ACCOUNTABILITY FRAMEWORK AGREEMENT FOR THE PORTSMOUTH AND SOUTH EAST HAMPSHIRE SYSTEM

14 May 2015

Contents

Annexes:

1. Changes since November Version and as issued to UCB,16th April

Section	Change
2. Introduction	**Updated to reflect actual performance since December and sets out purpose of the document to clarify:** ➢ the projects in phase 2 ➢ the governance arrangements and reporting requirements ➢ the approval of funds processes with regard to the available pump priming monies, previously referred to as ORCP and the case for any future investments
3. Objectives	Question for the Urgent Care Board: is the prime sole objective the delivery of the 4 hour target or also to ensure that the out-of-hospital alternative is sufficient to deliver Commissioning Strategies
6. Projects in Phase 2	To be agreed and developed into project plans with milestones and KPIs
8. Financial management and approval of funds	To reflect the reduction in ORCP funds; that cases need to be made for investment and establishing a gateway process.

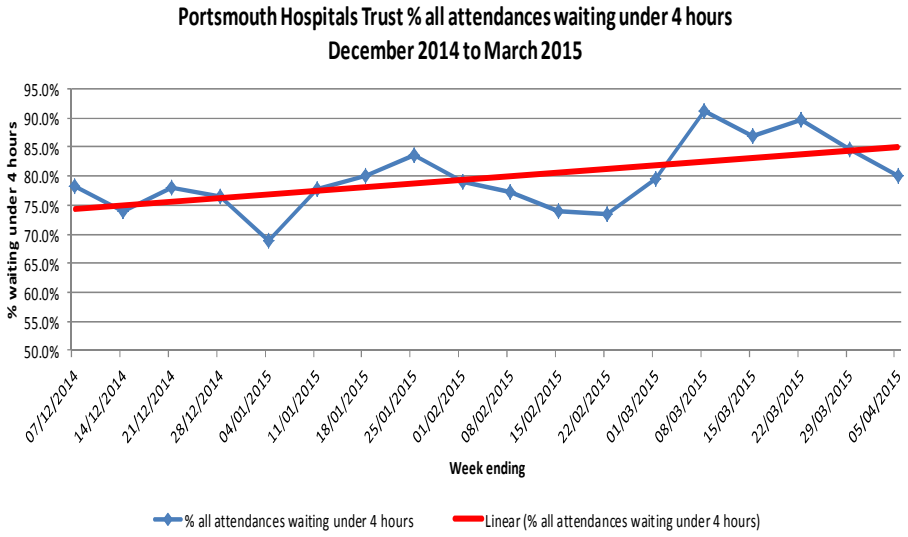
Update as a result of comments received for submission on 14th May UCB

Section	Change
2. Introduction	Increased rationale re why focus on 4 hour standard
8 Finance	Updated to reflect CCG Finance Director comments
Appendix	Quality appendix added

3. Introduction

- Long waiting times in ED departments not only deliver poor quality in terms of patient experience, they also compromise patient safety and reduce clinical effectiveness. We have an operational standard of 95% for patients being seen and discharged within 4 hours and we use this to be sure patients are being treated quickly. This operational standard is designed to deliver patients 'rights under the NHS Constitution.

- Performance against the standard was poor during 2014/15. Since the introduction of the Accountability Framework in November, there was an overall improvement in delivering the four hour target, demonstrated in the chart below, which shows performance for Portsmouth Hospital NHS Trust



- However, performance remains significantly below the original TDA trajectory and activity for the current year to 13th April is recorded as 81% in April and has continued to deteriorate.

- It should be noted that performance after including St Mary's NHS Treatment Centre typically increases the system performance figure between 3 and 5 percentage points

- This refreshed framework sets out confirmation of:

  - the objectives
  - the agreed set of principles
  - roles and responsibilities
  - the projects in phase 2
  - the governance arrangements and reporting requirements
  - the approval of funds processes with regard to the available pump priming monies, previously referred to as ORCP and the case for any future investments

- This agreement is between the following organisations:

  - Fareham and Gosport CCG
  - South Eastern Hampshire CCG
  - Portsmouth CCG
  - Portsmouth Hospitals NHS Trust
  - Southern Healthcare NHS Foundation Trust
  - Solent NHS Trust
  - Portsmouth City Council
  - Hampshire City Council
  - South Central Ambulance (covering 111 and ambulance)
  - PHL (covering HDCOS out of hours service)

  Together referred to collectively as Portsmouth and South East Hampshire System (PSEH system) and partner organisations.

4. Objectives

This revision of the Accountability Framework reflects the second phase, which will focus on areas not yet delivered in phase 1, the findings from phase 1 and the delivery of **integrated frail elderly** and long term conditions care for the Portsmouth and South East Hampshire as set out in the Portsmouth and South East Hampshire Sustainability Plan refresh 2012.

Key objective:

- To improve patient experience and clinical outcomes by achieving the 4 hour target in line with the agreed trajectory

To enable delivery, the following must be achieved:

- Identification and agreement of key milestones as part of the trajectory to 4 hours
- Identify and agree the set of programmes and projects designed to achieve the 4 hour target and improved flows across the system
- Continued reporting against delivery of actions not yet completed in phase 1 and against milestones and KPIs in new projects

This framework agreement recognises that the system is collectively responsible for securing the delivery of the urgent care changes and transformational changes required to support the out of hospitals and frail elderly model of care and as a consequence outlines the specific actions and outcomes each partner organisation is responsible for delivering.

5. Agreed Set of Principles

The Portsmouth and South East Hampshire System have agreed to work to a set of shared principles:

- **Clear accountability –** each organisation must be accountable for its actions, so each must have unambiguous and well defined responsibilities; rewards and consequences will be aligned

- **Transparency –** the public, area team, NHS England, TDA, monitor and LGA must know who is responsible for what

- **Avoidance of duplication –** each organisation must have a clearly defined role, to avoid second guessing, inefficiency and the unnecessary duplication of effort. This will help ensure proper accountability

- **Collaborative working** – each organisation will proactively take action to maintain and strengthen joint working arrangements

- **Regular information exchange** – this helps each organisation to discharge its responsibilities as efficiently and effectively as possible

6. Roles and Responsibilities

- The performance of ED is a challenge and its delivery is the responsibility of each organisation and between organisations within the system. Individual organisations will be held to account via their Boards with the System holding itself to account via the Urgent Care Board.

- The role of the commissioner will be to ensure that there is no uncertainty or ambiguity in terms of what is expected to be delivered by partner organisations and to align the contractual framework with the actions set out in the EUCRIP to ensure that there are no disincentives to delivery or misalignment between providers.

- Accountability is established at all levels, based on:

    - Clear agreement on what is to be done
    - Identification of who is responsible to carry out the function
    - System for monitoring and evaluating
    - Ensuring required resources/support is in place

Roles and responsibilities as an organisation within a system are summarised below;

- The reframed Urgent Care Improvement Plan sets out the priorities, outcomes and responsibilities it expects each organisation to deliver.

- Whilst the Urgent Care Board will oversee the delivery of the plan, each organisation remains accountable through its own Board for the delivery of its elements of the plan. Each organisation is therefore required to monitor and report on its performance to its Board or Committee.

The delivery of the plan will be ensured through the following mechanisms:

- The Boards of each organisation will hold its Executives to account for the delivery of its explicit actions and performance metrics set out in the Urgent Care Improvement Plan.
- The Urgent Care Board will collectively hold to account any organisation(s) that fails to deliver schemes to agreed timescales and have oversight of the application and delivery of the resource.

- The commissioners will hold individual organisations to account through the existing contractual framework. Commissioners will review performance monthly and will suspend fines and penalties associated with ED performance (excluding ambulance handovers) if

the provider are delivering the actions within the agreed timescales outlined in the EUCRIP. Commissioners will, however, expect a clear plan as to how the monies are to be re-invested if fines and penalties are suspended. If, however, the organisation is not delivering the changes it has committed to within the agreed timescales commissioners will fully enforce fine and penalties.

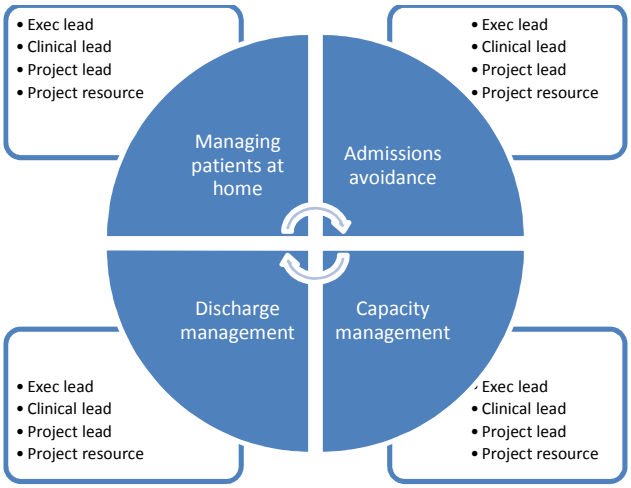
- To underpin the principle of good communication, arrangements will be put in place for managing communications within the system ensuring there are consistent messages going to Boards, staff, public and other key stakeholders. The Communication arrangements will be overseen by the CCGs, but each organisation will be required to lead on elements or where it is clearly the responsibility of the organisation concerned.

- The regulatory bodies; TDA, NHSE and Monitor, will hold the relevant individual organisations to account for the delivery of their agreed actions in partnership with the commissioners. The key regulators will also hold the system to account through the tripartite arrangements.

- Each organisation will understand what initiatives and therefore outcomes they are responsible for delivering as part of a system approach to delivery of the EUCRIP and ORCP initiatives. It is underpinned by contractual levers to ensure risk is shared appropriately by all organisations and Providers will be incentivised and rewarded for delivering and exceeding the outcomes they have committed to.

7. Projects in Phase Two

The schedule of projects and ideas from system partners has been received and has been refined into four programmes.



Urgent Care Board is asked to consider the lead arrangements for sponsoring each of the four programmes set out across. Each requires an Executive and Clinical Sponsor as a minimum.

The programmes are split into projects, set out below.

1.Managing patients at home	2. Admissions avoidance	3. Discharge management	4. Capacity management
Nursing Homes Project - access to specialist advice - GP support - local pharmacist	O/S actions from 2014/15	O/S actions from 2014/15	O/S actions from 2014/15
Local pharmacists - targeting patients at risk/those about to be discharged/allocated to nursing homes	ED model (PHT proposed new way of working)	Flow (A) Defining roles, responsibilities and communications - IDB function roles and responsibilities	Capacity plan - scenario testing re LoS (simul8) - winter planning
Rapid response	UCC development and implementation	Flow (B) Assessment planning - timeliness of requests - response times - CHC assessment process - Therapy input	Medical Model (community and hospital) - Job planning
OPAS	Ambulatory Care model	Adopting discharge date and plan	Nursing Model (community and hospital)
Long term conditions: Advice and support for patients Pathway development	Step-up model	Step-down model - access to care at home - access to residential homes - step-down beds	Therapy capacity (community and hospital)
Continence service (?)	Out-of-hours - consistency of approach and access to care plans	Advice and information available to patients/carers and relatives (packs re care homes/voluntary org/dom care etc)	CHC model
Development and use of risk registers to target resources - ensure care plan for all those on a risk register - ensure access to care plan			Social Care capacity

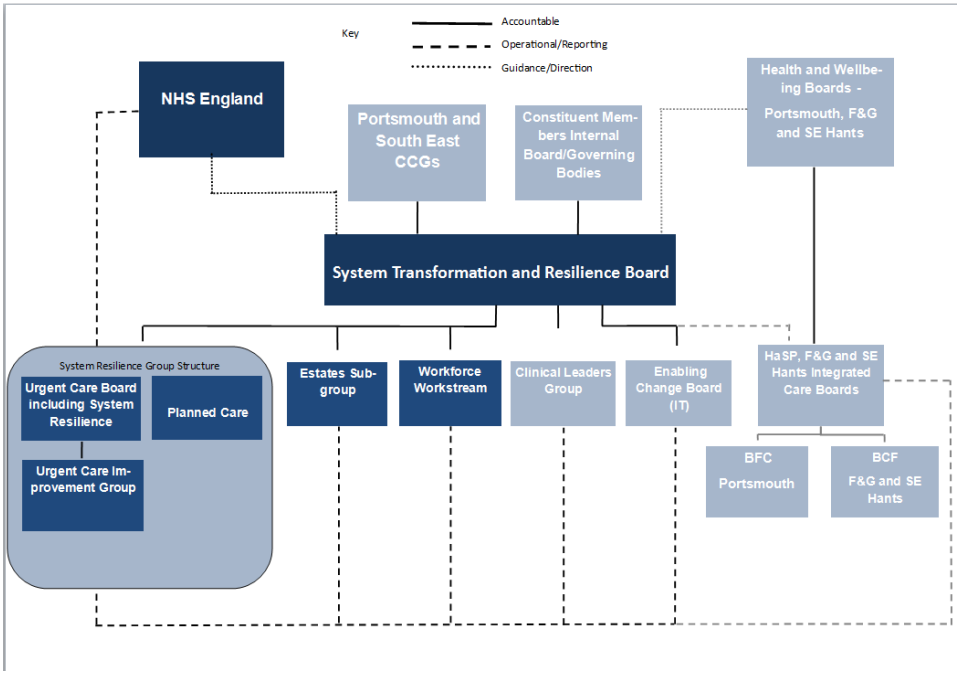
Actions for each partner are to be developed as part of the project planning, much of which is underway and requires some structure to develop a clear understanding of the key milestones which will support the improvements in the 4 hour target.

8. Governance and Reporting Requirements

The governance mechanism and arrangements by which we will effectively deliver the changes are through the following:

- Primary Accountability for the delivery of each organisations respective actions and outcomes will be via its Board,
- System accountability for the delivery of the plan will be via Urgent Care Board,
- Each organisation will be accountable for the implementation of its actions set out in the EUCRIP including quality and patient safety. This accountability will necessitate each organisation setting up its internal PMO and submitting timely reports and performance metrics into a system wide dashboard and performance,
- Each Organisation will establish an executive lead and ensure that its element of the plan is signed off and monitored through its Boards and internal governance arrangements,
- Accountable Officer Leadership for the oversight and delivery of the system plan will be through the Urgent Care Board. Accountable Officers will be responsible for ensuring the pace and execution of the plan being met, will have oversight of the key deliverable metrics and hold each other to account for any non-delivery (see section 5),
- Appropriate senior director level representation at the Urgent Care Improvement Group and operational control to ensure the delivery of the initiatives.

The diagram of the governance arrangements is overleaf with a short narrative in the table of what each group's role and remit is.



Group Name and Membership	Role
SYSTEM WIDE TRANSFORMATION AND RESILIENCE BOARD **Chair**: Richard Samuel Chief Executives	Responsible for the delivery of the aligned vision and strategy across Portsmouth and South East Hampshire; for everyone to have the support they need to live the life they want, to take control of their own health and be as independent as possible throughout their lives. The Group will have oversight of the application of MRET.
Urgent Care Board/System Resilience Group **Chair**: Dr. James Hogan Chief Executives and Operational Leads	Group meets monthly – it is time limited and will cease following sustained delivery of the ED target, following which the System Resilience Group will then be re- established. Its aims are to improve the experience and quality of care for patients, avoiding urgent care where possible and delivering high quality urgent care when necessary, for patients within Portsmouth and South East Hampshire. To enable the delivery of high quality urgent and emergency services, including the sustainable achievement of key national and local targets. To support close working between key partners for the delivery of integrated services for the benefit of public and carers. The group will be responsible for the oversight and delivery of the ORCP funds, reviewing the schemes that are having an impact and those that are not and agreeing across the system which should stop as a consequence.

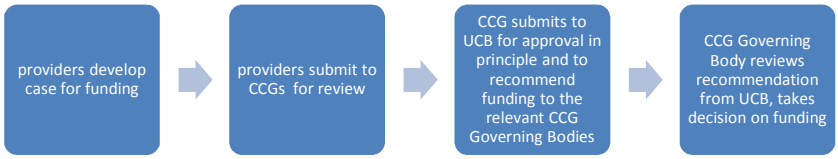
	Key success criteria • Delivery of the Improvement Plan • Sustained improvement in ED performance • An agreed Resilience Plan that supports Urgent Care performance • Agreed key metrics to monitor performance
Urgent Care Improvement Delivery Group **Chair**: ED Improvement Director **Membership**: Directors of Operations and Delivery	The system wide group will drive the delivery of the programmes. Focus on the key areas of delivery and sign off the system project plans. Take responsibility for all elements of the Project Plan. It will meet fortnightly. It will delegate specific tasks in line with requirements from UCB and as required to deliver the Programmes and Projects approved by UCB. The group will be managed and led by the ED Improvement Director. Actions and delivery will be monitored and fed through to the Urgent Care Improvement Board. **Key success criteria** • Delivery of the improvement plan • Delivery of the metrics • Oversight and assurance of actions

We recognise the need to share information in a range of areas and the wide benefit this can bring we will therefore;

- Provide each other with information necessary to help promote the objectives of each organisation when necessary
- Ensure we have a system wide information sharing protocol in place which can maximise the benefits from a framework that provides lawful, secure and confidential sharing of personal and depersonalised information between us
- Integrate engagement activity where possible to ensure a coordinated approach to involving residents and communities in the service design and decision making
- Ensure that there is a single version of the data which is agreed by all in the system
- Each of the PMO officers from each organisation will submit fortnightly reporting against each KPI for which they are being held to account through the programme and project reporting.

9. Financial Management and Approval of Funds

The UCB will consider any projects for funding and will make recommendations to the relevant Governing Body and/or Trust Board, recognising that funding in the system is extremely limited. In the case where funding is requested from the Commissioners, the following steps will be required, reflecting that currently, the UCB does not hold any delegated powers from the CCG Board other than those held by Executive Directors attending the UCB:



The CCG will supply standard formats for any funding proposal which should include:

- Objective(s)
- Benefits (non-financial and financial)
- KPIs
- Implementation plan (milestones and responsibilities)

Investment in schemes must be, as a minimum, cost neutral.

Financial principles

The system has agreed a shared set of financial principles:

- No organisation should expect to improve its financial bottom line from any additional funding unless/until ED target is delivered; any funds which may be applied from Commissioners need to result in a cost neutral position or saving for the system

- *Sources*: (a)Winter pressures/ORCP monies (at a much reduced level for 2015/16, noting that the latter are already fully committed by May 2015); (b) Where a case can demonstrate savings (and is a new scheme not currently relied upon by any organisation), investments will be considered; (c) Penalties and fines related to the A&E 4 hour standard only; (d) any further designated funds applied following receipt of project plans and impact on the financial and operational viability of the scheme.

- *Applications*: Will be made by organisations through the Urgent Care Board who will then recommend funding proposals to the relevant Governing Body/Board.

- *Monitoring Process;* monthly review via Urgent Care Board of delivery of the projects including outcomes and KPIs

- *Cashflow;* Any funds approved by the Urgent Care Board will be transmitted to the organisations via normal contractual routes e.g. via contract, as appropriate. In the case of any dispute, the dispute resolution clauses of the contract will apply.

Signature Page

Signed by

For and on behalf of
PORTSMOUTH CLINICAL COMMISSIONING GROUP
We confirm our agreement to the above

Signed by

For and on behalf of
FAREHAM AND GOSPORT CLINICAL COMMISSIONING GROUP
We confirm our agreement to the above

Signed by

For and on behalf of
SOUTH EASTERN HAMPSHIRE CLINICAL COMMISSIONING GROUP
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For and on behalf of
PORTSMOUTH HOSPITALS NHS TRUST
We confirm our agreement to the above

Signed by

For and on behalf of
SOUTHERN HEALTH NHS FOUNDATION TRUST
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Signed by

For and on behalf of
SOLENT NHS TRUST
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Signed by

For and on behalf of
PORTSMOUTH CITY COUNCIL
We confirm our agreement to the above

Signed by

For and on behalf of
HAMPSHIRE COUNTY COUNCIL
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Signed by

For and on behalf of
SOUTH CENTRAL AMBULANCE NHS FOUNDATION TRUST
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Signed by

For and on behalf of
PHL
We confirm our agreement to the above

Annex

Annex A: Emergency and Urgent Care Recovery and Improvement Plan

Annex B: APPLICATION OF RESOURCES (2015/16)

To be confirmed

Annex C: Quality Accountability Statement

Final version, 20th March 2015

Quality Accountability Statement

In addition to the accountabilities detailed in the main body of this framework, the following accountabilities have been added with specific reference to quality and safety of patient care and treatment across the urgent care pathway. These statements apply to all PSEH system member organisations.

No	Item	Accountability Statement
1	Principles and Values	• Members are committed to upholding the principles of: ✓ Transparency of reporting and information sharing ✓ Consistency ✓ "No blame" and just approach to errors ✓ Collaborative working ✓ Information governance
2	Membership of T&F Group	• Named members commit to attend every task and finish group or send nominated deputies, who are well briefed and have delegated responsibility to make decisions for the organisation.
3	Quality Monitoring	• Internal risk and quality processes will incorporate specific quality monitoring and assurance processes for urgent care. • Compliance with agreed internal and external escalation processes when risk and safety thresholds are not delivered. • Collation of the agreed set of quality metrics. • Use of internal risk processes • Making staff accountabilities clear and addressing non-conformity or lack of compliance with protocols or policies which may put patients at risk of harm.
4	Reporting	• To the PSEH system urgent care data system ensuring

		review at both the task and finish and urgent care improvement groups • Alerting partner organisations to any incidents or unsafe care using the correct procedures as set out by the receiving organisation. • To internal trust boards/governing bodies
5	Investigating Incidents	• Being cited on all patient safety and poor patient experience incidents across urgent care • Following internal SIRI process • Undertaking joint investigation activities where patient harm goes across more than one provider organisation.
6	Sharing Learning	• Participating in joint learning events • Disseminating learning across the organisations • Spread of good practice