this to take place - over time increasing

convergence of partners will allow a progressive move to a full ACO model, built on increasing levels of partner confidence and Trust and managed within a robust governance framework.

6.0 Primary Care

General practice must be at the heart of any model: the importance of primary care both as system leaders and as the provider of the bulk of health care contacts is not to be under-estimated. A new model of enhanced and integrated primary, community, and social care supported by specialists is core to our vision for WNEC and its ICCs.

It is not anticipated that any primary care subcontractor be forced to be part of any future changes in organisational arrangements, and there are no assumptions made in relation to the future management of primary care contracts. However, it is anticipated that our future organisational forms will be designed to maximise engagement of primary care partners, acknowledging that ability to control goes in tandem with responsibility for delivery and risk. There are a range of options possible in relation to general practices' direct GMS provision through from loose partnership working (alliance) at locality level through to salaried service, and it is expected that there will be differing choices made by different practices/practitioners. Exercising such choices is expected to remain in the control of primary care providers, and will be informed by national contract and policy discussions. Creation of a suitably flexible 'offer' to general practices is likely to be a key element of any eventual WNEC model.

Primary care leaders and CCG member practices will be considering models for future GMS/PMS provision, and their interface with emerging direction of travel for system wide integration over coming months; there will be close liaison between this work and that in relation to WNEC Accountable Care.

7.0 Case For Structural Change & End State Destination

Whilst the arrangements described in Sections 4 & 5 are expected to support further progress toward provider integration, assumptions of benefit for each specific proposal which alters current leadership accountability and governance arrangements must be robustly tested in advance of their implementation, acknowledging that such changes are not without risk.

A generic '*Case for Structural Change'* has been drafted in the first instance by CPFT colleagues and used by Board members of both CPFT and NCUH to inform their bilateral work, defining structural change in this context as:

"*Change that alters the way authority, information and responsibility flows in and across organisations. It includes things such as the organisational hierarchy, chain of command, management systems, job structure and supporting procedures. It does not necessarily require changes in organisations through mergers or acquisitions to initiate them, although they may be necessitated as a result of these"*

(BusinessDictionary.com)

This work sets out the context for both WNEC and Morecambe Bay, noting the key drivers, outlining the Citizen, Staff and Financial Cases respectively, and highlights the key risks of both progressing and not further progressing the integration agenda between the two Trusts.

This document can be adapted for wider WNEC use to consider changes that may be proposed over time under the PAG MoU arrangements.

As noted in the definition, structural change does not necessarily imply change to organisational form. However it is recognised that without it, '*authority, information and responsibility'* arrangements may prove insufficient to support the levels of integration sought at the frontline, with more far-reaching changes to current arrangements for leadership accountability and governance potentially deemed necessary to maximally achieve the triple aims of better outcomes, better quality and better use of resources. A similar approach will therefore be used to inform broader debate with stakeholders in consideration of emerging end-state proposals, setting out clearly how proposals will address local challenges, with explicit articulation of anticipated benefits. This work will be completed prior to Gateway 2 (see Section 10).

8.0 Clinical Services & Networks Beyond WNEC

A number of current services require a critical mass to be operationally viable, or require specialist leadership and expertise, and this has implications for WNEC given the integration work across the county which sees increasing focus on north and south as more discrete localities. The changes in commissioner configurations north and south of Cumbria have injected an added complexity, although the two responsible CCGs have committed to aligning commissioning intentions where possible. There is also a need to ensure appropriate interface with Local Authority provision in a number of areas.

8.1 Countywide Services

Mental health, learning disability, children's services and some specialist community services including neurology, diabetes and sexual health are currently delivered on a county-wide footprint. Whilst there is recognition of the potential for changes in configuration of these services in the future, in order to ensure stability for these

services in advance of any subsequently agreed changes they will continue to be delivered from the CPFT governance platform across the county.

For a number of services it is essential that they remain fully embedded within community arrangements at very local level – for example, primary mental health, specialist community services and end of life care – and management arrangements will ensure this can continue.

CPFT and commissioners will jointly explore options for the future delivery of these services, which may include the potential for alternative future leadership and governance models that could better support these services in the longer term through clinical networks outside Cumbria.

8.2 Wider Clinical Networking

Clinical networks beyond Cumbria are expected to play a significantly increased role in plans for local accountable care, addressing areas where low patient volumes, high costs, available workforce or other issues make quality achievement and/or maintained service viability difficult under current local arrangements. These arrangements are considered essential irrespective of any future changes in WNEC organisational form.

Commissioners and WNEC providers are actively developing closer network arrangements with North East and other partners, in particular NUTH. Work to formalise and progress these arrangements continues with the nature of partnership potentially extending across:

- development of clinical networks with peer review and audit, education and training, determination of clinical standards etc.
- in-reach local provision by alternative providers, potentially partially under the governance of current providers
- Sub-contracting of specific services by local providers

Active discussions are currently taking place with NUTH to put in place practical networked arrangements for:

- Local oncology and radiotherapy services; this includes use of confirmed funding for a new £35m Cancer Centre to be based at Cumberland Infirmary Carlisle
- An expanded NUTH's *Great North Children's Hospital,* supporting delivery of specialist children's services in Cumbria
- Strengthened networked vascular services, including for Dumfries & Galloway, compliant with Vascular Centre quality standards, and creating a hybrid vascular theatre and vascular laboratory at the Cumberland Infirmary
- Future delivery of hyper-acute and acute stroke services, noting the CCG decision to support development of a hyper-acute stroke service at the

Cumberland Infirmary, the workforce challenges and opportunities across the North East & Cumbria Region, and associated neurology issues (including CPFT provision)

- Gastroenterology future provision in the context of high volumes and significant local workforce challenges

In addition formal SLA arrangements with Northumbria Healthcare NHS Foundation Trust afford continued opportunity for collaborative working between the Trusts across a range of clinical and non-clinical support areas.

9.0 High Level Risks

It is too early as yet to articulate in detail the risks associated with further organisational (provider) integration as these will be dependent on the specific proposals. However, some high level risks can be identified and are set out in Appendix 4.

All proposals which alter current leadership accountability and governance arrangements will be required to set out a detailed risk assessment in addition to articulation of the benefits as above.

10.0 Local Gateways for Provider Integration

Three gateways have been locally described to monitor progress and provide an opportunity for participants to sense-check objectives.

- Gateway 1: From *(not on)* 1st April 2017 – introduction of more formalised arrangements for provider partners through the PAG MoU, and closer working between NCUH and CPFT through establishment of the Joint Group Board
- Gateway 2: From October 2017 – formation of an Executive Board of the full Accountable Care Organisation to run in shadow form
- Gateway 3: From 1st April 2018 – full establishment of the Accountable Care Organisation (ACO)

Whilst it is not possible to set out a detailed workplan against these Gateways given the evolutionary nature of the process and need for further work to determine desired changes in organisational form, some high level objectives and deliverables can be described. These are set out in Appendix 5.

11.0 NHS England Assurance

A paper setting out the provider integration plans for WNEC was taken to NHSE Cumbria & North East Senior Management Team (SMT) in February 2017. The paper advised SMT on changes to structural form being actively considered locally, noting that these changes were intended to underpin the delivery of the clinical strategy developed by the Success Regime, and build towards the delivery of an integrated system for accountable population based care.

The paper provided more detail on the:

- context to the work being undertaken
- the nature of the local Gateways and implications for the provider organisations concerned
- impact on NHS Improvement's regulatory approach and efforts to rationalise and streamline approach
- high-level risks to implementation

The proposals were supported with SMT emphasising that the organisational integration work can proceed independently of the clinical services post-consultation work – in other words success of the former is not dependent on outcome of the latter. These outline proposals are now being taken to a forthcoming meeting of NHSE's Regional Support Group.

It is considered likely that WNEC will be granted Vanguard status to take forward ACO proposals reflecting the progress made by the local STP in this regard. This will be important in allowing early resolution of any governance or other barriers encountered, opportunities to network with other emerging ACOs and learn from their experience, and may also provide some degree of additional supporting resource.

12.0 Working Arrangements & Communications

A senior Accountable Care Working Group has been meeting fortnightly to progress the work. The *Good Governance Institute* has provided some limited support and advice over the past 2 months. Further consideration of the case for change for specific proposals, tangible benefits, risks, option appraisal and associated governance arrangements for any anticipated end-state including due diligence will all require detailed work and consideration over coming months. It is noted that as work progresses a discrete ACO Programme Team will be needed: requirements for this will be developed in light of feedback on this paper and agreed next steps.

Close working with Bay Partner colleagues is essential to ensure stability of services reduce bureaucracy, and support stakeholder communication during any period of

transition. To facilitate this fortnightly calls are taking place between CPFT, NCUH and University Hospitals of Morecambe Bay (UHMB) and Cumbria County Council. In addition the Senior Responsible Officers for Organisational Form work in north and south of the patch are liaising regularly, and both supported by *Capsticks* to ensure consistency of legal advice, and alignment of work.

As noted in Section 6, discussion with primary care leaders must be a priority in coming weeks; a meeting held on 22nd March with GP leaders has formally initiated this process. In addition, and also of prime importance is early engagement with both staff and external stakeholders to develop the early thinking described within this paper into firm proposals which properly reflect the views of front line workers and users. Whilst this was not considered possible during the by-election purdah period, it is anticipated that communication and engagement aimed at staff and key stakeholders in the first instance will be undertaken at the earliest opportunity. Colleagues are working closely to ensure clear, single and consistent messaging across the Cumbria health and care patch both north and south. Mechanisms for broader involvement are being considered.

A high level governance schematic for the elements of work is provided at Appendix 6.

Dr Debbie Freake, STP Director
22nd March 2017

Appendix 1

Outline Indicative Terms of Reference: West, North and East Cumbria Integrated Commissioning Group

Membership

Cumbria County Council:

- Director of Adult Health, Care and Community Services
- Director of Children's Services
- Director of Public Health
- Assistant Director of Commissioning

NHS Cumbria CCG

- Chief Operating Officer
- Director of Children and Families
- Director of Nursing and Quality
- Director of Primary Care and Integrated Care Communities

NHS England

- Assistant Director Specialised Commissioning – North East and Cumbria

Frequency of Meetings and Quorum

The Group is expected to meet on a monthly basis.

The Group will be considered quorate where at least two member's representatives of each of Cumbria County Council and NHS North Cumbria CCG are in attendance, and at least one representative of NHS England.

Nominated Deputies will be able to attend the meeting and participate in decision making.

Review

The terms of reference are due for review in March 2018, but can be reviewed at the request of one or more member organisations at any time.

Scope and Purpose of the Group

The scope of the Group will be defined through the Annual Work Plan, and agreed by each of the three member organisations. The scope will include both Children's and Adult service commissioning.

The purpose of the Group includes:

- Planning and Strategy: to agree the collective shaping of strategic commissioning intentions, based on the JSNA, national and local policy considerations, and the collective strategy derived from the Pre-Consultation Business Case

- Joint Commissioning: to oversee the delivery of agreed areas of co-ordinated, collaborative, and integrated commissioning

- Performance Management and Quality Improvement: to ensure collective arrangements for performance management of the Provider sector, including the delivery of NHS constitutional standards

- Organisational Form: to oversee the development of, and transition to, any agreed revisions to organisational form for commissioning and to ensure a strong commissioning voice in determining Provider organisational forms. Also, to inform the agreement on any transfer to the Provider Alliance Group or other future organisational form for any tactical commissioning functions.

Governance and Delegation

The Integrated Commissioning Group governance will be based on delegated authority provided by:

- Any such delegations made by the individual statutory organisations to the Group, and as such require the formal assent of the relevant statutory organisation (i.e. nothing is delegated until it is delegated)

- Individual members within the scope of their own authority as determined by their own organisation, in tandem with other members of the group

- Over time and as the system moves towards "Accountable Care", it is expected that the Integrated Commissioning Group may take on formal delegated responsibilities on behalf of statutory organisations

Appendix 2

High Level Workplan for Integrated Commissioning

April - October 2017	October 2017- April 2018
Formal establishment of Integrated Commissioning Group Shared strategic commissioning intentions agreed including pan–Cumbria approach to existing LD Pooled Funds in 17/18 Review of BCF priorities and schemes and linkage with NHS contractual approach for 2017/18 Commissioning Development Plan including: • Agreed joint commissioning priorities • 'Roadmap for determining 'strategic' versus 'tactical' commissioning functions • 'Roadmap' for determining approach to pan-Cumbria commissioning issues (beyond pooled funds for 17/18 above) Management and mitigation of impact on commissioning activity and providers including immediate implications of CCG boundary changes for county-wide services Agreed detailed system processes for managing organisational change Shared information on budget and resource deployment including planned investments across the system. Review of potential for joint approaches to procurement and market management	Collaborative and Integrated Commissioning arrangements in place in line with plan from January 2018 Implementation of commissioning function realignment Formally delegated responsibilities to ICB and S75 arrangements Joint priority and outcomes based budget setting process for 18/19 Implementation of agreed elements relating to commissioning of primary care and/or specialised commissioning Contracting processes for Accountable Care.

Shared information on service level pricing and contractual information, and service specifications with a view to rationalisation of activity and process Progress with development of collaborative and integrated commissioning proposals in line with Commissioning Development Plan including: • Agreement regarding lead commissioner for service reviews and any shared/seconded staff arrangements • Agreement on future formally delegated responsibilities to ICB and broader Section 75 arrangements • Agreement of Joint Commissioning Plan for 2018/19 including BCF (e.g. possible expansion) • Agreement on realignment of commissioning functions with Provider Alliance/ACO • Collective arrangements for performance management of provider sector and oversight of 'virtual' pool arrangements Consideration of proposals for future specialised commissioning. CCG Level 3 Commissioner of GP services; consideration of proposals for future commissioning relating to primary care; consideration of emerging contractual models for general practice and local preferences *(n.b. developed with primary care)*	

DRAFT

Appendix 3

DATE **2017**

1. **Cumbria Partnership Foundation Trust**
2. **North Cumbria University Hospital NHS Trust**
3. **GP ICC Lead Representatives**
4. **Cumbria Health on Call Ltd. (CHOC)**
5. **North West Ambulance Services (NWAS)**

Note: Cumbria County Council will formally consider becoming a Party to this MoU in June 2017.

MEMORANDUM OF UNDERSTANDING FOR THE DEVELOPMENT OF THE WEST, NORTH & EAST CUMBRIA ACCOUNTABLE CARE ORGANISATION

No	Date	Version Number	Author
1	30.01.2017	1 – Draft 0.1	LXW
2	09.02.2017	Draft 0.2	RM/DF
3	05.03.2017	Draft 0.3	NCH/RM
4	07.03.2017	Draft 0.4	RYM/VXA
5	08.03.2017	Draft 0.5	DF
6	22.03.17	Draft 0.6	RM

Date: 2017

This Memorandum of Understanding (**MoU**) is made between:

1. CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST of Voreda House, Portland Place, Penrith CA11 7QQ **(CPFT)**; and
2. NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST of Cumberland Infirmary, Newtown Road, Carlisle CA2 7HY **(NCUH)**
3. **[**GP ICC LEADS**]** of [INSERT ADDRESS];
4. CUMBRIA HEALTH ON CALL LTD of Capital Building, Hilltop Heights, London Rd, Carlisle CA1 2NS (**CHoC**);
5. NORTH WEST AMBULANCE SERVICE NHS TRUST of Ladybridge Hall Headquarters, Chorley New Road, Bolton BL1 5DD (**NWAS**);

(each a "**Party**" and together the "**Parties**").

Note: Cumbria County Council **(CCC)** will formally consider becoming a Party to this MoU in June 2017.

BACKGROUND

A. The Five Year Forward View published in October 2014 (the **Forward View**) sets out a clear goal that "the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care."

B. The local West North & East Cumbria (**WNEC**) system Sustainability & Transformation Plan (**STP**) is being taken forward under governance arrangements which include a System Leadership Board, Integrated Commissioning Group (**ICG**) and Provider Alliance Group (**PAG**). As well as overseeing the developmental agenda and transformation of services across the STP footprint, it is envisaged that over time the STP governance arrangements will provide the basis for the management of the day-to-day operations of the WNEC system. These arrangements are summarised at Annex A.

C. Local leaders have collectively considered how future organisational arrangements can best support delivery of agreed STP plans and have committed to work together to enable a rapid move towards 'integrated'/'accountable' care. The key components identified in this shift to a population health approach are:

- integrated and outcome-based strategic commissioning between **CCC** in respect of adult social care, public health and children's health] and NHS bodies,

- integration of Tactical Commissioning and provision for the WNEC population under a single capitated budget and contract, and
- multi-disciplinary/multi-agency frontline delivery with our communities and third sector.

D. Core to the STP plans are the emerging Integrated Care Communities (**ICCs**), based on natural communities, and for practical reasons built up from the registered populations of clusters of general practice; ICCs share many features in keeping with the principles of Multi-Specialty Community Providers (**MCPs**) but are not MCPs in legal or governance terms. Programmes will necessarily dovetail with the Health & Wellbeing strategies and priorities of the CCC ensuring sufficient critical mass and standardisation in the ICC model to harmonise with operational delivery requirements of CCC.

E. All of the Parties to this MoU provide services for the WNEC Population and this MoU operates within the overall WNEC system arrangements. The role of PAG is to enable integrated delivery of health and care services for the footprint of WNEC (see Annex B). The PAG is intended to complement statutory organisations by providing a "system" based body for inter-related provider issues to be planned, agreed and monitored. PAG enables partners to work together effectively on all aspects of the pre/during/post STP implementation programme expected to include increasingly over time all operational integrated service delivery.

F. Over time and as the WNEC system moves as expected towards "Accountable Care", it is anticipated that PAG will take on a formal role in relation to the management of a number of Tactical Commissioning matters where appropriate, in addition to current provider issues. This would be in response to commissioning intentions approved by the ICG and subject to a formal contractual relationship. The delineation of tactical from strategic commissioning matters, and subsequent role transfer is yet to be agreed.

G. This MoU sets out the Parties' objectives for the establishment of closer working within the wider health and care system and the governance arrangements that underpin that closer working. More particularly, in entering into and performing their obligations under this MoU, the Parties are working towards the implementation of an integrated care model in line with those highlighted in the Forward View. In particular, this MoU is intended to support the Parties' ongoing work towards the establishment of an accountable care organisation **(ACO)** for WNEC, defined for the purposes of this document as "*an organisation or organisations accountable for care delivered for a given population through cross-system integrated working with other providers held accountable for achieving a set of pre-agreed quality outcomes within a given budget"*

H. This MoU sets out the Parties' shared commitment to look to develop the ACO for WNEC, what it means for organisations that want to be part of the ACO construct and what it means for those that do not want to be part of it.

I. This MoU is complemented by a separate formal bi-lateral memorandum of understanding between CPFT and NCUH (the Bilateral Agreement) which allows early progress on the following specific areas of integration between the two trusts in respect of:

- aligned governance and accountability mechanisms
- shared leadership and appointments between the two trusts.
- shared support services between the two trusts.

It is acknowledged and expected that over time it may become appropriate for other PAG members to become party to some or all of these bilateral arrangements, and where agreed either the PAG MoU or where appropriate the bilateral arrangements will provide the framework for this discussion.

J. In general terms where issues under consideration are bilateral between CPFT and NCUH then this will be discussed and agreed by the organisations via delegated authority and discussions within the Joint Group Board (as defined by the Bilateral Agreement), or via a decision of the Boards of both organisations after due consideration. Wider provider issues beyond just NCUH and CPFT will be discussed at PAG, and taken for consideration and agreement as necessary by the Parties

K. The Parties acknowledge that the development of the accountable care system in South Cumbria (**the Bay Health and Care Partners**) will be taking place concurrently with the WNEC ACO development and that to the extent that this work crosses over with WNEC organisations and that there are interdependencies that they will look to align the timetables for the respective programmes.

L. All Parties acknowledge that there is further work to be completed to fully describe quality and financial benefit deliverables, final organisational form and delivery vehicle(s), the concepts within the WNEC ACO (including without limitation calculation of the capitated budget and risk and reward arrangements), and to meet the timetable. Additional parties may be admitted to this MoU where appropriate in accordance with its terms and where agreed by the Parties.

M. The Parties are committed to ensuring that all communications relating to the ACO are easily understood and are transparent.

OPERATIVE PROVISIONS

1. **Definitions and interpretation**

a. In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

b. In this MoU, unless the context requires otherwise, the following rules of construction shall apply:

i. a reference to a "**Party**" is a reference to a party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

ii. a reference to writing or written includes faxes and e-mails;

iii. a reference to the "**ICC Place Based System**" shall mean the work led by commissioners to develop and implement individual ICC Commissioning Plans based on analysis of local health and care assets, health needs and performance

iv. a reference to the "**Integrated Health & Social Care Teams**" shall mean the integrated management structure and associated accountability arrangements for 8 ICC multidisciplinary teams each led and managed by an Integrated Team Manager

v. a reference to "**Intellectual Property**" shall mean means rights in and to inventions, patents, design rights (registered or unregistered), copyrights (including rights in software), rights in confidential information, database rights and any similar or analogous rights that exist anywhere in the world (including any application for any registration of them) related to the activities of the Parties under this MoU;

vi. a reference to "**Tactical Commissioning**" shall mean the commissioning and management of elements of the services in WNEC by the ACO under the contractual relationship with commissioners.

2. **Purpose and effect of MoU**

a. The Parties have agreed to work together to benefit the population of WNEC to deliver the best possible experience and outcomes within the available resources. The aim is for the Parties to organise themselves around the needs of the WNEC population rather than planning at an individual organisational level so as to deliver more integrated care for the population of WNEC and enable efficiencies. The Parties wish to record the basis on which they will collaborate with each other in developing an ACO approach in this MoU.

b. This MoU sets out:

i. The Parties' commitment to the ACO Principles as organisations;

ii. what is expected of Parties who are to be part of the ACO;

iii. what is expected of Parties who are not to be part of the ACO; and

iv. what will be required under due diligence later in the process.

c. The Parties agree that, notwithstanding the good faith consideration that each Party has afforded the terms set out in this MoU, save as provided in paragraph d below, this MoU shall not be legally binding.

d. Paragraphs 8 (Confidentiality), 11 (Charges and Liabilities), 12 (No Partnership) and 14 (Governing Law) shall come into force from the date hereof and shall give rise to legally binding commitments between the Parties.

e. In addition to the MoU, the Parties will seek to agree the following additional documents to manage their relationships for conflicts of interest and sharing of information between themselves in more detail:

i. a protocol to manage conflicts of interest; and/or

ii. a protocol to manage the sharing of information in accordance with legal requirements.

f. The Parties are the initial participating organisations in the development of the WNEC ACO programme, but it is intended that other providers in the WNEC region may also have input as stakeholders (including, for example other independent and third sector providers). Stakeholder organisations may, where appropriate, be invited to meetings of the PAG as observers or through an additional stakeholders' forum. If appropriate to achieve the ACO Objectives, the Parties may also agree to include additional parties to this MoU.

2. **Commitments to the ACO Principles**

The Parties agree to the following commitments in relation to objectives and principles for the development of an ACO model in WNEC:

a. The Parties intend that development of the ACO shall:

- improve the health and wellbeing of the population and improve outcomes and experience for the people of WNEC
- deliver integrated services and longer term service sustainability for our communities through our agreed clinical, care and health and wellbeing strategies.
- continuously improve services growing and retaining the workforce needed, enabled by a common culture of effective and collective leadership.
- make the best use of limited resources: human resources (talents and skills, capability and overall capacity) and, financial resources (Infrastructure assets, reduced real terms annual funding and collective purchasing power), and leadership (common vision, strategies and plans that can mobilise cohesive communities).

- address key gaps urgently – in health and care, well-being, service quality and financial performance – to achieve national standards for the WNEC population and to address regulatory concerns over specific areas of organisational viability within key parts of the system.

b. The Parties also intend to operate under the terms set out in this MoU whilst observing the ACO Principles in dealings with each other as set out in Annex C.

(together the "**ACO Principles**").

3. **ACO Membership**

a. The Parties intend that any organisation who is to be a member of the ACO structure shall:

i. commit to the ACO Principles and the Objectives and ownership of the system success/failure. The Parties acknowledge that the delivery of health and well-being outcomes is the biggest determining factor for success of the ACO (in other words, the organisational success of each individual Party is not a determining factor in judging the success of the WNEC ACO);

ii. agree to move long-term towards the adoption of a capitated health budget for WNEC as agreed with system regulators and acknowledge that the Parties have a shared responsibility to work together to help manage the system-wide finances efficiently;

iii. commit to being part of the ACO at this stage and shall engage with further work to define the capitation arrangements;

iv. commit to the development of the Integrated Care Communities and their constituent ICC Place Base System and Integrated Health & Social Care Teams elements positioned as the core building blocks for the WNEC place-based ACO system ACO system, complemented by strong clinical and care network arrangements and will make governance changes to assist and facilitate these developments;

v. commit to develop integrated management arrangements through a designated Integrated Team Manager for each constituent Integrated Care Team providing streamlined and where possible single assessment, proactive routine and urgent care to its locality population

vi. commit to development of ring-fenced staffing budgets for the integrated management structure

vii. commit to exploration of potential pooled or delegated budgets for specific services where this can be demonstrated to improve the quality of efficiency of care

viii. commit to the development of collective performance frameworks as part of expected integrated working

ix. commit to the development of a "Tactical Commissioning" model of operation across the providers with collective responsibility for the management of these elements (as subsequently defined and agreed with commissioners) of the provision of services in the WNEC system;

x. acknowledge that the consequence of a move to a capitation based budget is that each Party will have a more direct share in the financial risk and reward from the WNEC system and that this will be reflected in a risk/reward share mechanism to be agreed documented between the Parties. The PAG will determine how best to involve Parties where their activities do not match the regional footprint in respect of commissioning budgets; and

xi. agree to work towards developing how the principle of proportionality of impact and risk share will operate within the ACO governance and decision making.

(together the "**ACO Objectives**")

4. **Governance**

a. The Parties must communicate with each other and all relevant staff in dealing with PAG matters in a clear, direct and timely manner. The PAG will act in accordance with the Terms of Reference (as revised from time to time by agreement) set out in Annex B and must:

i. ensure alignment of all organisations to facilitate sustainable and better care which is able to meet the needs of the WNEC population;

ii. promote and encourage commitment to the ACO Principles and ACO Objectives amongst all the Parties; and

iii. formulate, agree and implement strategies for achieving the ACO Objectives.

b. The PAG is the forum for the Parties to collaborate and consolidate their respective organisational position to ensure alignment to the system vision and delivery of an ACO for WNEC. Sovereignty and overall accountability is retained by the Parties and their respective boards in the first instance.

c. This means that meetings of the PAG are initially advisory for the Parties – representatives present at the PAG shall only exercise functions and powers of the organisation that they represent to the extent that they are actually permitted to exercise such functions and powers under that organisations own internal governance arrangements.

d. The Parties intent is that the operation of the PAG will begin under the Terms of Reference as provided for in Annex B to this MoU but that these will necessarily be revised over time as the Parties develop the approach to the ACO. Any subsequently delegated or shared activities (excluding those bilateral arrangements between CPFT and NCUH) will be agreed through PAG with each accountable body and be detailed in schedules to this MoU.

5. **Other Non-ACO providers**

a. The Parties accept that a number of organisations may not be appropriate to be or wish to be ACO members and consider that organisations that deliver services to the population of WNEC who are not ACO members remain key to the success of the ACO as part of the delivery of the wider health and care system across WNEC and shall be expected to:

i. contribute to the health and wellbeing of the population through the delivery of their contracted services;

ii. acknowledge that the emerging ACO will determine the clinical strategy and direction in line with strategic commissioning intent, and shape contracts set to deliver the clinical strategy in respect of ACO scope of services;

iii. have a voice in developing care pathways as the ACO will need to harness the clinical and professional expertise of all providers of services to the population of WNEC; and

iv. continue to maintain and manage their own third sector and private contracts outside of this MoU, and in a number of instances outside the ACO;

v. acknowledge that in relation to commissioning arrangements, contracts with organisations outside the ACO membership could be separate from the capitated arrangements that operate for organisations within the ACO membership as set out in Paragraph 3 above dependent on the approach of the relevant commissioner.

b. The Parties acknowledge that the Cumbria Learning & Improvement Collaborative (CLIC) whilst not a formal party to this MoU are participating as a body currently hosted by the CCG and that they remain an important

element in the development of the WNEC system as the custodian of intellectual property. It is anticipated that CLIC will become part of the ACO system once it becomes operative although precise hosting arrangements for CLIC are to be determined by the CCG and Parties. (It is noted that this may result in a need to amend Section 13.)

6. **Involvement of Primary Care**

    a. The Parties all acknowledge that primary care is a vital aspect in the creation of an effective ACO construct for WNEC. The involvement of future primary care representatives mandated by North Cumbria CCG constituent practices will be a key consideration. The Parties agree that current proxy representatives of primary care through the GP ICC leads will be invited to re-consider their position under this MoU at such point as all the providers of primary care services have agreed their operating structure to engage with the other Parties in the ACO process. For the avoidance of doubt current GP representatives are party to the MoU only on behalf of the 8 GP ICC leads, and cannot enter into any binding decisions on behalf of general practice.

7. **Due Diligence**

    a. The Parties each commit in principle to operating as a member of the ACO in accordance with the ACO Principles in order to meet the ACO Objectives when appropriate and shall work through an anticipated future due diligence process together to assess the viability and detail of the ACO construct.

    b. Any Parties who have not decided as to whether they intend to be an ACO member or to be a provider working outside of the ACO at the date of this MoU shall confirm their position to the other Parties as soon as practicable and thereafter undertake due diligence in an agreed process if they decide that they are committed to being a ACO member. The admission process for new members to the ACO will form part of an annual review cycle allowing for the entry of additional parties at later stages.

    c. Parties that have decided not to be part of the initial membership of the ACO do not need to engage in the due diligence process but may form part of a subsequent due diligence process for later entry into the membership of the ACO.

8. **Confidentiality**

a. Each Party undertakes that it shall not at any time disclose to any person any confidential information concerning the business, affairs, customers, clients or suppliers of another Party, except as permitted by Paragraph 8 b.

b. Each Party may disclose another party's confidential information:

    i. to its employees, officers, representatives or advisers who need to know such information for the purposes of exercising the Party's rights or carrying out its obligations under or in connection with this MoU. Each Party shall ensure that its employees, officers, representatives or advisers to whom it discloses the other Party's confidential information comply with this Paragraph 8; and

    ii. as may be required by law, a court of competent jurisdiction or any governmental or regulatory authority.

c. No Party shall use any other Party's confidential information for any purpose other than to exercise its rights and perform its obligations under or in connection with this MoU.

d. The Parties further:

    i. acknowledge that they are statutory bodies subject to primary and secondary legislation and guidance; and

    ii. agree that the provisions of this Paragraph 8 are subject always to the Parties' statutory obligations including but not limited to competition law and procurement law.

9. **Term and Termination**

a. This MoU shall commence on the date of signature by all the Parties, and shall expire on the earlier of the execution of a formal legally binding agreement between the Parties in connection with the delivery of the ACO or [INSERT].

b. Any Party may withdraw from this MoU by giving at least 30 calendar days' notice in writing to the other Parties.

10. **Variation**

a. This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

11. **Charges and liabilities**

a. Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU,

including in respect of any losses or liabilities incurred due to their own or their employee's actions.

b. No Party intends that any other Party shall be liable for any loss it suffers as a result of adherence to the terms of this MoU.

12. **No partnership**

a. Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

13. **Intellectual Property Rights**

Existing Intellectual Property

a. Each Party has its own existing Intellectual Property and the Parties have agreed that each Party will be able to protect its respective existing Intellectual Property as set out in this MoU.

b. The Parties also agree that, in the interests of achieving the ACO Objectives that they may share their relevant existing Intellectual Property by agreement at the PAG, but and except as set out in this Paragraph, no party will acquire the Intellectual Property of any other Party to this MoU.

c. Each Party grants each of the other Parties a fully paid up non-exclusive licence to use its existing Intellectual Property which the Parties determine is required to be shared by the PAG for the purposes of the exercise of its role under this MoU and the achievement of the ACO Objectives under this MoU and/or the fulfilment of the Parties obligations under this MoU.

ACO Intellectual Property

d. If any Party creates any Intellectual Property via the PAG, the Party which creates the Intellectual Property will assign to [ ], with full title guarantee, title to and all rights and interest in the Intellectual Property so created.

e. In turn, [ ], will grant to the rest of the Parties a fully paid up non-exclusive licence to use the Intellectual Property for the purposes of the achievement of the ACO Objectives under this MoU.

14. **Counterparts**

a. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same memorandum of understanding. .

b. The expression “counterpart” shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

c. No counterpart shall be effective until each Party has executed at least one counterpart.

15. **Governing law and jurisdiction**

a. This MoU shall be governed by and construed in accordance with English law and each Party agrees to submit to the exclusive jurisdiction of the courts of England.

16. **Dispute Resolution**

a. Every effort will be made to resolve disputes initially by the involved Parties. Any unresolved issues will then be escalated to the PAG which will seek to resolve the issue.

b. Where an issue remains unresolved after more than one month after referral to the PAG then any Party (or the PAG) may escalate the issue to a suitable regulatory body for resolution having regard to the nature of the Parties involved in the dispute and the matter in dispute.

We have signed this MoU on the date written at the head of this memorandum.

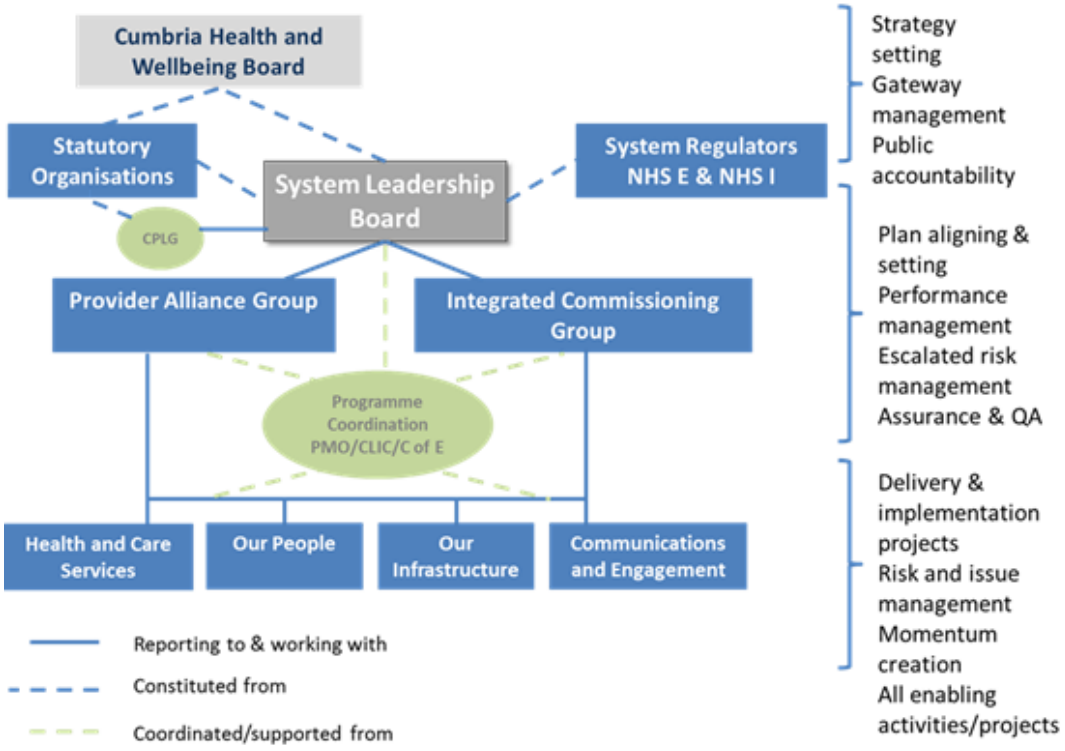
SIGNED by	**)**	.....
Duly authorised to sign for and on	**)**	Authorised Signatory
behalf of	**)**	Title:
CUMBRIA PARTNERSHIP NHS	**)**	
FOUNDATION TRUST	**)**	DATE:
SIGNED by	**)**	.....
Duly authorised to sign for and on	**)**	Authorised Signatory
behalf of	**)**	Title:
NORTH CUMBRIA UNIVERSITY	**)**	
HOSPITALS NHS TRUST	**)**	DATE:
SIGNED by	**)**	.....
Duly authorised to sign for and on	**)**	Authorised Signatory
behalf of	**)**	Title:
GP ICC LEADS	**)**	
	)	DATE:
SIGNED by	**)**	.....
Duly authorised to sign for and on	**)**	Authorised Signatory
behalf of	**)**	Title:
CUMBRIA HEALTH ON CALL LTD	**)**	
(CHOC)	**)**	DATE:
SIGNED by	**)**	.....
Duly authorised to sign for and on	**)**	Authorised Signatory
behalf of	**)**	Title:
NORTH WEST AMBULANCE	**)**	
SERVICES NHS FOUNDATION	**)**	DATE:
TRUST (NWAS)		

Annex A

WNEC System Governance & Leadership Arrangements

1.0 The WNEC STP footprint is co-terminous with the WNEC Success Regime. The governance of the latter sat alongside local statutory organisational governance; equally STP governance nationally has not been established through legislation or regulation. In moving from Success Regime arrangements which focused on planning and some specific service challenges, into new STP arrangements with a broader remit and an emphasis on delivery, the WNEC statutory partners have formed locally mandated governance and leadership arrangements that more explicitly connect all local statutory organisations.

The adopted structure shown below has enabled transition from Success Regime arrangements to collaborative system governance, with the expectation that over time these will be in turn replaced by longer term arrangements for accountable care:



Group & Function	Specific issues
Health and Wellbeing Board	
Sets Cumbria Health and Wellbeing Strategy and oversees Better Care Fund.	Broadened membership to include statutory NHS providers
Statutory Organisations	
Set organisational strategies and plans and are accountable for delivery and performance of to the public and regulators	Are all represented on both the health and wellbeing board and WNEC systems leadership board
System Regulators – NHSI & NHSE	
Regulate NHS commissioner and provider organisations to deliver NHS outcome and performance standards. Coordinate gateway control for significant resource/service change programmes. Assure STPs.	Are represented on the WNEC systems leadership board.
Systems Leadership Board	
Strategy – collective oversight of the development and implementation of sustainable system strategies and plans including consultation processes **Performance** – monitor/ intervene collectively by exception **Organisational Form(s)** – to ensure optimum system effectiveness and to collectively develop and propose future commissioning and provision organisational form(s) for recommendation to statutory bodies to achieve this.	Chaired by Success Regime chair and vice chaired by STP lead. Membership includes: each statutory organisation NHS England/Improvement Cumbria Healthwatch Primary Care Works within statutory organisational arrangements.
Integrated Commissioning Group	
Planning and Strategy – agrees priorities for population outcomes and achieve these through increasingly integrated commissioning arrangements across the public sector (potentially encompassing NHS care, public health, adult social care, children's social care), To make decisions on priorities for the system including procurement of providers as necessary. **Operational Performance** – to ensure providers are commissioned to deliver required performance and intervene as commissioners as appropriate to ensure this **Organisational Form –** to oversee the development of and transition to joint commissioning arrangements through the steps of 'co-ordinated commissioning', 'collaborative commissioning' and 'integrated commissioning', ensuring robust models, necessary governance and other arrangements to support objectives as agreed by partners	Chair & Vice Chair TBA - primarily constituted from CCC and CCCG with other members TBA Currently works within statutory organisational arrangements.

Provider Alliance Group	
Planning and Strategy - agrees collective shaping of and responding to commissioning requirements from a provider perspective. To advise commissioners on the feasibility of their commissioning plans and to inform commissioning activities of the frontline perspective. **Operational Performance** – develops the necessary arrangements to support the integration of services locally required to achieve desired system outcomes. To work together to ensure optimum system resilience and sustainability of services overall. **Organisational Form** – oversees the development of, and transition to, new organisational forms for service provision ensuring robust cases for change, delivery models, governance and other arrangements are in place to support objectives as agreed by partners	Chair NCUH CEO & Vice Chair CPFT CEO - Membership includes: Primary Care NCUH & CPFT Social Care Third Sector Currently works within statutory organisational arrangements.
Implementation Groups	
HEALTH & CARE SERVICES: a matrix approach ensures integrated pathway development across current setting interfaces, whilst enabling control of delivery within specific organisational areas of health and care provider communities.	CEO Sponsors & SRO's Various
COMMUNICATIONS AND ENGAGEMENT - includes communications as required during and following consultation in tandem with bought-in and internal Trust/CCG arrangements; responsibility for comprehensive approach to community, public, patient and staff participation and involvement.	SRO – STP Communications Lead.
OUR INFRASTRUCTURE– hard infrastructure enabling workstreams clustered together to ensure a cohesive approach linked to FBC and other business case development requirements (including STP financial returns etc.). Includes Finance, Estates, IT/Informatics and Transport Infrastructure. Each of the above areas operate working groups with overall coordination as necessary	SRO - STP Coordination Lead.
OUR PEOPLE – Overall design and delivery for the system's Organisational Development strategy and programme. Includes specific workstreams focussing on Workforce Plan Leadership Development and OD	SRO – CPFT Director of HR & OD

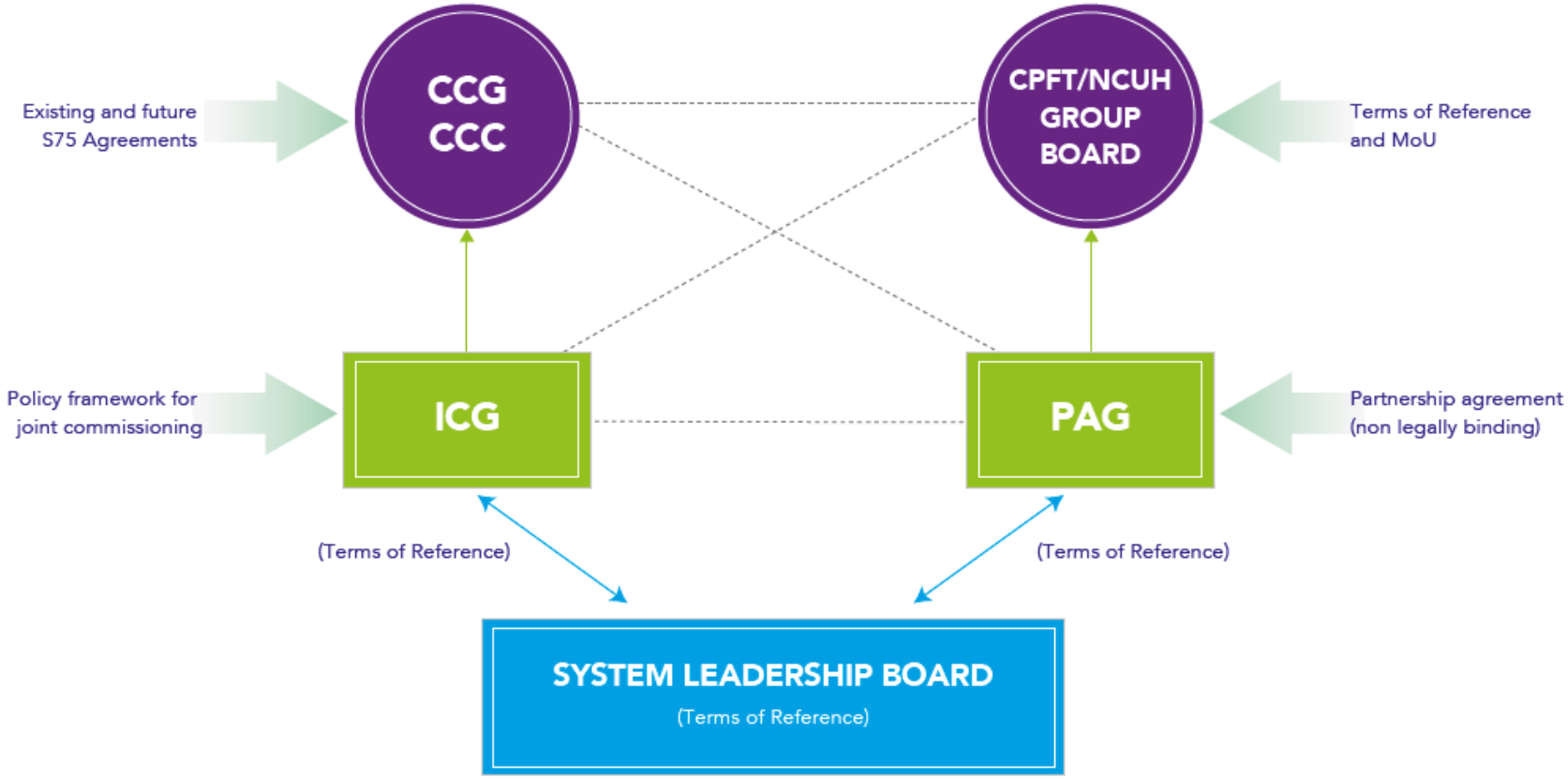
In addition to the above formal governance groups:

1.1. Clinical/Professional Learning Group (to be established) –considers professional issues (e.g. profession based strategies, operational issues, professional risks, audit outcomes, incident outcomes, learning and development etc.) and provision of advice to the Systems Leadership Board as necessary.

1.2. Programme Coordination Group –coordinates the activities across the programme including;
    - Programme plans
    - Programme communication across the workgroups
    - Effective meetings, agendas
    - Coordinated support for SRO's and setting accountabilities collaboratively with SRO's.
    - Project support for specific deliverables
    - Aligned approaches for the above with CLIC and full utilisation of the Cumbria Production System.

Membership of the programme coordination group is from the PMO, CLIC and SROs from within the programme. The SR/STP Coordinator chairs the group.

SYSTEM GOVERNANCE & PARTNERSHIP AGREEMENTS



1) Current Section 75s are pan-Cumbria
2) Risk share and tactical commissioning arrangements including any elements relating to social care to be determined

Annex B

Provider Alliance Group (PAG)

PURPOSE:
The PAG does not initially have any delegated functions from the Board/Governing Bodies of the Parties which remain separate statutory organisations. Individual PAG members are however able to make decisions within the scope of their own authority in tandem with other members of the group.

The PAG will:	**The PAG is not intended *at this stage* to:**
Provide strategic leadership and oversight to support achievement of our shared vision and objectives through delivery of the ACO Objectives.	Be the place where 'normal' day to day work of the partners is led or managed. Although it can provide a place for consideration of difficult system issues, such as system resilience. However over time it is anticipated that PAG as a shadow ACO will take on this role.
Discharge its collective accountability for delivery to respective Parties through representation of appropriate Accountable Officers.	Take on any formal delegation from the Parties; any future delegations where legally permissible will be formally agreed by the relevant parties and included in the MoU when appropriate. .
Make decisions in the context of the shared vision and ACO Principles but within the parameters of the Terms of Reference.	Replace local organisational decision making in advance of any legally permissible formally delegated authorities. However, the PAG and its supporting leadership will need to work through what this means in practice as and when difficult situations arise.
Consider investment decisions collectively and agree the use of any nationally drawn down monies.	Result in parties incurring liability for their share of the deficit out-with any further formal risk and benefit agreement. GPs will not incur personal liability for a share of a deficit on the capitated budget.
Negotiate potential conflicts of interest between WNEC system needs and priorities and individual/organisational needs and priorities.	Take a leadership role in the management of contracts with individual providers, for example, GMS contracts.
Operate through an informal shared leadership structure for this phase of development. The PAG will support the development of leadership and devolved decision making through the ICCs and Clinical Networks to establish a more formal leadership structure in the next phase	Make any changes to current contractual arrangements for GPs. GPs will remain within their existing contractual framework, with contracts held with NHSE and any changes to GP practice contract income will only be via their existing contractual framework.

Provider Alliance Group (PAG) Terms of Reference [November 2016]

PURPOSE:

The role of the Provider Alliance Group is to enable integrated delivery of health and care services for the footprint of WNE Cumbria. The Group is intended to complement statutory organisations by providing a "system" based body for inter-related provider issues to be planned, agreed and monitored. The Provider Alliance Group works within the governance arrangements for the WNE Cumbria STP footprint enabling partners to work together effectively on all aspects of the pre/during/post STP implementation programme.

Over time and as the system moves as expected towards "Accountable Care", it is anticipated that the Provider Alliance Group will take on a formal role in relation to a number of tactical commissioning functions, in addition to current provider issues. This would be in response to commissioning intentions approved by the Integrated Commissioning Group.

The Provider Alliance Group will not initially have any delegated functions from the Board/Governing Bodies of statutory organisations. Individual members will however be able to make decisions within the scope of their own authority in tandem with other members of the group. Over time and as the system moves towards "Accountable Care", it is expected that the Provider Alliance Group will take on formal delegated responsibilities on behalf of statutory organisations. Any such agreements will need to be formally constituted and result in amended Terms of Reference.

RESPONSIBILITIES:

The Provider Alliance Group will be responsible for:

Planning and Strategy - to agree collective shaping of and responding to commissioning requirements from a provider perspective. Direct the work of the Provider Alliance through the workstream governance arrangements, holding each other to for delivery of agreed programme objectives. To advise commissioners on the feasibility of their commissioning plans and to inform commissioning activities of the frontline perspective.

Operational Performance – to develop the necessary arrangements to support the integration of services locally required to achieve desired system outcomes. To work together to ensure optimum system resilience and sustainability of services overall. Importantly, the Provider Alliance Group will ensure cohesion and collective leadership for the majority of the workforce within our system so that all staff have clarity over their positive and aligned contribution within the overall system.

Organisational Form – to oversee the development of, and transition to, agreed new organisational forms for service provision ensuring robust cases for change, delivery models, governance and other arrangements are in place to support objectives as agreed by partners.

The Provider Alliance Group will be responsible for escalation to the System Leadership Board of risks to delivery: these may be risks in relation 'business as usual' including delivery of key constitutional targets or operational fragility, or in relation to delivery aspects of service change.

MEMBERSHIP:

The Provider Alliance Group will be chaired by the STP CEO Lead and vice-Chaired by the CEO of Cumbria Partnership Foundation Trust. (Once the Success Regime is stood down and the System Leadership Board is chaired by the STP CEO Lead and vice-chaired by a local CEO, these arrangements may need to be re-visited.) The members will be CEO/Director or equivalent (or their nominated and brief deputies):

NAME	ROLE	Role on Board
Stephen Eames	Chief Executive, NCUH	Chair, CEO Sponsor Acute Service Delivery Framework, NCUH member
Claire Molloy	Chief Executive, CPFT	Vice Chair, CEO Sponsor ICCs Delivery Framework, CPFT member
Brenda Smith	Corporate Director Health, Care and Community Services	CEO Sponsor Health & Well-Being Delivery Framework on behalf of Diane Wood), CCC member
Joanna Forster Adams	Chief Operating Officer, CPFT	CPFT member
Helen Ray	Chief Operating Officer, NCUH	NCUH member
Mark Alban Rachel Preston Simon Desert	General Practitioners	GP Clinical & Provider Representatives
Susan Blakemore	Cumbria Health on Call (CHOC)	Primary Care Provider Member
Ged Blezard (Peter Mulchay - deputy)	Responsible Executive, NWAS	NWAS member
Sue Stevenson	Chief Operating Officer, Healthwatch	Independent Advisor
Colin Cox	Director Public Health, CCC	SRO Health & Wellbeing Delivery Framework
Caroline Rea	Director of Primary Care, CCCG	SRO ICC Delivery Framework
Niall McGreevy	GP, Allerdale Locality Lead, CCCG	Clinical Lead ICC Delivery Framework
Rod Harpin	Medical Director, NCUH	SRO/Clinical Lead Acute Services

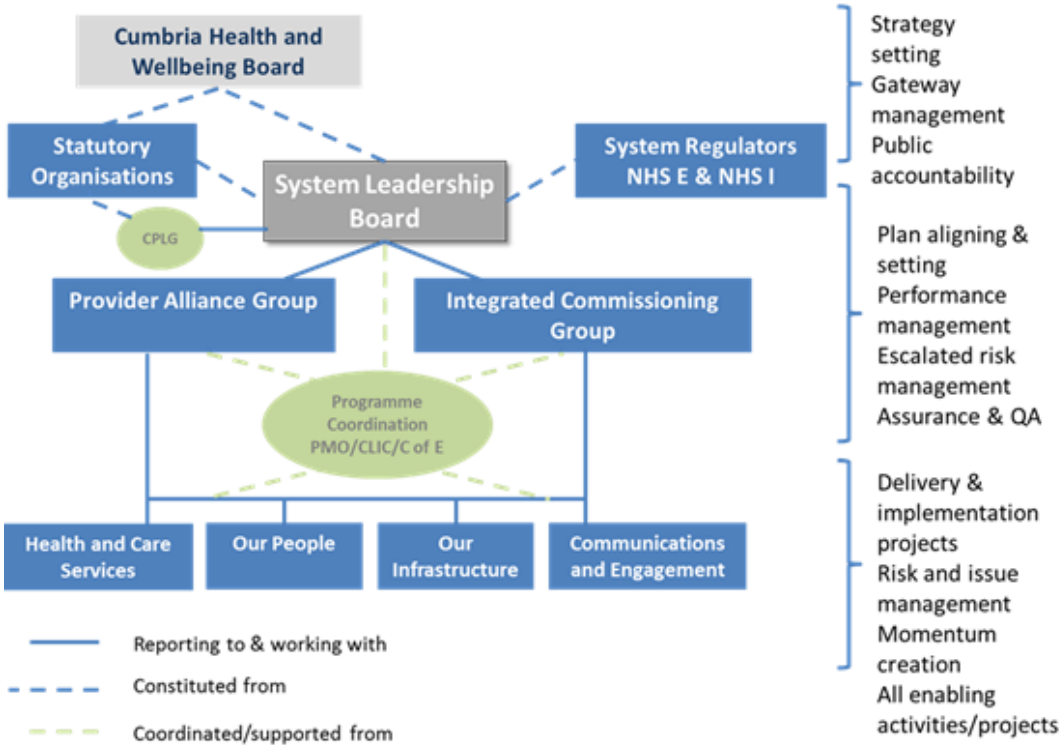
		Delivery Framework
Lynn Marsland	Director of Workforce & OD	SRO Our People
Stephen Singleton	CLIC Director & SR Medical Director	SRO OD
Julie Clayton	Head of Communications & Engagement, CCG	SRO Communications and Engagement
Michael Smillie	STP Coordination Director	SRO Our Infrastructure & PMO member
Debbie Freake	STP Director of Strategy	SRO Organisational Form & PMO member
Kirsty Roberton	Transformation and Delivery Programme Manager	In Attendance

Clinical pathway managerial and clinical leads will be welcome to attend meetings and will be specifically invited to attend for particular agenda items.

SUPPORT:

The Provider Alliance Group will be supported by SR/STP Programme Management Office (lead Director Debbie Freake).

The Group will work within the below Governance Structure;



FREQUENCY

Monthly and as required

ACCOUNTABILITY

All clinical and enabling workstream activities/projects in relation to delivery and implementation will report to and be held to account by the Provider Alliance Group via their SROs (or for clinical pathway workstreams, their managerial & clinical leads). Delivery Frameworks will report to and be held account by the Provider Alliance Group via their SROs.

The Provider Alliance Group is accountable to the System Leadership Board. Individual members remain accountable via their own employing organisations to Board and Regulators as current.

A written report will be provided by the Group to the System Leadership Board in advance of each meeting.

QUORUM

To be quorate each of the Cumbria based statutory provider organisations is required to be present – CCC, CPFT, NCUH. If members and deputies are not available then other nominated deputies are allowed by exception and with the Chair's agreement.

REVIEW DATE

The role of the Group will be reviewed March 2017

Annex C

Principles for Organisational Form Development

Future WNEC organisational form must support improving health and care services to individuals and communities by building a population health system for integrated care which deliberately supports and/or further enables:

Clinical & Care Services:

a) A shift in focus and investment to support ill-health prevention (primary, secondary and tertiary), and to promote population health and well-being
b) Continuous communication between front-line health and social care professionals involved in co-delivery of care through integrated multidisciplinary team working and case co-ordination
c) Health and care services systematically designed around the needs of individuals and their families in their usual place of residence and deliberately focused on reducing disadvantage
d) An asset-based approach where services are built on strong partnerships with local communities and across public, voluntary, private and academic sectors
e) Reduced reliance on any form of institutionalised care provision – including acute and community hospital beds, and residential and nursing home provision

Culture

a) Common values, objectives, ways of working and priorities, understood and demonstrated by all and in all that we do
b) A continuous learning environment, where learning occurs cross-system without 'traditional' organisational or professional boundaries, and which demonstrates our ambition as a remote and rural health system of excellence
c) All staff engaged in continuous improvement activities as a norm, equipped with the right skills and tools
d) An environment which demonstrably values the contribution of all workers and in particular which creates an new trust-based partnership with primary care
e) Ready and well-understood access to opportunities for professional and personal development
f) Genuine co-production with individuals, families, professionals, and communities through a process of continuous dialogue and mutual respect
g) A shift from reactive management to proactive deliberate design and delivery of services

Structure

a) Integrated Care Communities positioned as the core building blocks for our system, complemented by strong clinical and care network arrangements within and beyond WNEC
b) Recognition of the influence of the wider determinants of health and the role of prevention and early help in the whole system approach to population health
c) Driver alignment (financial, professional, priorities) which smooths early shift of care
d) Subsidiarity with appropriate devolution of responsibility, control and decision-making
e) Maximum use of technology to enable care to be delivered as close to home as possible, reduce travel by public and professionals, and support professionals in their activities
f) Reduced duplication and waste in clinical and care service provision by design, with an emphasis on efficient delivery of agreed priority outcomes
g) Maximum efficiency in the delivery of non-clinical support services and leadership functions to allow as much resource to be invested in direct care provision as possible
h) System simplification with a reduction in organisational interfaces, transactions and hand-offs
i) Recognition of whole system contribution including communities, parish and district councils

Appendix 4

High Level Risks Associated with Provider Integration
1. There is a lack of agreement and buy-in from Governors, staff and other key stakeholders to the proposals
2. The programme of work distracts leadership from managing the significant performance issues faced by their organisations
3. Governance arrangements are perceived to simply reflect current arrangements, rather than delivering genuine transformation
4. Governance arrangements are not sufficiently inclusive of primary care
5. Governance arrangements are not sufficiently inclusive of third sector partners.
6. Cultural differences between existing organisations and 'local politics' inhibit the formation of the ACO.
7. There is a negative public and media reaction in relation to proposed changes
8. Transition increases inherent governance risks (eyes off the ball).
9. Change is poorly executed.
10. Some areas of business receive inadequate attention (for example acute service issues dominate).
11. Focus on bilateral arrangements between the two trusts negatively impacts on other partnerships
12. There is high staff turnover due to unsettlement and uncertainty.
13. Positive aspects of existing culture and ways of working are diluted and/or adversely affected

14. Specialist services provided pan-Cumbria by CPFT and the Council are adversely affected.
15. There is mis-alignment of timetabling for organisational changes pan-Cumbria.
16. Early formal integration between CPFT and NCUH is deemed to constitute a transaction.
17. A change in national guidance, or regulatory approach, hinders the pace at which the ACO proposals can be implemented.

Appendix 5

High Level Workplan for Provider Integration

(Note: Some items relate only to bilateral activities between CPFT & NCUH)

April - October 2017	**October 2017- April 2018**
System-wide Common operating model for integrated care delivery:	
Confirmation of activity shifts in 17/18, pump priming and other investment; finalised plans for each Delivery Framework County Council confirmation of scope and degree of anticipated social care integration and timeframes Agreed resources and support offer for ICCs including support services, management & leadership Common Operating Model agreed in line with Clinical Model across the 3 System Delivery Frameworks; monitoring arrangements in place via PAG Agreed integrated management structure for ICC Teams and potentially ring-fenced staffing budgets Agreed pooled budgets (where appropriate) Scheme(s) of Delegation and associated transition plans agreed as required (Schedules to PAG MoU) Scheme(s) of delegation with appropriate monitoring arrangements in place	Outline activity shift plans for years 18/19 onwards Regular collective performance review of Integrated Care deliverables/outcomes across the 3 Delivery Frameworks Shadow arrangements for ICC governance within wider system plans implemented Further schemes of delegation as required

Agreed governance structure for ICCs within Shadow ‘ACO’ arrangements Agreed collective performance framework for Integrated Care Delivery; to include individual ICC targets and metrics agreed Established performance review process to PAG/ACO	

April - October 2017	October 2017- April 2018
Common platform including back office functions:	
Regular financial reporting and collective management against system financial control total Collective performance management of agreed whole system improvement plans and metrics Aligned processes for managing system organisational change (transition and permanent) in place Agreement of strategic framework for, and initial implementation of cultural change programme Implementation of agreed strategic approach to engagement with local communities and staff: co-production and participation; cross-system communications strategy and team alignment proposals Agreement and initial implementation of a Common Platform Delivery Plan (initially Bilateral), with outline programme for further development during 2017-19; to include in addition to above: • NHS contracting mechanisms/payment • policy and standards alignment/harmonisation • risk approach & clinical governance arrrangements • common leadership (see next section) Support Services: Approval and initial implementation of strategic priority Shared Service Business Cases **(Bilateral)** Exploration by County Council and NHS of opportunities for early joint working	Continued collective management of system control target; agreed approach to 2018/19 Continued collective performance management of whole system implementation plans and metrics; draft operating plans for 2018/19 Review and adjustment of cultural change programme as required Review and adjustment of approach to community and staff co-design/production/ delivery as required Review and adjustment of implementation of Common Platform Delivery Plan as required

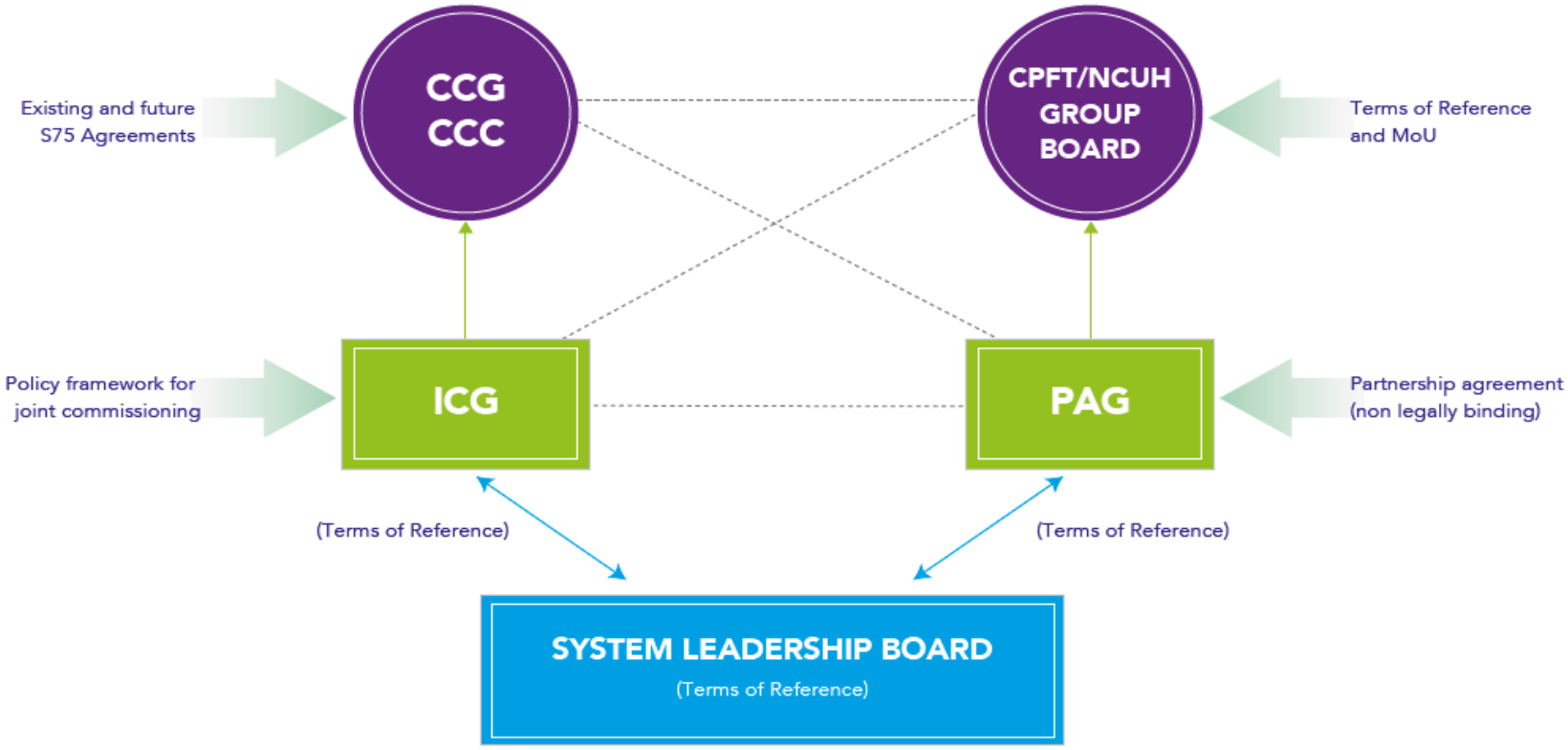
Dialogue with neighbouring STPs in relation to joint opportunities and interface. Future shared services vehicle options plus development of Business Cases and proposals for wider potential pool of services	Support Services: Approval and implementation of business case(s) for shared services for remaining strategic and wider pool services over a phased period

April - October 2017	October 2017- April 2018
Shared leadership, accountability and governance:	
Leadership: Development of planned approach to joint appointments; proposals and process for integrated system leadership and management structure (initially Bilateral); early implementation Proposals for system Governors to be considered Agreed system leadership Development Plan in place Accountability & Governance: Agreed proposals for scheme of delegation under transitional arrangements including ICCs; formal arrangements in place (Bilateral and wider PAG) Formal agreements in place for Clinical Networks beyond WNEC; detailed proposals for specific service areas agreed Work with primary care to understand emerging models for GMS/PMS and interface with ACO proposals; clear 'offer' to primary care partners Detailed work and formal agreement on end state delivery vehicles and associated governance requirements, including full benefits and risk appraisal Due Diligence programme defined: clinical, financial, workforce, quality & legal Consideration of regulatory impact and discussion with regulators; agreed timetabling and	Leadership: Full implementation of agreed integrated system leadership and management structures Implementation of agreed new system leadership arrangements and support Accountability & Governance: Any further transitional arrangements for scheme of delegation, governance and accountability framework under 'shadow end-stage' arrangements Implementation of Clinical Network arrangements for service areas Detailed governance and due diligence work on agreed final form; integrated regulatory arrangements in place Preparation and Gateway review of

regulatory requirements	arrangements for final form; commissioning process and legal mechanisms for final form implemented from April 2018 onwards

Appendix 6

SYSTEM GOVERNANCE & PARTNERSHIP AGREEMENTS



1) Current Section 75s are pan-Cumbria
2) Risk share and tactical commissioning arrangements including any elements relating to social care to be determined