Strategic health authorities

Key issues and notable practice from the ‘Fitness for Purpose’ audits
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As an independent watchdog, we provide important information on the quality of public services. As a driving force for improvement in those services, we provide practical recommendations and spread best practice. As an independent auditor, we monitor spending to ensure public services are good value for money.

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Introduction

1 Strategic health authorities (SHAs) came into operation on 1 October 2002, having been in shadow form since 1 April 2002. The Audit Commission appointed auditors to the 28 newly formed SHAs from its Operations Directorate.

2 The key functions of SHAs are to:
   - create a coherent strategic framework;
   - agree annual performance agreements and performance management; and
   - build capacity and support performance improvement.1

3 One of the first challenges facing the Audit Commission’s appointed auditors was to develop an audit to:
   - assess how effectively SHAs are carrying out or moving towards these functions;
   - highlight areas of potential risk and the action needed to address them;
   - suggest further work, if necessary; and
   - share practice across SHAs.

4 We developed the ‘Fitness for Purpose’ audit and conducted the audits between February and September 2003 at all 28 SHAs. Our work also included a survey of constituent trusts’ and primary care trusts’ (PCTs’) views. Each SHA has received an individual report aimed at assessing their progress in developing their role.

5 The Department of Health has undertaken its own assessment of SHAs and has referred to the results of these ‘Fitness for Purpose’ audits.

Purpose of this briefing

6 To enable SHAs to review their results in a national context, this bulletin summarises key messages, key issues and notable practice found while completing the ‘Fitness for Purpose’ audits.

7 The audit results contain an overall auditor assessment followed by detailed auditor judgements of the key priority areas, which are set out under the following key headings:
   - Is there a coherent strategic framework?
   - Are robust performance agreements and management arrangements in place?
   - Are structures in place to build capacity and to support performance improvement?

8 Given the developing role of SHAs, and the lack of any obvious comparisons, our auditor assessments are to a large extent subjective and are not intended to provide...
absolute measures of performance. However, to provide a context for individual assessment we have produced graphs based on our view of 1 = little or no progress; 2 = progress in some areas; 3 = good progress and 4 = excellent progress. These scores have been subject to peer review by auditors and should therefore provide a fair indication of performance.

**Overall auditor assessment**

SHAs are new and developing organisations, tasked with redesigning services to meet both national and local priorities in a demanding and changing environment. The abolition of the Directorate of Health and Social Care creates further uncertainties and challenges. Against this background, SHAs have done extremely well in establishing their new roles and creating structures and processes. However, SHAs recognise that some significant issues remain to be addressed, such as increased public and patient involvement in the development of Local Delivery Plans. Critically, it is too early to determine whether progress to date will result in improved and sustained outcomes for patients. Based on auditor assessments over each of the priority areas, Exhibit 1 provides a picture of overall progress.

**Exhibit 1**

**Good progress has been made in priority areas**

While good progress has been made in developing strategic frameworks, there are significant issues to be addressed in obtaining increased public and patient involvement and in managing and developing information management and technology.

*Note:* The nearer to the outside of the web, the greater the progress.

*Source:* Audit Commission auditor assessments 2003
Is there a coherent strategic framework?

In this section of our audit we sought evidence of a strategic framework that is based on the following:

- national and local priorities;
- an assessment of local health needs;
- a long-term vision linking resources to priorities and objectives; and
- involvement of health, local government and voluntary organisations, staff, patients and the public.

Key messages

We found that the majority of SHAs have a clear idea of what they want to achieve, primarily built on the national priorities (Exhibit 2). This focus on national priorities is understandable given the very short timescales to produce plans and the resources available.

Exhibit 2

Auditor assessments

The auditor assessments are summarised in the following graphs.
In many cases Local delivery plans (LDPs) were developed separately from strategic plans. Links were not clear, particularly around how plans would be financed and resourced.

Developing a strategic framework

<table>
<thead>
<tr>
<th>Issue</th>
<th>Notable practice</th>
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<tbody>
<tr>
<td>In many cases Local delivery plans (LDPs) were developed separately from strategic plans. Links were not clear, particularly around how plans would be financed and resourced.</td>
<td>Developing a strategic framework – building on their Franchise Plans 2 SHAs, Dorset and Somerset, and Leicestershire, Northamptonshire and Rutland, developed their strategic frameworks showing their local and national priorities, the associated resources and clear targets for monitoring achievement clearly. PCT and Trust LDPs/accountability agreements demonstrate how the long-term strategic plan, short-term objectives and clear accountability are allocated to each NHS organisation to deliver their contribution to the overall improvement of the local NHS.</td>
</tr>
</tbody>
</table>

12 During the study we found several examples of notable practice and common issues, some of which are noted here. These are set against summarised findings of our survey of constituent trusts and PCTs.

Survey findings

**There is clarity about the role of the SHA**

*In general there is clarity about the role of the SHA.*

**The introduction of the SHA has created a clearer strategic direction**

*There are mixed views as to whether the introduction of the SHA has created a clearer strategic direction, but many trusts and PCTs agreed that the introduction of the SHA had facilitated whole system thinking.*

**The SHA has introduced effective arrangements to facilitate the production of a robust LDP**

*Several PCTs and trusts did not think the SHA had introduced effective arrangements to facilitate the production of robust LDPs.*

**The Trust/PCT can influence the strategic direction of the health economy through timely informative meetings which meet their objective**

*The majority of trusts and PCTs can influence strategic direction through timely informative meetings.*
Public Health is an essential part of identifying the health needs of the local population, which in turn forms the basis for developing a strategic framework. Key issues include:

- some PCTs and SHAs were unclear about their roles, and that of the DoH, for public health functions;
- a shortage of public health consultants;
- an increase in the number of directors of public health (DPH), each of whom have corporate responsibilities, has reduced the total amount of time that consultants in public health can spend on specific clinically related work; and
- networks are being set up but what they do and their effectiveness varies.

A number of SHAs drew attention to the difficulties caused by the fragmentation of the Public Health discipline consequent on the devolution of responsibilities to PCTs. Some SHAs, for example County Durham and Tees Valley SHAs, have mitigated the effects of fragmentation by developing a collaborative approach with PCTs in which individual DPHs lead for the health community on particular subjects, thus reducing duplication of effort between consultants and their teams. Without this collaborative approach, the ability of public health specialists to contribute to delivering the strategy would be compromised further.

Another SHA has a joint funded post with another SHA and a PCT. Kent and Medway SHA has developed a Public Health Network Management Group and Public Health Network Board with:

- clear terms of reference;
- an annual action plan agreed with PCTs;
- monthly meetings with representation from all PCTs, SHA, academic public health, health promotion, dentistry, health informatics, and health protection unit;
- management support provided by a host PCT;
- a clear business plan with objectives and required actions with a timescale, which is being monitored; and
- a Public Health Performance Framework for PCTs, containing a ‘Recommended process for Performance Managing Public Health Delivery in PCTs’ based on the six broad areas of PCT public health responsibility.

North West London SHA has a combined Public Health and Performance Directorate. This allows closer working and routine reporting of some clinical data, enabling national targets to be set in the context of local circumstances. For example, their population has some of the highest rates of heart bypass grafts and angioplasties in England. The SHA, while addressing the need for improved access to treatment, also looks at preventative strategies to tackle the public health need.

Norfolk Suffolk and Cambridgeshire SHA have developed a Health Atlas System. This was developed by a Public Health Data Analyst, which is a shared post with Eastern Regional Public Health Observatory. The Health Atlas system uses the public health minimum data set. It shows how healthcare is delivered using demographic, activity and disease data. It is in easy to read format – presented on one page graphically.

Survey findings

Has the introduction of the SHA enhanced efforts to improve health services locally?
The majority of PCTs and trusts did not think that the introduction of the SHA had enhanced efforts to improve health services locally.
Public and patient involvement

<table>
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<tr>
<th>Issue</th>
<th>Notable practice</th>
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<tbody>
<tr>
<td>So far, consultation and patient involvement in the formulation of LDPs and strategies has been limited.</td>
<td>Essex SHA launched a system-wide interactive exercise designed by public participation specialists at their local University. This was made up of a range of events across the county with staff and the public and included 15,000 questionnaires. In particular this exercise was designed to engage hard-to-reach communities. The findings have been used to underpin the direction of the SHA through informing its LDP.</td>
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<tr>
<td>There is ambiguity over the roles of SHAs, PCTs and trusts with regard to public and patient involvement.</td>
<td>Leicestershire, Northamptonshire and Rutland SHA has undertaken a major stakeholder consultation exercise, involving both citizens and health service users. The findings underpinned the direction of the SHA, as laid out in its strategic framework.</td>
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Survey findings

Has the SHA introduced effective arrangements to support the development of public and patient involvements?  
The majority of PCTs and trusts do not think that the SHA has yet introduced effective arrangements to support the development of patient and public involvement processes.
Many SHAs have yet to undertake a baseline assessment of the IM&T infrastructure or local information needs. Given the absence of this basic information, the scale and complexity of the new arrangements will present significant risks for health bodies. SHAs have a pivotal role in:

- assessing the current state and capacity of IM&T across their health communities;
- assessing local needs;
- developing sound strategies and programme governance arrangements for delivery;
- communicating local requirements and national priorities; and
- ensuring use of best practice standards for:
  - project management;
  - information governance; and
  - IT service management.

Many SHAs have inherited a legacy of under-investment in IM&T by PCTs, trusts and former health authorities. The engagement of clinicians in the sponsorship of change needs to be formally recognised. There has been a tendency for those clinicians with the interest and commitment in ICT to take an informal lead. Although the value of that contribution is acknowledged, without increased formal commitment it is debatable whether the NHS can achieve the critical mass required to support the successful implementation of the national programme.

Information management and technology (IM&T)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Notable practice</th>
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<tbody>
<tr>
<td>Many SHAs have yet to undertake a baseline assessment of the IM&amp;T</td>
<td>A number of SHAs are implementing programme management structures based on best</td>
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<tr>
<td>infrastructure or local information needs. Given the absence of this</td>
<td>practice methodology (PRINCE2) that monitor business cases and provide a basis</td>
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<tr>
<td>basic information, the scale and complexity of the new</td>
<td>for funding approval. This is particularly important, given the pace of change</td>
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<tr>
<td>arrangements will present significant risks for health bodies. SHAs</td>
<td>associated with the NHS National Programme for IT.</td>
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<td>have a pivotal role in:</td>
<td>• Information governance is a key risk area because of the type of information</td>
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<td>recorded on NHS systems. A number of SHAs have commissioned or undertaken a</td>
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<td>health community review of information governance against the legislative</td>
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<td>framework. For example:</td>
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<td>– Data Protection Act;</td>
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<td>– Freedom of Information Action;</td>
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<td>– Human Rights Act; and</td>
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<td></td>
<td><strong>Shropshire &amp; Staffordshire SHA</strong> held a workshop with clinicians, where they</td>
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<td>expressed a clear desire to be actively involved in change involving Information</td>
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<td></td>
<td>Communication Technology (ICT). As a result of this initiative, the SHA is</td>
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<td>exploring the development of formal ‘change agent’ training for clinicians in</td>
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<td>partnership with a local university.</td>
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Are robust performance agreements and management arrangements in place?

In this section of our audit we sought evidence of robust performance management that included:

- delivery agreements with all trusts and PCTs;
- direct links with the strategic framework;
- agreed national and local targets including resources; and
- effective monitoring arrangements.

Key messages

We did find established performance and corporate governance systems in place but the former concentrated almost entirely on national targets. Performance management was weak around prescribing where there is no national target (Exhibit 3). We have specifically referred to prescribing because of its volatility in terms of expenditure levels year on year, and the impact of prescribing policy on both patient care and cost. This is a topic in which SHAs can have an important role to play. It is too early to assess whether performance management systems will lead to service improvements.

Exhibit 3
Auditor assessments

The auditor assessments are summarised in the following graphs.

Source: Audit Commission auditor assessments 2003
During the study we found several examples of notable practice and common issues, some of which are noted here. These are set against summarised findings of our survey of constituent trusts and PCTs.

Performance management

<table>
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<tr>
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<th>Notable practice</th>
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<tbody>
<tr>
<td>Most of the performance management systems we reviewed, perhaps not surprisingly, monitored figures rather than measures of health improvement.</td>
<td>Several SHAs had comprehensive performance management systems in place. These link to annual accountability agreements and link LDP targets with those contained in NSFs, Commission for Health Improvement performance ratings and the NHS Plan.</td>
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<tr>
<td>The performance management ‘loop’ (see below) was often not being followed for the latter stages – that is, ‘what did we do well and what should we do differently?’</td>
<td>In addition SHAs had open reporting across the whole health economy. This encouraged wider ownership of the problems and solutions.</td>
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<td>Roles and responsibilities for performance management are unclear between SHAs, PCTs, trusts and the DoH.</td>
<td>North West London SHA is not only basing its performance information on local reporting/report card concepts, it is also developing ‘open reporting’ across the SHA area via an electronic system.</td>
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<td></td>
<td>At Greater Manchester SHA, weekly health economy performance meetings, supported by advanced reporting of relevant data, are used to deliver key access and LDP targets. They are also used to get beyond the headline numbers to the interventions needed to deliver the key elements of the LDP.</td>
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<td></td>
<td>Its Performance Directorate covers performance management and improvement. This makes it easier to tackle both aspects of performance. There are regular two day performance and modernisation visits to trust and PCTs. Further flexibility is provided through one of the three assistant directors being a joint appointment between Performance and Clinical Strategy. This has made it easier for the SHA to extend performance beyond a focus on activity and toward the establishment of strategic forums for NSF areas and the shaping of appropriate clinical pathways and sharing of staff and equipment as appropriate.</td>
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<tr>
<td>Norfolk Suffolk and Cambridgeshire SHA Performance Management Framework is aimed at delivering continuous service improvement. It sets out the process for agreeing annual accountability agreements, monitoring and review at PCT and trust level involving Director of Social Services and local authority cabinet member. It has been agreed with SHA Board and chief executives of the eight health systems (local PCTs and trusts). A protocol is being designed that sets out attendance and agenda. It is in line with the Audit Commission’s good performance framework (Exhibit 4).</td>
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Survey findings

Has the SHA introduced effective arrangements to manage performance with PCTs?
Many PCTs and trusts did not think that the SHA has introduced effective arrangements to manage performance with PCTs.

Has the SHA introduced effective arrangements to manage performance with trusts?
A significant minority did not think that the SHA had introduced effective arrangements to manage performance with trusts.
Exhibit 4

Elements of a performance management framework

Many SHAs’ performance management systems failed to ‘close the loop’.

Financial aspects of corporate governance

<table>
<thead>
<tr>
<th>Issue</th>
<th>Notable practice</th>
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<tbody>
<tr>
<td>Many of the LDPs appear to contain high levels of cost improvement savings without clear strategies to show how these will be delivered. As part of our work on the NHS Plan, to be conducted in 2003, we will be reviewing the robustness of these plans. Weaknesses in the commissioning and monitoring of financial functions, provided by shared services agencies, have led to difficulties in producing reliable financial information and delays in preparing final accounts. Few SHAs are taking a strategic view about the extent and performance of shared services in their health community. Uncertainty about the future of national shared services has slowed progress.</td>
<td>Surrey and Sussex SHA has produced a guide on ‘Improving Your Financial Health’ which it has shared with its trusts and PCTs to help them develop their financial recovery plans. It has also set up a database of financial recovery plans to ensure that these are integrated with local delivery plans, commissioning plans, etc. All significant cost-saving projects making up the financial recovery plans are validated and risks are factored in to help ensure the overall recovery plan is robust. One SHA was conducting a review of the viability and location of all of its shared service functions with the objective of ensuring value for money and improved efficiency. West Midlands South SHA Audit Committee was keen to ensure that it had an effective impact on the operation of the authority and it spent some time looking at different models of effective governance. It has now adopted the 5 top risks identified by their external auditor as standing items on its agenda, which has resulted in a more focused and balanced approach. The next stage is to separate the membership of the Audit Committee from the Performance Management Committee to allow independent scrutiny of how the Performance Management Committee carries out its role.</td>
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Prescribing

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<tr>
<td>Prescribing is a key risk area, yet many SHAs do not have pharmacist input. Consequently: • performance management is often limited to prescribing spend; • support for PCT prescribing teams is often limited; and • prescribing issues, such as the use of high-cost, new drugs that affect the whole health community, may not be tackled in a cost effective, equitable manner.</td>
<td>Prescribing: Dorset and Somerset SHA have robust prescribing performance management systems that incorporate both clinical and financial targets. There is regular review of targets with the SHA to ensure that problems are identified early on. The SHA will offer appropriate support if necessary.</td>
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</table>
Are structures in place to build capacity and support performance improvement?

16 In this section of our audit we concentrated on the ability of the SHAs to build capacity and support performance improvement. Specifically we were looking for evidence of:

- the delivery of continuous service improvement;
- clinical governance arrangements that underpin service delivery and improvement;
- effective networks and partnerships;
- strong leadership with the ability to resolve conflict and engage people; and
- structures and resources within the SHA to deliver the agenda.

Key messages

17 We did find evidence that sound structures are emerging to build capacity and support performance improvement, but some of the more difficult areas still need to be addressed, including clinical governance, partnerships, shared services and internal human resources (Exhibit 5, overleaf).
Exhibit 5
Auditor assessments

The auditor assessments are summarised in the following graphs.

Source: Audit Commission auditor assessments 2003
During the study we found several examples of notable practice and common issues, some of which are noted here. These are set against summarised findings of our survey of constituent trusts and PCTs.

**Performance improvement**

<table>
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<tr>
<td>Significant investment was being made in service improvements but notwithstanding this, SHAs had identified desirable service reconfigurations which could not proceed because of resource (sometimes capital) constraints.</td>
<td><strong>Dorset and Somerset Health Community</strong> has established its own local ‘NHS Bank’ for 2003/04. All constituent PCTs have contributed to the NHS Bank, which is used to secure the delivery of strategic change and modernisation. Similarly, <strong>North East London SHA</strong> allocated funding to a central pot. Trusts and PCTs then agreed to focus on health economy priorities and move away from service-led bidding. The LDP is used as a driver and projects are assessed against its priorities using a sector-wide Service Development Framework. <strong>West Yorkshire SHA</strong> has put in place a proactive system to tackle key risks and issues. The SHA has developed a set of indicators to reflect progress against a full range of organisational activity, alongside a risk register for each trust. A rolling cycle of meetings for each sub health economy has been established where the SHA reviews the risk registers, performance data and other local intelligence gathered by managers. This ensures that there is a strategic and proactive approach to the management of key issues and risks. <strong>North West London SHA</strong> has a PCT Transition Unit within the Modernisation Directorate whose purpose is to support PCTs with modernisation. A reference group directs the work of the unit and members include PCT chief executives (CEOs) plus other key players. As it is led by the health community itself, its work has been accepted and this has helped PCTs to make progress.</td>
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<tr>
<th>Human resources</th>
<th>Notable practice</th>
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<tr>
<td>So far many SHAs need to develop their internal HR processes; for example there is a lack of continuing professional development. Some internal human resources (HR) processes are being transferred to the WDCs next April 2004, and some have already. They are at early stages of developing policies and organisational development arrangements.</td>
<td><strong>Dorset and Somerset SHA</strong> has devised a modular development programme for non-executive directors covering a number of topics, including corporate governance, finance, patient and public involvement, clinical governance and health improvement. <strong>North Central London SHA</strong> recently ran a 24 Hour Review, facilitated by the Organisational Development Advisor, to assist the organisation in the harmonisation of policies and best HR practice. This event involved a range of staff from across the organisation working to develop one standard policy file across the organisation. The aim of the workshop was to ensure that staff across the organisation felt that they had ownership of the developing policies.</td>
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Human resources (continued)

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<thead>
<tr>
<th>Issue</th>
<th>Notable practice</th>
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<tr>
<td>The group worked on a range of policies, bringing together previous policies and best practice from the previous Health Authorities including:</td>
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<td>• flexible working;</td>
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<td>• recruitment, retention and retirement; and</td>
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<td>• whistle blowing.</td>
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<tr>
<td>Each area was discussed in groups and previous policies were analysed for best practice. Following the workshop, an action plan has been drawn up which covers who will take each of the policies forward, the consultation process and a plan to take them to the Board.</td>
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Leadership

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<tr>
<td>Indicators which reflect the SHA’s management and leadership capacity, including staff satisfaction surveys, are seldom used and could be a useful addition to the SHA performance management system.</td>
<td>Shropshire and Staffordshire SHA has adopted the NHS Modernisation Agency ‘Gateway to Leadership’ programme across the health economy to bring new managerial talent into the NHS from the private and independent sectors, as well as for fast-tracking potential leaders from within the NHS. Provider Trusts have been identified as host sites for up to 50 entrants at different management levels, and are supported by the SHA’s Head of Human Resources in a structured programme of leadership development. South West London SHA has given consideration to the type and style of organisation that it wants to be. This is described in the Franchise Plan. The organisation and management structure reflects this style. For example, cross directorate/matrix working is promoted across the SHA in a project based way. Evidence of this approach to working was found throughout the audit and working in this flexible way helps this small organisation achieve its overall aims and objectives.</td>
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Survey findings

It is clear who to contact to discuss National Service Frameworks financial health, waiting time/access performance, implementation of the IM&T agenda and communication?

It is not always clear who within the SHA should be contacted to discuss National Service Framework implementation. But it is clear who to contact to discuss financial health, waiting times/access performance, implementation of the IM&T agenda and communications.

Overall, the SHA’s management style is based on openness, trust, listening and partnership.

PCTs and trusts responded that while their SHA’s style was open and trustworthy, they were less convinced about the SHA’s ability to listen to their views and enhance partnership working.
As SHAs developed, a number of existing partnerships were neglected. Efforts now need to be made to revive these important links and encourage PCTs to take a more dominant role. Essex SHA has established a Communications Co-operative led by a management team representing the 23 ‘partner’ bodies. The Co-operative has its own website which contains DoH guidance, as well as communications strategies, action plans and protocols. The Co-operative aims to develop local capacity and capability through a Communications Skills Development Programme that is available to all senior staff.

<table>
<thead>
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<th>Partnerships</th>
<th>Notable practice</th>
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<th>Notable practice</th>
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| Trusts and PCTs had mixed views regarding SHA’s effectiveness in resolving difficult local issues, brokering solutions to reach the best outcome for all stakeholders. |

The SHA has assisted in resolving some difficult local issues, brokering solutions to reach the best outcome for all stakeholders. North East London SHA ensures that rules for handling conflict are agreed at the outset of any project. This is particularly important for cross-organisational projects. Various methods have been used, for example, involvement of external experts, independent facilitation and personal involvement of the SHA Chief Executive. Support also comes from the CEOs Forum, a meeting of all CEOs within the health economy, which has excellent attendance and is very participative.
Clinical governance

<table>
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<th>Issue</th>
<th>Notable practice</th>
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| Where clear structures for handling clinical governance issues exist, these are not always integrated into the core performance management processes within the SHA. SHAs need to strengthen their involvement in managing clinical governance performance across their health economies. | **Leicestershire, Northamptonshire and Rutland SHA** has made a strong commitment to quality, clinical governance and risk management, led by a dedicated team. Principles and targets are set out in the SHA's clinical governance and risk management strategy. The strategy is underpinned by a clinical governance development framework, which lays out minimum expectations and a development plan. There are named links to each organisation across the SHA area who meet regularly. An accredited clinical governance education and training programme is currently being developed.  
**At County Durham and Tees Valley SHA** the Director responsible for leading on modernisation activity is also the clinical governance lead. The intention of this combination of roles is that information gleaned from clinical audit, complaints reviews, reports of untoward incidents and other sources of information about the quality of patient services can help to direct the Authority's efforts to modernise services: ensuring that modernisation is explicitly about remedying known shortcomings and enhancing the quality of service delivery, as well as improving access, efficiency and cost effectiveness.  
**Norfolk Suffolk and Cambridgeshire SHA** has completed clinical governance baseline assessments at all NHS organisations to establish the SHA's level of clinical governance. Templates were used for assessments based on seven pillars of leadership, child protection, and so on. Assessments involved visits and interviews. Results were reported on a county basis deliberately not to name and shame. Since the assessments have taken place significant progress has been made. For example:  
• formation of networks;  
• trust action plans are reviewed twice a year;  
• comprehensive board reports;  
• £40,000 fund for innovative developments;  
• twice yearly clinical governance workshops organised by the networks; and  
• pilot scheme operating on educating and training board members on clinical governance issues. |

Survey findings

**The SHA has introduced effective arrangements to support the implementation of effective clinical governance arrangements**  
The majority of PCTs and trusts did not feel that the SHA had introduced effective arrangements to support the implementation of effective clinical governance arrangements.
Summary and the way forward

A great deal of progress has been made in a very short time. Two key areas for further consideration are:

- As expected, many of the LDPs’ capacity plans reflect national priorities but have yet to be developed to reflect local needs. This is in part due to the short timescales allowed to produce such plans and the resources available.

- Key areas that require particular attention in the future include:
  - development of Public Health networks;
  - public patient involvement;
  - measures to demonstrate the achievement of continuous service improvement; and
  - improved support for prescribing and medicines management.

Further work planned by the Audit Commission on local delivery plans and the achievement of NHS Plan targets will provide additional information on how successful SHAs are in developing their new roles. Building on the results of this additional work we will follow up this study early in 2004.

We are currently reviewing Workforce Development Confederations’ fitness for purpose arrangements and anticipate the publication of a similar bulletin early in 2004.

If you wish to discuss any of the issues covered in this bulletin please contact your local Relationship Manager/District Auditor.

We welcome your views on how helpful you found this bulletin, and in particular whether the identified ‘notable practices’ were helpful. In addition, if there are topics that you think the Audit Commission could usefully explore or research further, please contact us by email to: enquiries@audit-commission.gov.uk
Appendix A: survey results

Exhibit A1
Q: There is clarity about the role of the SHA

Exhibit A2
Q: It is clear who within the SHA should be contacted to discuss: financial health
Exhibit A3
Q: It is clear who within the SHA should be contacted to discuss: waiting time/access performance

Exhibit A4
Q: It is clear who within the SHA should be contacted to discuss: NSF implementation
Exhibit A5
Q: It is clear who within the SHA should be contacted to discuss: local implementation of national IM&T agenda

Exhibit A6
Q: It is clear who within the SHA should be contacted to discuss: communications
Q: The SHA has introduced effective arrangements to: manage performance with trusts

Exhibit A8
Q: The SHA has introduced effective arrangements to: manage performance with PCTs
Exhibit A9
Q: The SHA has introduced effective arrangements to:
support the implementation of effective clinical
governance arrangements

Exhibit A10
Q: The SHA has introduced effective arrangements to:
facilitate the production of robust local delivery plans
Exhibit A11
Q: The SHA has introduced effective arrangements to: support the development of patient and public involvement processes

Exhibit A12
Q: The SHA has assisted in resolving some difficult local issues, brokering solutions to reach the best outcomes for all stakeholders
Exhibit A13
Q: The introduction of the SHA has: created a clearer strategic direction

Exhibit A14
Q: The introduction of the SHA has: facilitated whole-system thinking
Exhibit A15
Q: The introduction of the SHA has: enhanced efforts to improve health services locally

Exhibit A16
Q: Overall, the SHA’s management style is based on: openness
Exhibit A17
Q: Overall, the SHA's management style is based on: trust

Exhibit A18
Q: Overall, the SHA's management style is based on: listening
Exhibit A19
Q: Overall, the SHA's management style is based on: partnership

Exhibit A20
Q: Overall, the SHA's management style is based on: earned autonomy
**Exhibit A21**

Q: This trust/PCT can influence the strategic direction of the health economy through: timely informative meetings which meet their objective

![Bar Chart](chart1)

- Strongly agree
- Agree
- Disagree
- Strongly disagree

**Exhibit A22**

Q: This trust/PCT can influence the strategic direction of the health economy through: commenting on documents with plenty of time to do so

![Bar Chart](chart2)

- Strongly agree
- Agree
- Disagree
- Strongly disagree
Exhibit A23
Q: This trust/PCT can influence the strategic direction of the health economy through: direct access to the Chief Executive

Exhibit A24
Q: Key principles – KP1 focus
Exhibit A25
Q: Key principles – KP2 commitment

Exhibit A26
Q: Key principles – KP3 empowering
Exhibit A27
Q: Key principles – KP4 facilitative

Exhibit A28
Q: Key principles – KP5 developmental
Exhibit A29
Q: Key principles – KP6 involving

Exhibit A30
Q: Key principles – KP7 leading
This report is available on our website at www.audit-commission.gov.uk. Our website also contains a searchable version of this report.