HFMA briefing
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System decision-making and governance

Key considerations

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Introduction

As NHS bodies emerge from Covid-19, with demands for increased productivity within a tighter funding regime than for the last couple of years, they also enter an NHS where integrated care has been put on a more formal basis with a clear direction that this is the new way of working. As part of this, NHS bodies now have (inter alia) both their statutory duty to break-even, but also the statutory duty of their integrated care system (ICS) to break-even and the wider statutory duty to collaborate and make decisions in the public interest. At the same time their other non-NHS ICS partners will have different financial regimes and pressures.

However, each ICS is very different, in terms of geography, number and nature of partners, historic levels of funding and underlying demographic trends. They are also then very different in their relative maturity, reflected in a mixture of the way that they have evolved to work (or the way that they have been instructed to work when in oversight or recovery).

Because there has been, understandably, the desire to move from a framework of 'one size fits all' to a greater local determination, there is an associated risk of the blurring of lines of authority, including blurring the lines of statutory authority – albeit that this may be through best intentions and may lead to better outcomes.

Introducing greater collaborative system governance decision-making, particularly in the context of financial and operational pressures, is complex. Financial decision-making, after the Covid years, is now more of a tension between organisations because of the re-assertion of control over funding and the pressures on expenditure; both cost of living, in recovering from Covid and the longer-term demographic changes.

The acid test is when an NHS organisation has to take an action that is not in the best interest of that organisation, but is in that of the ICS and the population of that area (or vice versa). The majority of these decisions will cover decisions on the prioritisation on the delivery of health and social care, but for chief finance officers (CFOs) this could be where their organisation fails to break-even, so that their ICS can.

This paper starts to explore the tension about the competing financial duties and how decision-making and the governance arrangements need to be considered, now, to ensure that effective decision-making can be made to work, and in the future. This can be by challenging old ways of working, taking advantage of new freedoms, but generally this all requires clarity and is best settled before there is a crisis or governance failure.

Recognising that there is no one simple approach to making this work and that at this point in time each system is still developing its own arrangements, this paper sets out the context and key questions to be asked locally in shaping arrangements. It will be revisited as arrangements have had time to develop.

Who are the current decision-makers?

The main NHS bodies are:

- **Integrated care boards (ICBs)** are statutory NHS organisations responsible for developing a plan in collaboration with NHS trusts/ foundation trusts and other system partners for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the defined area. How each ICB makes its decisions are brought together in its governance handbook.
- **NHS trusts and foundation trusts** are the organisations that provide most hospital, community, mental health, ambulance and specialist NHS services. Trusts' governance arrangements are set out in their standing orders/ financial instructions, schemes of reservation and delegation, and so on, based on national models.
- **Primary care networks (PCNs)** are groups of GP practices working closely together – along with other healthcare staff and organisations – providing integrated services to the local population.

The main non-NHS ICS partner organisations are:

- **Local authorities** which are responsible for a range of vital services for people in their defined areas. Among them are well known functions such as social care, schools and housing, as well as public health.
  Third sector (voluntary, community, faith and social enterprise sector (VCFSE) organisations) are not for profit/ non-governmental bodies who provide services in health and social care.

Within each of the above organisations there will be key people and groups that will make decisions:

- chief executive officer (also accountable officer)
- chief finance officer (and other executive directors; medical, nursing, human resources, digital, estates, etc)
- governing bodies/ boards
- sub-committees of the board/ executive groups.

Above the ICS, the key players are:

- **NHS England** which leads on the NHS in England, through its seven regional offices, supporting NHS organisations to work in partnership to deliver better outcomes for patients and communities, at the best possible value for taxpayers and to continuously improve the NHS.
- **The Care Quality Commission**, the independent regulator of health and social care in England.
- **The Department of Health & Social Care (DHSC)**, a ministerial department, supported by 24 agencies and public bodies, that leads the nation's health and social care to help people live more independent, healthier lives for longer.

The current possible alternative models for decision-making are:

- **Joint committees:** each organisation nominates a representative who would have delegated authority to make binding decisions on behalf of each of the organisations.
- **Committees in common:** meets at the same time, in the same location as other committees, with identical agendas but may come to different decisions.
- **Other committees**
- **S75 arrangements:** are a contractual framework for the use of pooled funds between the local authorities and NHS bodies, to enable services to be delivered and commissioned co-dependently.
- **Provider collaboratives:** are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements.

The other 'players' in this area are:

- **Place** is the local partnership of NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners who lead on the detailed design and delivery of integrated services across their localities and neighbourhoods (populations circa 250,000 to 500,000 people).
- **Integrated care partnerships (ICPs)** are statutory committees jointly formed between the NHS ICB and all upper-tier local authorities that fall within the ICS area, along with other partners, responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

What are the key factors that will shape a solution?

As arrangements are evolving, there is uncertainty about decision-making within an ICS.

Table 1 sets out the key questions each system should consider in developing effective system finance and governance. For each of these, this paper goes on to explore the key principles to be applied in considering what works locally, and how these might be applied in practice within an ICS.

Table 1: Key factors to consider in system decision-making and governance

Theme	Key question
Duty, authority and power	Is there complete clarity on who has the duty, authority and power within the ICS, and for which decisions? If not, what steps can be made locally to create this clarity (or does this need a national minimum framework to list out the potential areas and allow ICSs to make explicit decisions on how these will be governed)?
Accountability, responsibility and funding	Is there complete clarity on who has accountability within the ICS, and for which decisions? If not, what steps can be made locally to create this clarity (or does this need escalating)?
Governance and delegation	Has the delegation of powers from organisations to ICS bodies been agreed?
Differences in governance	Do ICS partners understand the different regimes, pressures and dynamics that their partners operate within?
Barriers in integrated decision-making	Has there been an honest discussion on the barriers to effective integrated working, particularly around culture and behaviour as much as about processes?
Collective decision-making	Have the principles and rules of collective decision-making and responsibility been agreed?
Managing conflict	Have ICSs agreed how they will manage conflict and the actions that can be taken?
Handling fundamental disagreement	Does the ICS have clarity on how fundamental differences in opinion are to handled?
Conflict within an NHS organisation	Do NHS organisations have effective communication and decision-making arrangements in place to ensure that ICS decisions are accepted?
Assurance mechanisms	Should ICS members agree an 'assurance strategy' which agrees a proportionate and pragmatic approach to assurance, based primarily on trusted reporting, but allowing for a risk based escalation to independent assurance in certain circumstances?

Each theme is considered further in the sections below.

Ultimately, the main things that ICSs should be looking to clarify are:

- What is the current role of the ICB, what should it be and what might it be?
- Whilst one size doesn't fit all, what are the minimum standards and principles that should be adopted by all?
- How might performance management through partnership by applied in practice?
- How can we bridge where accountability and responsibility do not align?

Duty, authority and power

Principles
In deciding on decision-making there needs to be clarity about who (both organisationally and individually) has:

- the duty to ensure that the decision is made
- the authority to make that decision
- the power to ensure that the decision is implemented.

These need not be, indeed seldom are, all held by one organisation or individual. However, there needs to be clarity in who does what to avoid omission, duplication or confusion. To be effective, authority needs to be linked to accountability for both the decision and the effectiveness of the implementation, while taking into account that some understanding needs to be given for when events beyond their control (for example the Covid-19 pandemic) subsequently occur. Within the NHS, and wider public sector, the source of duty, authority and power comes from Parliament, through legislation and regulation. This is then internally determined through governance arrangements, such as reservation and delegation of powers, standing orders and so on.

Application
Clarity about who has the duty, authority and power for ICS decision-making is critical to enable effective decision-making, and this clarity needs to be established early and objectively. Trying to establish such rules, in reaction to an actual problem, will seldom produce a process that is sustainable.

If this clarity is not clear from legislation and regulation, then the ICS – either itself or led by the ICB – needs to develop the rules for their system and gain agreement. These need to be written down, not to create paperwork but to ensure effective communication of the rules. One of the lessons from governance failings in the NHS in the 1990s was that the basic governance structure for many NHS organisations (standing orders, standing financial instructions, schemes of delegation and so on that are now taken for granted) was not in place and so model documents were prepared.

Within an ICS the role of the ICB becomes critical, both in terms of its own authority and power, but also its convening authority to bring together organisations to reach solutions. There is therefore a level of ‘soft’ power, from this convening authority, that an ICB can use to influence decisions. This ‘soft’ power also operates at NHS England level and can be where there is a blurring of the duty to ensure that a decision is made, with the authority to make or enforce it. There must, however, be limits to the power of ICBs/ NHS England to exert undue influence in areas that are outside its remit, for instance the internal management of a partner organisation.

Power of patronage

Throughout history, kings and queens used the power of patronage to reward followers and supporters, gaining their loyalty through appointing them to positions of government. It is today felt to be one of the strongest powers available to the Prime Minister, in the ability to appoint or dismiss ministers.

The relevance for ICSs? Within NHS organisations there are some critical individual roles, such as the chair, chief executive and other executive and non-executive director roles. These are important appointments, but is it appropriate that ICBs and NHS England should have a say in these decisions?

These post-holders may also be asked to lead on ICS wide roles, resulting in dual reporting lines and potential conflicts of interest.

At the same time, an ICB needs to use its commissioning role for the purposes of equitable commissioning and not allow this to be used as a bargaining factor in other decisions (such as. trading capital decisions against commissioning plans).

Scenario 1: Additional capital allocation

The DHSC announces an additional capital allocation for diagnostic service developments, with each ICS receiving its share.

The 'duty' of making the decision that allocates the capital equitably to meet the policy objectives most effectively rests with the ICB, through the chief executive as accountable officer.

The 'authority' for the decision will, most likely, be delegated to a committee of chief finance officers from the ICS, who will agree the criteria for how the capital bids will be prioritised (on the basis that the bids will exceed the allocation), oversee the process and agree the final allocation.

The 'implementation' of the decision will transfer to the selected organisations to deliver their projects within time, budget and quality.

The most likely area of dispute will be on the final allocation, no matter how logical the process may appear.

Key question

Is there complete clarity on who has the duty, authority and power within the ICS, and for which decisions? If not, what steps can be made locally to create this clarity (or does this need NHS England to set out a national minimum framework to list out the potential areas and allow ICSs to make explicit decisions on how these will be governed)?

Accountability, responsibility and funding

Principles

The Nolan principles[1] describe accountability as 'Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.' As mentioned above, accountability needs to be linked to authority, but this is one of three links. If accountability is for 'decisions and actions' then it needs to be linked to:

- the authority to make the decision
- accepted responsibility for both the decision and ensuing action
- the ability to implement the necessary action.

The ability to implement the decision is inextricably linked to the need to have the necessary resources (for example, financial, human, data, estates) to achieve the objective. It is therefore important that there is this alignment of accountability for a decision with the ability to deliver it. This is best achieved by involvement in the decision-making process and explicit acceptance.

There is a final step, in terms of accountability to 'who'? NHS partners are accountable to the ICB, both through their system membership as well as commissioning relationship. NHS partners, including the ICB, then have an accountability to NHS England and, ultimately, through to the DHSC and Parliament. Along the way there is also local scrutiny and oversight.

[1] Committee on standards in public life, *The seven principles of public life*, May 1995

The division of policy making from implementation

Central government departments generally split their policy teams away from any other parts of the department (indeed there is a specific policy profession within government). This allows them to design, develop and propose appropriate courses of action to help meet key government priorities and ministerial objectives.

Implementation of policies is usually then transferred for others to implement, which may take many years to come to fruition, by which time – cynics might suggest – it is difficult to hold the policy makers to account.

Applications

What is not yet tested is joint accountability, for instance what the ICS breaking-even means in practice. Theoretically it could mean that all accountable officers in an ICS appear together in front of the Public Accounts Committee, or that their organisations take an equitable share of the deficit.

One mechanism used by sustainability and transformation partnerships (STPs) was to have financial risk sharing arrangements in place, agreeing in advance how financial risk would be managed. These need to balance both principles (the role of equity and mutual support) and rules (how issues are escalated and decisions made)

In many cases it can feel as if the ICB is being asked, primarily by NHSE and other national bodies, to make decisions or make commitments on behalf of the whole system; with examples of requests for letters of support for works or research funds. Unless clearly delegated to the ICB (see the section on Duty, authority and power above), this can lead to bureaucracy overload in an attempt to get all “fingerprints” on decisions. It is important to consider how best to balance system sign offs with a streamlined process, deciding if / when the ICB can sign off on behalf of the system and when it needs the explicit agreement of the system members. This is challenging to do with a number of NHS partners, and even more complex when involving other partners, such as local authorities or the voluntary sector.

Scenario 2: Accountability and events beyond control

An acute trust has been set a performance target to achieve increased productivity in its theatre utilisation and thereby reduce its 65 week waiting list, failure to achieve which would reduce its income under the terms of its aligned payment and incentive contract.

Following torrential and unseasonal rain, the main theatre suite is flooded and put out of action for two weeks. The trust has some alternative theatre capacity, so can maintain non-elective activity, but will fail to achieve its theatre utilisation target and also fail to reduce its 65 week wait target.

Alternatively, industrial action against an issue of national terms and conditions, could result in the cancellation of a similar level of inpatient activity.

Neither the act of God (torrential and unseasonal rain) nor the national issue (industrial action) are within the control of the trust, so is it fair that they lose access to income?

It could be argued that a well-managed trust would have had better arrangements in place to deal with the risk of torrential rain, so they would bear some proportion of the risk.

Key question:

Is there complete clarity on who has accountability within the ICS, and for which decisions? If not, what steps can be made locally to create this clarity (or does this need escalating)?

Governance and delegation

Principles

Governance arrangements are, essentially, about agreeing **who** makes **what** decision (with the mechanics then setting out **how** the decision is to be reached, in **which** forum and **when**).

Effective governance is about making these decisions at the most appropriate level; the most significant at the highest level, hence the reservation of powers to the board within an NHS organisation that sets out decisions that can only be made by the board, and the scheme of delegation that provides a clear line of sight for the authority working down through the organisation.

Decision-making needs to be an explicit and purposeful action, that adds value in making the most effective decisions. There is some (but little) value in decisions being approved or ratified by others once they have been made by the delegated individual or organisation, but this tends to add time to the process.

Application

Within the context of an ICS, the power to make a decision that binds an organisation is multi-faceted. At one level there is the simple ability of an organisation to delegate its authority to either an ICS body (possibly directly to the ICB or one of its committees) or to individuals from their organisation who are a member of an ICS body (such as the ICP in agreeing an integrated care strategy that will need agreeing upon).

This will need to be supported by a form of delegation from the organisation, probably being quite specific on when and where it is used.

However, the problem for many ICSs is how to achieve effective decision-making with the number of system partners involved. A small ICS might be able to include representatives from each partner in one meeting, but the larger ones would find such meetings unwieldy. This would then require representation of partners of a common type (for example acute trusts), which in turn would need to be sure that they can accurately reflect the views of their ‘constituents’ and bind them.

Scenario 3: Decision-making for others

There are some 1,250 primary care networks (PCNs) in England, and 42 ICSs, giving an average of 30 PCNs per ICS.

Representatives for PCNs will need to ensure that they can represent the interests of all their members, including a way of balancing the views of those who agree or disagree with a decision, as well as their own personal opinion. This brings with it a degree of accountability to their “constituents”.

Effective communication might mean that the PCN representative shares papers for key decisions, highlighting those that have most impact on their members, and give them time to communicate their preferences. Timing then becomes important to ensure that all members have the chance to consider and communicate.

Where PCNs are not in agreement, the level of “minority” disagreement may need to be taken into account by the other ICS members.

Magna Carta for an ICS?

Whilst not 'wholly' historically accurate, the Magna Carta was the first attempt to document how the 'ruled' were prepared to be ruled, rather than accept the primacy of the king. The Great Charter was written by the barons (or the Archbishop of Canterbury) and agreed to (albeit fleetingly) by King John.

The relevance for ICSs? There is more likely to be acceptance of how organisations are governed, by those organisations, if they have offered up a way of working that they believe is acceptable, rather than having it imposed upon them.

Key question

Has the delegation of powers from organisations to ICS bodies been agreed?

Differences in governance

Principles
NHS bodies, generally, fit within a governance and financial regime that is based around similar principles and they have a long history of understanding each others' issues and ways of working. Increasingly the difference between NHS trusts and NHS foundation trusts has become marginal, so that the main differences in regimes are between trusts and ICBs, albeit that the evolution of PCNs offers interesting potential.

The introduction of STPs from 2016 and the move to ICSs has brought local authorities and the third sector into closer working with NHS bodies.

These non-NHS bodies have important differences:

- local authorities have directly elected councillors on their governing body, have a role on oversight/ scrutiny of local healthcare services, while also working within a financial regime that does not allow them to budget for, or run, a deficit (for further detail see HFMA's briefing, *Local authority finance and governance*[2])
- third sector bodies, whether charities or social enterprises, live in a financial regime where going concern is more of a realistic risk to the future of the organisation (than, might be argued, the theoretical discussions within NHS bodies). They can also include a wide-range of different types of organisation.

Application
NHS bodies need to be aware that decisions that could be made within their body, may not be so readily made in other organisations. For instance, a financial risk sharing agreement may not be able to be equitable if the loss attributable to one organisation might risk its viability.

This means that NHS organisations need to build greater understanding of their partners' positions, probably through workshops / teach-ins.

Different organisations will have different decision-making mechanisms and timeframes. For example, these can be different at different councils and for different types of decision, likely to be multi-staged, highly procedural and not aligned to NHS timelines. Local understanding of the decision-making context, processes and timelines needs to be clearly understood.

There will also need to be a high degree of transparency and trust, between partners, that will have to balance the legal position with the desire for effective collaboration for a sustainable future.

[2] HFMA, *Local authority finance and governance: what NHS professionals need to know*, July 2023

Principles for uniting nations

Two of the founding principles of the United Nations are:

- To achieve international co-operation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion.
- To ensure sovereign equality of all its members, and to settle disputes by peaceful and amicable means in such a manner as to not endanger or jeopardize international peace, security, and justice.

These could be aligned to the needs of health and social care in the UK:

- To achieve local co-operation in solving local problems of health and social care and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion.
- To ensure sovereign equality of all its members, and to settle disputes by peaceful and amicable means in such a manner as to not endanger…

Key question

Do ICS partners understand the different regimes, pressures and dynamics that their partners operate within?

Barriers to integrated decision-making

Principles

Much of the guidance on the development of ICSs is based on aspirations of how organisations would like to work together, but there is also a need to recognise that there will be a wide range of barriers to integration and, to manage these, they need to be explicitly acknowledged.

Developments in corporate governance, whether in the private or public sector, started by looking at policies, processes and structures and defining what were the best practices that organisations should follow (with a comply or explain mantra). In more recent years the focus has shifted to emphasising the importance of culture and behaviour in effective governance, not least the risks from a toxic culture.

Application

While some barriers may arise from legal powers or governance arrangements, the experience of STPs and, more widespread, business collaborations is that the main barriers to success are about behaviours and cultures. The lessons learned can appear slightly trite, but they invariably focus on having open, honest and productive communication, building mutual trust and respect, and ensuring that each partner is allowed to add value in their area.

Time invested in team building (forming, storming, norming and performing) is often an investment well worth making, rather than assuming that senior leaders do not need this time and space.

ICSs need to agree on what is acceptable culture and behaviour. This needs to go beyond ‘fine phrases’ into how this is embodied in the ways of working and exceptions are ‘called out’. This emphasises the importance of those chairing meetings acting as the arbiter of behaviour. This leads to the value of an independent chair to run critical meetings with no ‘skin in the game’ (a vested interest) so that their focus is on effective decision-making and not the outcome.

Should ICBs hear bed pans?

The quote attributed to Nye Bevan is 'If a bedpan is dropped in a hospital corridor in Tredegar, the reverberations should echo around Whitehall.'

The relevance for ICSs? For the ICB, as regulator or system performance manager, how much should they know about what is happening in the local NHS, in terms of the detailed operational performance?

Key question

Has there been an honest discussion on the barriers to effective integrated working, particularly around culture and behaviour as much as about processes?

Collective decision-making

Principles

Collective decision-making is successful when there is a clear focus by all participants on a set of agreed objectives and the strategy to achieve them. This seeks to avoid fundamental underlying disagreements remaining unaddressed.

Decisions then need to be made within a framework of principles and rules. Generally, the principles will be based upon ways of working and behaviours (the Nolan principles have withstood the test of time), such as codes of governance. Much of the current debate around effective governance focuses on the importance of culture within an organisation, but for an ICS it is important that that there is some consistency of cultures, both across the ICS and amongst its members, or if not complete consistency, then a high degree of complementarity.

These principles can then be supported by a set of rules that dictate the processes needed to reach a decision through collation of evidence, assessment of options, and so on (much as standing orders complement the code of governance).

Clarity and transparency of the process for decision-making is essential to ensure that all participants can buy into the process and, ultimately, the final decision. If the process is seen to be fair, even if the result may not meet individual preferences, it is more likely to be accepted.

Most organisations seek to make decisions by consensus, rather than through some form of majority voting, and this is at the heart of co-operation and collaboration as key success factors for ICS. However, once a decision has been made then there is a need for collective responsibility for that decision.

One tension that is inherent within the public sector is that of the accountable officer with the accountability of unitary boards. This tension is heightened when the chief executive, as accountable officer with their personal accountability, might not agree with the decision of their board. In central government the main mechanism for managing this is for an accounting officer direction (from the minister or secretary of state) that provides a defence.

The relative maturity of governance arrangements, both within organisations and – particularly here – within ICS, is important and is based upon experience and trust that has been built over time. An important element of this is about culture and behaviour.

Application

The principles and rules of collective responsibility need to be set out in advance, based upon sound good practice and experience. For many ICSs this can be built upon their experience and ways of working as STPs, duly updated for lessons learned and the new integrated world.

As with other areas of governance, ICSs need to spend some time in explicitly looking at how they build collective responsibility, particularly in the behaviours of accepting a decision that may not be the individual's preference.

Key question

Have the principles and rules of collective decision-making and responsibility been agreed?

Managing conflict

Principles
While challenge and scrutiny are important elements of effective decision-making, there will inevitably be times when there is clear conflict in the process, either through the behaviour of individuals or the needs of their organisations.

The key lesson from conflict management is to recognise conflict and find ways to manage it. Avoiding conflict, while often desirable, is often only a short-term expedient and no replacement for resolving conflict (both immediate and root cause).

Conflict can often be caused by a lack of trust (hence the importance of such Nolan principles as integrity), in turn this can be due to people being seen to 'game' the system (for example, starting negotiations from a clearly unrealistic position, or setting their absolute standards at unacceptable levels).

Conflicts of interest can also undermine trust, whether they are actual conflicts with tangible benefits attached, or perceived ones. Processes for managing individual conflicts of interest are embedded within the public and corporate sector (the need to declare a potential interest and avoid involvement in any decision where a direct benefit may ensue). However, the processes for managing inter-organisational conflicts of interest are less embedded.

Application
ICSs need to be prepared for managing conflict between its members and have clear processes in place to help identify and resolve them. These need to be developed in advance of any conflict emerging, to prevent processes being developed for particular instances.

Scenario 4: Conflicts of interest

Central to this paper is the potential conflict of interest that the CFO of an NHS provider may have where the duty to break-even for their organisation conflicts with their duty for the ICS to break-even.

While it is easy to declare these conflicts, the people who can resolve the conflict are those most conflicted!

Within this there are alternative scenarios, such as, a decision is made that favours one partner through either unintended or undisclosed reasons, or one partner does not implement (nor ever intended to implement) that agreed action.

There is potentially a role for non-executive directors to play in overseeing resolution, particularly those within the ICB given that they are recruited for their independence.

Key question

Have ICSs agreed how they will manage conflict and the actions that can be taken?

Handling fundamental disagreement

Principles
While the objective of collective decision-making is to reach consensus for all parties, it will be inevitable that – at some time – the impact of some decisions may be so extreme (or existential) that one or more participants would not be able to abide by the decision. To manage this ICS could consider:

- the right to veto a significant decision
- seek independent arbitration
- escalation to a higher authority.

Within the NHS, during the pre-collaboration days when competition was the watchword, disputes between commissioners and providers often had mechanisms in place to either appeal to a higher authority or seek some form of independent arbitration.

There may be value in having this ability if, like in law, there is a need to establish some 'case law' or a decision on a wider-ranging principle. However, such processes are against the spirit of collaboration.

Normally any move to this level is indicative of a breakdown in relationships and trust, where the root cause needs to be addressed.

Application
ICSs need to discuss where – and clearly by exception – a partner has the right to veto a decision, or seek arbitration or escalation (the latter would be to NHS England). This should contrast with decisions that can be agreed to be binding by a majority.

Additionally, there may be times when, after a decision has been made, circumstances have changed so significantly (either through subsequent events, clarity over an area of previous uncertainty or the discovery of a significant new piece of evidence) that a partner may wish to revisit a decision because it is now felt to be unsafe (which is different to a decision that they may not have wholly accepted at the start, but agreed to under collective responsibility).

In escalating disputes to NHS England it is important that clear 'de minimis' levels are set and that moving to this should be the last resort. There needs to be clarity that all other avenues have been explored before any level of arbitration or escalation is considered.

Key question

Does the ICS have clarity on how fundamental differences in opinion are to handled?

Conflict within an NHS organisation

Principles
NHS organisations should have in place a scheme of delegation that empowers its executives to make decisions that bind their organisation, albeit within parameters that involve the board and internal decision-making processes.

Nearly all decisions have multi-faceted implications, so that clinical decisions will have financial implications (and vice versa) not least in the balance of achieving value for money (economy, efficiency and effectiveness).

Theoretically, developments in the ICS should be heralded in advance so that NHS organisations can discuss their approach and negotiating stance. The executive can then discuss the matter within the ICS, reporting back to their organisation.

Application
When decisions need to be made by a CFO to ensure that one of the break-even duties is achieved, particularly if it involves making cost savings/ efficiencies, it is likely that their fellow executives will be unhappy with the steps that need to be taken – particularly if they believe that it will impact on quality or priorities.

Timing of the decision-making process within the organisation will be critical, both in terms of informing all board members (executive and non-executive) of the issues as they arise, and then the process that needs to be adopted.

The role of the chief executive officer, not just in managing the executive team but as the accountable officer, is critical in supporting the CFO. They need to be aware of the issue and involved in the discussions, internally and externally.

Key question

Do NHS organisations have effective communication and decision-making arrangements in place to ensure that ICS decisions are accepted?

Assurance mechanisms

Principles
While much of decision-making relies upon trust between the partners, there is an important role for assurance mechanisms to be in place, particularly in the early years. This is about using assurance to build trust (rather than trying to combat mistrust).

Such assurances mechanisms should, primarily, be built upon openness and transparency between organisations (and not a focus of seeking independent assurances from auditors and third parties, although they may have their place).

What is important is the establishment of 'assurance on what' and 'when'.

Application
The three lines of defence model, applied to ICS finances, would suggest that organisations should be able to give 'first line' assurance that financial reporting has followed the correct and consistent application of accounting rules, including agreed assumptions and judgements.

They can then give 'second line' assurance that appropriate oversight has been applied in the review of financial reports; such as confirmation of month-end routines, budget holder review and senior management reviews.

The third line, independent and objective assurance, can then come from either professional internal auditors (or, in extremis, external audit) or from peer review on an open book basis.

Scenario 5: Assurance on forecasts

At month 6, initial high-level forecasts from ICS members are suggesting a year-end deficit of £30 million, breaching the agreed year-end break-even position and signed-off budgets.

The ICS has a finance committee where all the CFOs meet.

In terms of transparency, copies of all the forecasts are included within the papers, including assurance from each CFO that their forecast is based on the agreed assumptions. Following a full and frank discussion at the finance committee it is agreed that the forecasts should be checked for the two acute and one PCN that have the most significant forecast deficits.

The ICB offers its internal auditors to carry out the work, but the community trust (which is still forecasting break-even) has offered two of its finance staff to do the work, given that they know the financial assumptions, have some time available and this would be a good personal development opportunity for them, albeit that they are not professional auditors.

Key question

Should ICS members agree an 'assurance strategy' which agrees a proportionate and pragmatic approach to assurance, based primarily on trusted reporting, but allowing for a risk based escalation to independent assurance in certain circumstances?

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

HFMA

4 Broad Plain Way, Bristol BS2 0JP

T 0117 929 4789

E info@hfma.org.uk

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www.hfma.org.uk