HFMA briefing

Sustainability and transformation partnerships

Developing robust governance arrangements

Introduction

The issue of governance in relation to sustainability and transformation partnerships (STPs), accountable care systems and new models of care is a priority consideration on the watching brief of the HFMA's Governance and Audit Committee. Robust governance arrangements are needed as local plans are implemented, and partnerships evolve.

In essence, the new arrangements are driven by 'at scale' partnership working inside and outside of the NHS. This is likely to include working with health, local government, primary care, private and third sector bodies including GPs and limited liability partnerships. It is this that leads to the need for new principles-based governance arrangements; arrangements that also need to be future-proof. The approach needs to be tailored to fit the size and complexity of the partnership in question.

Sustainability and transformation partnerships

Sustainability and transformation partnerships (STPs) were introduced in 2016. They bring together local NHS organisations and local authorities (county/ unitary councils) to develop proposals to improve health and the quality of care to provide better services for patients in the areas they serve. They must also meet the challenges set out in the NHS five year forward view. There are 44 covering all of England.

STP can also stand for a 'sustainability and transformation plan'. This is the strategic plan drawn up for each of area setting out practical ways to improve NHS and care services to maintain population health and resolve:

- the health and well-being gap
- the care and quality gap
- the finance and efficiency gap.

The focus is on developing sustainable services – no one size fits all 44 partnerships: they are massive, complex and doing different things. NHS England states that 'Partnerships will be forums for shared decision making, supplementing the role of individual boards and organisations.'[1] It is vital to note that STPs are not new statutory bodies. However, NHS England requires all STPs to have:

- a board drawn from constituent organisations with appropriate non-executive director/ lay member representation
- an appointed STP lead/ chair[2].

The success of STPs is judged by a series of metrics aligned with the single oversight framework (providers) and the improvement and assessment framework (CCGs), the first results of which were published in July 2017. The performance of an STP is assessed across 9 domains as follows[3]:

- hospital performance
  - emergency care
  - elective care
  - patient safety
- patient focussed change
  - general practice
  - mental health
  - cancer
- transformation
  - demand management
  - leadership
  - finance.

Progress against these metrics will need reporting to STP member organisations at regular points.

STPs and accountable care systems

An STP may evolve into an accountable care system (ACS)[4]. Working in partnership with local authorities, NHS organisations (both commissioners and providers) take collective responsibility for resources and population health. They combine budgets and share resources to deliver an integrated health system to a defined population. NHS England states that an ACS needs '…an effective collective decision making and governance structure, aligning the ongoing and continuing individual statutory accountabilities of (its) constituent bodies'[5]. In time, an ACS may lead to the establishment of an accountable care organisation (ACO)[6].

STPs and new models of care

NHS England also identifies that 'One of the original aims of STPs was to develop new care models, blueprints for future care introduced initially under the 'vanguard' and 'pioneer' programmes.' NHS England makes it clear that STPs '…will allow more parts of England to build on (this) success, by providing a collaborative system of leadership and governance in every part of the country which will allow new care models to evolve and spread.'[7] So an STP footprint may contain one or more new models of care. The creation of a new model of care is likely to involve the merger of functions or organisations. This is particularly relevant to two possible models of care being developed to meet the challenges set out in the five year forward view:

- multispecialty community providers (MCPs) consist of a group of providers delivering integrated community services. Where the MCP involves a group of GPs, they must be

[1] www.england.nhs.uk/stps/faqs/
[2] *Next steps on the NHS five year forward view*, NHS England, 2017
[3] NHS England board papers, July 2017
[4] *Next steps on the NHS five year forward view*, NHS England, 2017
[5] *Next steps on the NHS five year forward view*, NHS England, 2017
[6] An ACO is a single organisation with long term responsibility for population health and the delivery of integrated health and care services for a defined area
[7] www.england.nhs.uk/stps/faqs/

operating as a federation to hold the contract; alternatively, the MCP provider requires sign up from the GPs that they can work together – i.e. some form of alliance agreement
- a primary and acute care system (PACS) is an integrated organisation bringing together NHS list-based primary care services currently provided by GPs and acute hospital services, together with mental health and community services.

Both MCPs and PACSs can become ACOs in time although as STP work continues different versions of these initial new models of care will emerge. However, the common characteristics of these arrangements are summarised by Chris Ham, Chief Executive of the King's Fund[8]:

'First, they involve a provider or more usually an alliance of providers that come together to collaborate in meeting the needs of a defined population. Second, these providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population. And third, ACOs work under a contract that specifies the outcomes they are required to achieve within the given budget, often extending over a number of years.'

Key challenges

Through the HFMA's research into STP governance arrangements[9], we know that governance structures vary between STPs. We also identified several shared challenges to be addressed as follows:

- effective engagement – with the public, patients and clinical and front-line staff
- organisational accountability – the conflict between organisational sovereignty and system-wide working/ accountability
- financial position – the conflict between organisational financial position/ control total and the control total for the STP. Historically, a competitive environment has existed, promoting organisational self-interest
- reporting – alignment of data and reporting as well as sharing information and data
- complexity of structures - ensuring appropriate and timely outcomes with many organisations involved – for example, decision-making may be prolonged and unable to react to challenges quickly
- NHS/ local government working together – a challenge to overcome historic and funding differences and an opportunity to provide truly integrated services and outcomes for the benefit of the local population
- capacity and capability of leaders
- time, pace, cost – scale of change needed to realise operational and financial benefits
- the financial pressure on both the NHS and local authorities.

In 2017/18 and 2018/19, the achievement of both organisational statutory duties and system-wide administrative duties will be challenging. NHS England and NHS Improvement require:

- each provider trust and CCG to agree and meet a financial control total (which may by prior agreement be flexed between organisations within an STP or ACS system control total)
- each provider trust and CCG to meet its own financial objectives, some of which are statutory requirements[10].

[8] *Moving to accountable care*, HFMA, 2017 www.hfma.org.uk/news/blogs/blog-post/moving-to-accountable-care
[9] *Developing sustainability and transformation plan governance arrangements*, HFMA, 2017
[10] *Next steps on the NHS five year forward view*, NHS England, 2017

In Chris Ham's blog[11] for the HFMA he says: 'Careful thought will have to be given to aligning system control totals with the accountabilities of NHS organisations, and the risk sharing arrangements required in how system control totals are applied in practice'.

The HFMA's summer 2017 *Temperature Check* survey[12] found that 74% of trust finance directors and 60% of CCG CFOs still have concerns about the governance arrangements of their STP. Key concerns are that current governance arrangements are immature and in some cases unwieldy; there is a lack of clear accountability of delivery responsibility and decision-making.

Integrated support and assurance process (ISAP)

Following the collapse of the Uniting Care Partnership contract[13], NHS England and NHS Improvement published a regulatory framework to centrally govern all novel contracts. The joint NHS England/ NHS Improvement assurance process is built around 4 checkpoints and a number of key lines of enquiry[14]. Although still to be fully tested, it is expected that any novel contract – for example, one awarded within an ACS, will go through the process – its application mitigating any risks arising from the new arrangement:

'Specifically, if contract forms, risk sharing arrangements or calculations of the contract value are taking a previously unused approach, or if potential providers are creating legal entities involving new organisational forms, the ISAP will apply.'

New arrangements and governance considerations

The development of appropriate governance arrangements needs to be applicable to:

- an individual organisation in an STP/ ACS/ PACS/ MCP – or combinations of these
- an STP in relation to all partner organisations, including new organisations evolving from new models of care i.e. an MCP or PACS.

Organisations are likely to be working under different statutory/ legal frameworks that will result in different and conflicting priorities and pressures.

In essence, the new arrangements are driven by 'at scale' working together across partnerships inside and outside the NHS. This is likely to include working with health, local government, primary care, private (GPs and limited liability partnerships) and third sector bodies. The arrangements also need to be future-proof – for example, in the event that a PACS becomes an ACO.

NHS Providers' chief executive Chris Hopson writes: 'This means maintaining our investment in good corporate governance by organisations but developing a more robust approach to governance between organisations and being clearer on lines of accountability at the local system level.'[15] These arrangements are complementary not mutually exclusive.

A tool for discussion

From our experience and research, knowledge and assurance of developing STP governance arrangements is mixed, with some organisations feeling that they have less understanding than others. Therefore, the following diagnostic tool could be helpful - to be used as a basis for discussion by the board/ governing body and/ or audit committee of an NHS body. Discussing a series of open questions will support assurance that feeds into risk registers. For organisations

[11] www.hfma.org.uk/news/blogs/blog-post/moving-to-accountable-care
[12] *NHS Financial Temperature Check,* HFMA, 2017
[13] www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2016/04/uniting-care-mar16.pdf
[14] *The Integrated Supported Assurance Process (ISAP): an introduction to assuring novel and complex contracts*, NHS England, 2016
[15] www.nhsproviders.org/news-blogs/blogs/why-governance-and-accountability-matter-in-the-provider-sector

completing the ISAP process, its completion could be helpful in identifying risks and therefore possible mitigations.

Rated questions

A series of questions need to be considered to identify specific risks (operational, financial, strategic). The focus is on a legally compliant, simple and effective approach to governance processes[16] in terms of:

- the board including clear roles for chairs and non-executive directors
- accountability
- decision-making
- reporting
- managing risk.

The questions (set out in appendix 1) are comprehensive and focus on the greatest risks in the governance process whilst not becoming so numerous as to be unwieldy (depending on the local situation it may not be necessary to have all the items in the tool in place). The tool breaks down governance into the following key areas[17]:

[16] *NHS Operational Planning and Contracting Guidance*, NHS England 2016
[17] *Developing sustainability and transformation plan governance arrangements*, HFMA, 2017

The answers to the questions are rated red, amber or green. An example is provided below:

Question	Red	Amber	Green
Are data sharing arrangements in place?	No	Planned for next 6 months	Yes
Has a memorandum of understanding been established and agreed by all parties?	No	Planned for next 6 months	Yes
Has the partnership agreed who has decision-making powers?	No	Yes, but we don't know what they are	Yes, and we know what they are

The benefits come from working through the questions and discussing the output within the organisation and with partners. Each area of the tool has a main question for consideration and further areas to facilitate discussion. The exercise will also enable organisations to identify areas for further work to secure appropriate assurance. This will focus attention on whether governance arrangements for working together at scale are robust.

Appendix 1: Governance tool

[Questions in orange text are taken from the ISAP Key Lines of Enquiry]

Questions	Red	Amber	Green
Clinical quality: are you assured that the changes are clinically beneficial? • Are there clear clinical transformational benefits? • Are clinical outcomes properly understood? • Is quality maintained or improved as a result of the complex contract? • Are patients fully engaged?			
Vision: is there an agreed and common purpose? • Has this vision been shared? • Have stakeholders confirmed they support the vision? • Have stakeholders made a commitment to help deliver the vision? • If a complex contract is involved, is there a clear strategic rationale for it?			
Leadership: are you assured that there is appropriate and strong leadership in place? • Have all leaders been appointed? • Is there the capability and capacity to transform and deliver? • Does the board have the capability, capacity and experience to deliver the strategy? • Has an appropriate leadership structure been agreed for the partnership? • Has the partnership considered whether any more formalised partnerships are appropriate? • Does the partnership have sufficient buy-in from senior management within the individual organisations to achieve its objectives? • Are processes in place to manage any transition?			
Memorandum of understanding (MOU): has an MOU been established and agreed? • Is there clear documentation of the governance structure?			

- is the governance and management appropriate? - does this include committees/ groups in place and how they interlink? - does this include who is represented on the board/ committee? - does this include any formalised partnerships in place/ planned? • Is the governance assurance process set out? • Are roles and responsibilities defined? • Does the MOU detail how often meetings take place? • Are any delegations clearly set out in formal schemes of delegation (individual bodies and the partnership)? • Are conflict resolution arrangements agreed and documented? • Do arrangements ensure that all organisations are not at risk of breaching statutory duties?			
Engagement and communication: are you assured that appropriate measures are in place? • Has the plan been published? • Has there been or is there planned public/ patient involvement? • Has there been or is there planned clinical involvement? • Do plans clearly communicate what changes mean for patient experience and outcomes and help explain efficiency savings and the impact on patients? • Will local authority health and overview scrutiny committees and health and wellbeing boards be involved during implementation? • Is there a communications plan in place? • Does the communications plan cover both internal and external audiences? • Does the communication strategy support meaningful engagement with patients, carers, the public and their representatives across all appropriate populations? • Does your engagement plan clearly link to existing plans, demonstrate those areas which are continuations of existing plans and those which are new ideas? • Have individual organisations set up appropriate assurance arrangements to ensure they are actively being engaged with,			

appropriate evidence based decision making exists and appropriate information flows are in place?			
Planning: are you certain that the plan is based on a clear understanding of the existing position and where you want to be? • Has planning been aligned with, or taken due account of, each organisation's strategic and business planning? • Has any sensitivity analysis been carried out? • Are the contracted services financially sustainable? • Is there a clear workstream development plan in place to deliver the vision with clear and agreed outcomes, milestones and leads beyond planning and set up arrangements? • Has the partnership agreed who approves the overall plan and changes?			
Decision-making: are you assured how decision-making will work? • Who has decision-making powers? • Are these set out in a scheme of delegation? • Has the partnership agreed how stakeholders are represented through the decision-making process? • Are there arrangements in place for leaders to involve partner organisations throughout the decision-making process? • For each type of decision, has it been agreed who will be involved, how many people need to agree and if this is in accordance with individual schemes of delegation? • Where appropriate, have delegated powers been sought and agreed? • Are arrangements in place to ensure decisions are evidence based? • Are decisions required to be informed by quality impact assessments? • Are arrangements in place to determine how collective decisions will be reached, through respective schemes of delegation? • Are arrangements set out in the MOU? • Are procedures in place to identify and manage potential conflicts of interest?			

Accountability and delivery: are you assured that arrangements are in place to monitor and measure delivery and that everyone involved knows and understands their role? • Has the partnership agreed how implementation of individual plans will be managed across the footprint? • Is the individual liability of organisations and how this is managed and mitigated clearly documented and reflected in the MOU? • Are performance management arrangements in place? • Are accountability arrangements clearly set out in the MOU? • Is it clear what needs to be in place to ensure that individual statutory responsibilities can still be delivered? • Are scrutiny and assurance arrangements in place, including who is involved? • Does the provider have the ability to execute the complex contract successfully? • Does the complex contract result in an entity that is financially viable?			
Resources: is the arrangement appropriately resourced? • Has resource for management arrangements from the partner organisations been agreed? Is the control total agreed? • Are there either full time team members working or sufficient capacity created from existing workloads? • Has the partnership considered whether financial resources are at an appropriate level? • Has the operation of financial flows within the partnership been agreed? • Is the procurement and contract documentation appropriate? • Are existing or planned pooled budget arrangements and responsibilities clearly documented (especially regarding health/ local authority interactions)? • Have funding plans been reconciled to individual organisational plans? • Have capital investment requirements been determined and taken forward? • Has the partnership agreed how gains are shared equally amongst participants - for example, covering stranded costs?			

• Have shared financial frameworks and other financial management processes been established?			
Reporting: are you assured that internal and external reporting arrangements are in place and will deliver? • Have all appropriate returns been agreed and submitted to regulators? • Have governance arrangements been reported internally to individual boards and governing bodies? • Are arrangements in place to ensure any governance changes are reflected in individual organisation annual reports and annual governance statements? • Are data sharing arrangements in place? • Are data quality assurance arrangements in place? • Have the differing planning timelines of local government and the NHS been considered and incorporated into the implementation plans? • Does the structure mitigate potential duplication of review and reporting? • Is there a sufficiently clear thread linking action plans, milestones and progress updates? • Are reporting arrangements covered in the MOU?			
Risk management: are risk management arrangements in place? • Have legal risks been identified and mitigated? • Has the partnership agreed which risks can be shared and how will they be managed? • Does the partnership have a risk register? • Are the risks included on individual organisation risk registers? • Is there a clear process for identifying emerging risks during the implementation phase? • In the event of provider failure, are contingency plans in place?			