

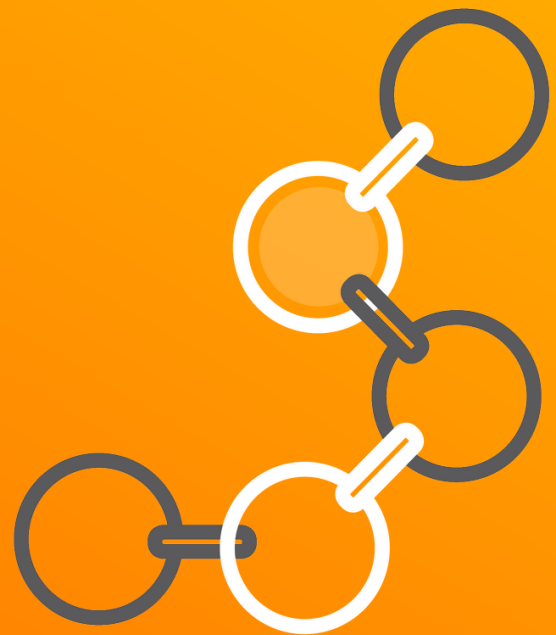


HFMA briefing
March 2021



Developing system finance and governance arrangements

Key considerations for 2021/22



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Introduction

Integrated care systems (ICS) are a key element of the NHS architecture as care is transformed to deliver the aims of the NHS long-term plan¹. The proposals for a health and care bill, as set out in the white paper² and summarised by the HFMA³, include legislation for every part of England to be covered by an ICS. Building on sustainability and transformation partnerships (STPs) set up in 2016, an ICS is 'a new type of even closer collaboration. In an ICS, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve'⁴.

The recent NHS England and NHS Improvement (NHSE&I) paper *Next steps to building strong and effective integrated care systems across England*⁵, and its resulting recommendations to Government⁶, focus on how systems and their constituent organisations will accelerate collaborative working. The white paper recognises that 'the case couldn't be clearer for joining up and integrating care around people rather than institutional silos'. Its legislative proposals aim to remove the barriers that stop systems from being truly integrated and also to reduce bureaucracy.

Across the country good progress has been made towards greater system working, in many cases accelerated by the Covid-19 pandemic. However, there is a mixed picture of maturity and progress needs to gather pace. As the number of systems designated as ICSs reached 29 (out of 42) in December 2020, Sir Simon Stevens said, 'NHS organisations will need to intensify partnership working with local authorities and the voluntary sector to tackle health inequalities resulting from Covid-19'⁷.

The direction of travel and aims of system working are clear. However, there are financial and governance complexities that make system working difficult. As recognised in the white paper, legislation is just one part of the change and much relies on having the right workforce, good leadership and getting the incentives and financial flows right.

While recognising that there is no one size fits all for an ICS, there are a number of common enablers, as well as challenges, in establishing agreed and effective system-wide finance and governance arrangements. Most importantly, the pre-requisites for any arrangement are a shared vision, trust and transparency.

Conversations are needed both within and across systems. As NHS systems, and their constituent organisations, formalise and develop arrangements for 2021/22, the aim of this paper is to provide material to feed into discussions. It focuses on:

- **system approach:** building collaborative relationships, the role of the ICS, shared vision and strategy and working with partners
- **financial arrangements:** financial arrangements and sharing financial information
- **system governance:** governance framework and role of non-executive directors.

For each topic, this paper includes a brief context; signposting of existing guidance; and shared experiences from across the country including challenges and suggestions of what might work well to address those challenges.

This discussion paper has been developed as a result of a desktop review of material; interviews with finance leaders and NEDs; and a focus group of senior system finance leaders to further consider particularly challenging system finance and governance issues. It aims to provide a reference point for developing arrangements and it is expected that much more will be learnt over the coming year. The HFMA will continue to share lessons from across the country via events, webinars and briefings.

If you do have examples that you are happy to share with others, please e-mail lisa.robertson@hfma.org.uk.

¹ NHS England and NHS Improvement, *NHS long-term plan*, January 2019

² DHSC, *Integration and innovation: working together to improve health and social care for all*, February 2021

³ HFMA, *Summary of Integration and innovation: working together to improve health and social care for all*, February 2021

⁴ NHS England and NHS Improvement, *Integrated care systems*, January 2021

⁵ NHS England and NHS Improvement, *Integrated care – next steps to building strong and effective integrated care systems across England*, November 2020

⁶ NHS England and NHS Improvement, *Legislating for integrated care systems: five recommendations to government and parliament*, February 2021

⁷ NHS England and NHS Improvement, *NHS chief confirms 11 new integrated care systems serving 14 million people*, December 2020

Background

In recent years the NHS has begun the move away from competition to collaboration. The main aim is to provide a more integrated service for the benefit of patients. As set out in *Next steps to building strong and effective integrated care systems across England*, 'this will require all parts of our health and care system to work together as ICSs, involving:

- stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care
- **provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale
- developing strategic **commissioning** through systems with a focus on population health outcomes
- the use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.'⁵

The white paper cements the move to collaboration. Two forms of integration underpin its proposals for legislation: 'integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.' The white paper sets out that each statutory ICS will be made up of:

- an NHS body (focusing on the day to day running of the ICS); and
- a separate health and care partnership (bringing together NHS, local government and partners to focus on strategic planning).

The ICS NHS body will merge some of the functions currently being fulfilled by non-statutory STPs/ICSs with the functions of a clinical commissioning group (CCG) and the aim is to begin implementation in 2022.

The financial and governance arrangements to make this happen are complicated, relating not only to the 42 systems covering England but each of their constituent organisations and partners, as well as ICS 'place' based sub-sets. Many ICSs are now establishing place focused integrated care partnerships (ICPs) as part of new arrangements. As set out in *Designing integrated care systems in England*, 'there are three important levels at which decisions are made:

- **Neighbourhoods** (populations circa 30,000 to 50,000 people) - served by groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services, including through primary care networks (PCNs).
- **Places** (populations circa 250,000 to 500,000 people) - served by a set of health and care providers in a town or district, connecting PCNs to broader services including those provided by local councils, community hospitals or voluntary organisations.
- **Systems** (populations circa 1 million to 3 million people) - in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale.'⁸

The Covid-19 pandemic has built on the existing appetite to fundamentally change the way the NHS works. There is a real opportunity now as we rebuild an NHS to improve healthcare, provide equality and increase patient trust. Strong financial and governance arrangements need to be in place to support this, rather than create barriers.

⁸ NHS England and NHS Improvement, *Designing integrated care systems in England*, June 2019

Figure 1 provides links to key guidance currently available. It is an area that the HFMA has been looking at since STPs were announced in 2016, starting with a review of emerging approaches to developing governance arrangements (including a checklist for consideration)⁹, followed by a mini-series of briefings specifically looking at decision-making¹⁰; system risk management¹¹; and aligned resource plans¹². The HFMA response¹³ to the next steps also set out key elements that must be addressed as part of the proposed national changes.

Figure 1: Key guidance

NHSE&I: *FutureNHS Collaboration Platform – including Managing collective financial resources space and System operating framework space*

DHSC: *Integration and innovation: working together to improve health and social care for all*, February 2021

HFMA: *Summary of integration and innovation: working together to improve health and social care for all*, February 2021

NHSE&I: *Legislating for integrated care systems: five recommendations to Government and Parliament*, February 2021

HFMA: *Developing system working through changes to the NHS financial regime*, December 2020

HFMA: *The future NHS financial regime in England: recommendations*, December 2020

NHSE&I: *Integrating care – next steps to building strong and effective integrated care systems across England*, November 2020

NHS Confederation: *The future of integrated care in England*, November 2020

The King's Fund: *Integrated care systems explained: making sense of systems, place and neighbourhoods*, April 2020

NHS Confederation: *Improving the scrutiny of integrated care systems and sustainability and transformation partnerships – a guide to good practice*, February 2020

NHSE&I: *System collaboration and financial management agreement*, December 2019

NHSE&I: *Designing integrated care systems in England*, June 2019

NHSE&I: *The NHS long term plan*, January 2019

HFMA: *How do you ensure robust system risk management arrangements?* December 2018

HFMA: *How do you support effective system decision-making?* November 2018

HFMA: *How do you align resource plans across a system?* October 2018

HFMA: *Emerging approaches - developing STP governance arrangements*, March 2017

NHSE&I: *Integrated care – local partnerships to improve health and care*, webpage

⁹ HFMA, *Developing sustainability and transformation governance arrangements*, March 2017

¹⁰ HFMA, *How do you support effective system decision-making?*, November 2018

¹¹ HFMA, *How do you ensure robust system risk management arrangements?*, December 2018

¹² HFMA, *How do you align resource plans across a system?*, October 2018

¹³ HFMA, *The HFMA's response to integrating care: next steps to building strong and effective integrated care systems across England*, January 2021

NHSE&I recognise that with so much variation in context, an overly prescriptive approach to system working arrangements is not appropriate. The ICS maturity matrix⁸ is a self-assessment tool, developed around core characteristics of systems, covering:

- system leadership, partnerships and change capacity
- system architecture and strong financial management and planning
- integrated care models
- track record of delivery
- coherent and defined population.

To support fundamental elements of system working arrangements NHSE&I has also produced learning tools and case studies which can be found on the *FutureNHS collaboration platform*¹⁴, particularly within the *Managing collective resources workspace* and the *System operating framework workspace*. This includes the *Managing collective financial resources framework* (see **Figure 2**), setting out key activities to support systems to manage financial resources collectively.

While significant progress has been made to build relationships, trust and partnership working across systems, there continues to be financial and governance complexities that make system working difficult. For example:

- how do you ensure that members act on behalf of the system rather than their own organisations?
- how do you ensure both place and system are able to influence the agenda?
- how do you manage decisions when there are differences of opinion?

In many cases, system working relationships and arrangements are often relatively informal and a more robust set-up is now needed to provide the required clarity, transparency and assurance. With much uncertainty remaining - such as changes to the financial regime and overall NHS sector due to the pandemic and white paper implementation - many feel caught in limbo. Although a number of questions remain, systems must continue to focus on how best to develop working arrangements to meet the current and future needs of their populations. The following sections explore key areas that need to be considered with the aim of supporting individual systems to tailor their own arrangements to best meet local needs.

Figure 2: Managing collective resources framework



Source: *FutureNHS collaboration platform*¹⁴

¹⁴ NHS England and NHS Improvement, *FutureNHS collaboration platform*

System approach

Building collaborative relationships

A fundamental pre-requisite to joint working is trust. Following a number of years of competitive working behaviours, this cultural change will take time and effort to achieve. It cannot be imposed by governance structures or statute and, unless nurtured, fragile collaborative relationships can easily fall apart. Mature relationships are not always frictionless, but are ones where it is possible to have difficult conversations and agree a way forward to address the challenges faced together.

Collaborative relationships are required across all parts of the system including between finance staff, clinicians, executive and non-executive directors, the public and regulators. They must be based on honesty and trust. For many of the people we spoke to there is a willingness to work together, but several years of being organisation-centric can lead to cultural issues and resistance to change in moving to greater system working.

Many of the current challenges facing systems result from their non-statutory status, with no formal accountability or powers, and trying to fulfil their role of managing the allocation of resource to, and monitoring the performance of, statutory organisations. It is important to create an inclusive environment based on effective relationships, so that the ICS does not feel like a separate or remote entity and that individuals feel they are part of it.

For those who have developed good collaborative relationships, key elements that helped include:

- **Allowing time to talk:** the value of getting to know each other cannot be underestimated. It is not a one-off exercise but takes time to build. For many, the first step is to allow time for individuals to talk. For example, this may be a half hour set aside for finance directors to chat informally each week or more formal meetings every month. For formal meetings, the agenda must be planned to ensure that all attendees get value from the meeting. Spending time together informally as well as formally is important.
- **Involving all:** cultural change requires effort from everyone at all levels. Senior management leadership is essential, but a collaborative culture will only happen if all levels are involved. Finance teams have an important role in supporting new collaborative relationships, but cultural change will not happen if we don't look beyond the finance community.
- **Demonstrating integrity:** for many building trust is a case of 'actions speak louder than words' so be prepared to take the first step to demonstrate decisions for the benefit of the system rather than a specific organisation.
- **Having a common focus:** to maintain ongoing valuable conversations it is important to have a focus for the time set aside, while not losing informal relationship building. This may be to take stock of what the system strengths and weaknesses are and what has been achieved; what information is shared; what the key common priority programmes are; what the agreed principles are; who is involved, what is the future view; a specific joint procurement, return or programme.
- **Celebrating successes:** break down system working goals into small steps to manage ambitions around timelines and celebrate together when progress is made.
- **Don't avoid challenges:** holding each other to account is important so the aim is not to avoid a difficult conversation because you think it might damage relationships.
- **Using networks:** share experiences with others outside of your usual network. For example, the HFMA and Future-Focused Finance have finance networks available that can be used at an organisational and system level as well as across the wider NHS.¹⁵
- **Having an independent lead:** some systems find an independent individual, for example to lead an area such as finance, really helpful to facilitate shared discussions.

In your system:

What are the key relationships needed to drive collaborative working?

What facilitative arrangements can you put in place to allow time for relationships to develop?

How do you celebrate success together?

¹⁵ Future-Focused Finance, *Virtual finance networks*

Shared vision and strategy

In order to work effectively systems must work to aligned strategies. The ICS will need to have a clear, coherent and agreed understanding of its role in agreeing a shared vision and objectives, prioritising plans and putting in place monitoring arrangements. It is important to ensure all voices – acute, community, mental health, ambulance, local authority, voluntary, community and social enterprise (VCSE), and independent sector – feed into this. The statutory bodies that form part of the ICS will also need to understand their role in making the ICS’s vision and strategy a reality, and ensuring any individual strategies are aligned. This may require a change in mindset from the leaders of all the entities involved in the ICS.

The NHS Confederation has examined local ICSs that have been successful in communicating and engaging across local communities, staff and the full range of partners that comprise their systems, finding that: ‘a compelling narrative that all system partners buy into and which is well understood and supported by the public and staff is among the hallmarks of a thriving integrated care system’.¹⁶ The aim is to build a clear blueprint of what that overall vision is, considering elements such as population health and costs across pathways, that can then be used to drive decisions at all levels.

One of the main challenges to developing a shared vision and strategy is the multiple different drivers impacting across a system. For example, having a mix of urban and rural geographies or priorities for an acute trust compared to a mental health trust compared to the local authority. Another key barrier is the clarity of direction for social care and public health, which needs to be understood as they are integral to the provision of healthcare.

Some key elements to help develop a share vision and strategy include:

- **Developing a shared understanding:** with so many partners involved, it is important to take time to understand, and respect, each other’s priorities and challenges. Finding a common language is helpful, often being the patient and population. A shared understanding of what resources the system does (or doesn’t) have, such as estates, workforce and funding is an important starting point to feed into how a shared vision can be delivered.
- **Aligning strategies at each level:** work happens at a number of levels such as individual; place; system; and working across systems. A shared understanding of goals, and how these fit together, is important. Each will have its own strategy that needs to be aligned with the aim to come together where there is a benefit to do so.
- **Developing a roadmap:** a clear story of the vision, mission, aims and objectives should be articulated in a way that is easy to understand in terms of deliverable actions. The roadmap provides the opportunity to clearly articulate long-term approaches.
- **Considering ICS branding:** for some areas a clear branding helps all parties to come together and own a common vision.
- **Ongoing review:** a periodic review of the effectiveness of the strategy is helpful and, particularly in fast changing times, regular development and refresh is to be expected.

In your system:

How do you ensure all voices are included in, and feel ownership of, the system-wide strategy?

Are all strategies (ICS, place and organisation) within the system aligned?

Is there a clear narrative underpinning the strategy?

¹⁶ NHS Confederation, *Building common purpose: Learning on engagement and communications in integrated care systems*, December 2020

The role of the ICS

ICSs bring together local organisations in a pragmatic and practical way to deliver the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care. Through ICSs, commissioners will be able to make shared decisions with providers on population health, service redesign and *NHS long-term plan*¹ implementation. The clarity of the role of the ICS is a key element in designing effective finance and governance arrangements.

The suggested statutory footing from 2022, set out in the white paper, is a significant step in the right direction. To function effectively, systems need clear and transparent arrangements and the establishment of a single statutory body with authority to lead the system will enable that. It will provide a clear central path of vertical and horizontal communication and accountability between organisational, place-based, regional and national plans. This will enable managers to focus on the provision of health and social care that achieves maximum value from available resources.

As set out in the white paper, the ICS NHS body will be responsible for: developing a plan to meet the health needs of their population; developing a capital plan for NHS providers within their geography; and securing the provision of health services to meet the needs of the system population. Each system needs to be clear on how its role, both in relation to individual organisations and NHSE&I. For example, what is the ICS role in terms of:

- setting priorities?
- system resource co-ordination (beyond initial allocations)?
- performance and quality?
- system oversight?
- interlinking functions of system, place (commonly using ICPs) and neighbourhoods?
- interlinking with other ICSs?

The scope will be refined over time as trust in system working grows.

A common system oversight framework approach that sets clear and consistent expectations for systems and their constituent organisations is important. It may not be the same for each part of the country, but it does need to be agreed and clear in terms of what interventions can be made, when and how.

One key challenge for ICSs is around remaining part of the system, rather than another oversight layer. With the transfer of CCG functions to the ICS, the risk is that ICSs will be seen as a large commissioner. As one finance director commented, ‘we are an integrated care system, not an incident command system’.

Some tips shared from experiences in developing arrangements include:

- **Understanding the patient perspective:** in reviewing the role of the ICS, it is helpful to understand how the system works from the perspective of the patient.
- **Collaborative leadership:** chairing of meetings should be carried out so that the ICS is not seen as controlling but promoting collaboration and co-ordination and giving a sense of direction.
- **Agreed operating framework:** a clear framework setting out the ICS role is helpful and it should be monitored based on peer appraisal and peer support.
- **Assurance:** confidence is improved with a clear approach to how the ICS will provide assurance to its constituent organisations and NHSE&I
- **Skills and capacity:** The ICS has an umbrella role and requires specific skills to promote the right behaviours and approach – such as modelling, intelligence and negotiating – to support intelligence led decisions to enable the best outcomes. While avoiding creating another layer of bureaucracy, capacity is needed to co-ordinate all parties, particularly for large systems. Although some specific ICS roles may be needed, it may be a case of freeing up and utilising the skills and capacity of the partnership bodies.

In your system:

Is the role of the ICS (and ICPs), including strategy setting, finances and performance oversight and communications clearly documented?

Have the skills and capacity required for the ICS been identified and put in place, and how does this align to the workforce people plan for the ICS?

How will the role of the ICS be assessed and refined as it matures?

Working with local authorities, general practice and other partners

One of the fundamental principles of an ICS is to use the power of partnership working to coalesce around the citizen to deliver health and social care. To improve population health, address inequalities, improve allocative efficiency, and help to support broader social and economic development, there will need to be real clarity on the relative and combined role of all partners on these agendas. As we emerge from the Covid-19 pandemic the ICS role in economic recovery¹⁷, including key anchor institutions, is vital. For some systems this will need a stepped change in joint working. Key NHS partners include:

- local authorities: run by democratically elected councillors accountable to the electorate to provide local services including housing, education, social care and public health
- general practice: self-employed private sector businesses which are the first point of contact for many people when they have a health problem, each expected to be part of a PCN¹⁸
- VCSE sector: a large number of organisations, often working at a community level, essential to delivering a greater shift towards prevention and self-care, supporting mental health issues and accessing deprived communities.¹⁹

The Health and Social Care Act 2012 required the establishment of health and wellbeing boards (HWB)²⁰ designed to provide strategic co-ordination to the commissioning of NHS services, social care and health improvement. HWBs have a statutory duty, with CCGs, to produce a joint strategic needs assessment (JSNA) and a joint health and wellbeing strategy (JHWS) for their local population. The white paper recognises that the ICS and HWB are complimentary bodies at system and place level. The ICS will need to work closely with HWBs, having regard to their assessments and strategies.

The current level of engagement with local authorities, general practice and the VCSE sector is mixed, with many ICSs feeling like an NHS bubble. The ICS board role is often focused on NHS money and achievement of control totals. Particularly for those partners in the independent sector, there can be an understandable reluctance to be transparent about their finances. Even where partners come to the table, in most cases further work is required to ensure they are genuinely able to be involved in tackling system wide issues and see the benefit to them and the populations they serve.

There are a number of challenges that must be overcome to ensure that these essential partnerships are effective. Aside from the NHS financial challenges, local authorities and the VCSE sector are facing huge financial challenges, having seen significant reductions to their funding over the last decade. Without trust, these financial pressures lead to concerns about the possibility of cost shunting. There are a number of differences to reconcile from language used (such as 'specialities', 'activity' and 'patient' in the NHS and 'residents' in local authorities); financial information and reporting requirements in terms of timing and content (including local authority statutory duty to balance the books annually and the different VAT regimes²¹); information systems and data sets; and governance arrangements (such as local authority cabinets). Working with a large number of different partners, often serving non co-terminous communities is complex. A larger ICS footprint can make partnership working more difficult due to the number of partners, while those ICSs with a smaller footprint can have capacity constraints.

Based on experiences across the country, the following approaches can help:

- **Being clear on the aims and benefits:** specific meetings must have clear aims and be meaningful for all attendees. It can be difficult to balance items of interest to a particular sector with the wider system interest. It may be helpful to split out meetings covering operational and strategic finance to avoid putting off non-NHS partners with talk of operational details.
- **Collaborating on joint objectives and joint investment plans:** working together to articulate and document joint objectives and plans helps to avoid sector specific jargon or bias.
- **Engaging with clinicians and politicians:** politicians and clinicians have a similar 'population facing' role which should be used to drive shared plans for improvements. Partners will be more committed when they are involved in proposed actions.

¹⁷ NHS Confederation, *NHS Reset: The role of health and care in the economy: a five-point plan for every system*, July 2020

¹⁸ HFMA, *How it works – primary care finance and primary care networks*, March 2020

¹⁹ NHS Confederation, *How health and care systems can work better with VCSE partners*, August 2020

²⁰ The King's Fund, *Health and wellbeing boards (HWBs) explained*, June 2016

²¹ Although this is being addressed through an HMRC consultation that the HFMA has also responded to (HFMA, *The HFMA response to the VAT and the public sector: reform to VAT refund rules*, November 2020).

- **Using place:** firstly, there is a need for clarity on what 'place' means to all partners. This is commonly aligned with either a CCG or local authority boundary but does vary. With an aligned definition, partnerships focused at place level can work well to respond to specific local population issues. As one local authority officer interviewed commented, it needs to be 'strategically significant, locally relevant.'
- **Pooled budgets:** Pooled budgets can help both NHS bodies and local authorities manage financial risk over time and deliver improved outcomes. Less formal approaches that may be helpful include an amalgamation of sources of funding on paper to support aligned budget decision-making.
- **Shared commissioning:** Shared commissioning functions can be more efficient and enable improved care pathways for patients and service users. For some, shared commissioning between the local authority and providers is a practical starting point.
- **Using existing committees:** use existing arrangements (such as HWBs and overview and scrutiny committees) to be transparent, provide challenge and avoid duplication. HWBs are often formed around place and scrutiny committees for health can be used to complement their strategic role.
- **Ensuring a common understanding:** it is helpful to understand the context each partner is operating in, so take time to talk to partners; read budget books; and develop a shared language that focuses on talking about people and how they are treated across all services. For example, 'care pathway' is less focused on individual organisation priorities. It is important to understand both the impact on decision-making of the democratic process in local authorities and the role of regulators in health. HFMA and CIPFA's *An introduction and glossary to NHS and local government finance and governance in England*²² can aid understanding in NHS and local authority systems and terms.
- **Having shared roles:** examples include joint leadership across NHS and social care, joint staffing (such as community teams) and joint project teams (focused on specific areas such as digital development). Secondments and shadowing, within and outside NHS, are helpful to build a shared understanding.
- **Building on success:** fully embedded partnership working will take time so celebrate success where progress has been made, such as on public health or budget sharing programmes.

In your system:

How does the ICS build on the role of the HWB and place-based working with non-NHS partners?

Is it clear what benefit all partners will gain from the meetings held and are attendees matched to agendas?

What specific areas could be considered for joint pots of funding, shared roles or programmes?

²² HFMA and CIPFA, *An introduction and glossary to NHS and local government finance and governance in England*, November 2019

Financial framework

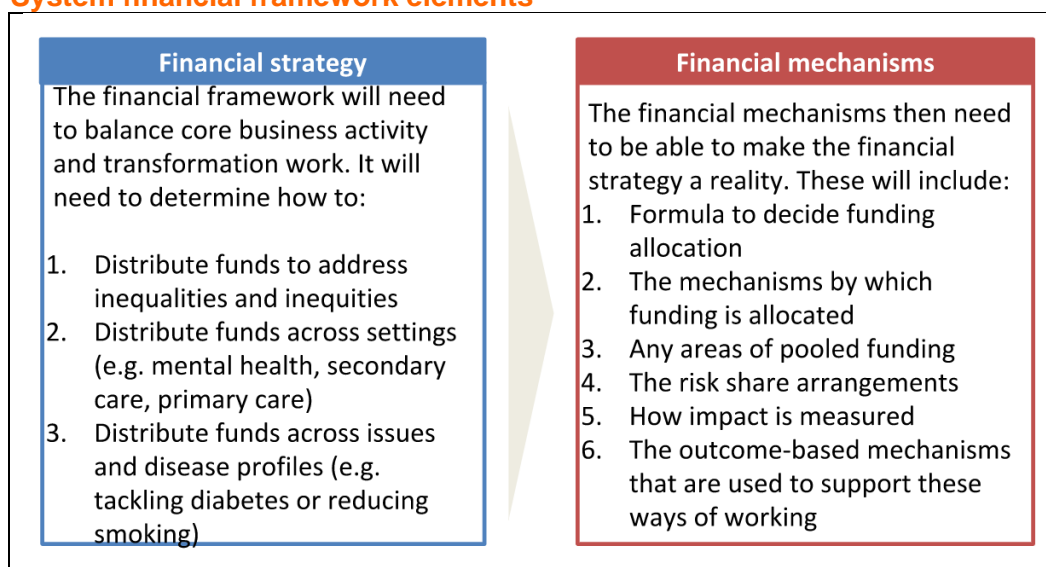
Financial arrangements

During 2020/21, as a result of the Covid-19 pandemic, the normal NHS financial regime was paused and simplified payment mechanisms and contracts were put in place. This removed many financial barriers to co-operation and innovation and has demonstrated how organisations can work together to achieve a shared, although single, objective when traditional areas of conflict are removed. HFMA's *The future NHS financial regime in England: recommendations*²³, makes recommendations for the development of the future financial regime.

This simplified financial regime will continue into quarter one of 2021/22 with the expectation that later in the year system envelopes and a blended payments approach will form the basis of financial arrangements. As set out in the white paper, there will be a duty placed on the ICS NHS body to meet the system financial objectives which will require financial balance to be delivered. This will require collaborative working to develop a shared financial framework and system wide plan. The draft *NHS standard contract 2021/22 consultation*²⁴ outlines a raft of financial changes, including a move to quarterly reconciliation and the removal of sanctions. Its aim is to simplify the financial aspects of NHS contracting to reduce the time spent on transactional processes. The contract will continue to require CCGs and trusts to sign and act in accordance with an overarching system collaboration and financial management agreement²⁵, which sets out how they will work together to achieve system financial balance.

A system financial framework should enable systems to make sure funds are transferred to where they are needed most. The framework comprises a financial strategy and financial mechanisms (**figure 3**).

Figure 3: System financial framework elements



Source: HFMA annual conference learning lab – Frimley Health and Care ICS

Although the majority of funding through the ICS is NHS funding, other elements such as relevant social care budgets need to be identified to get to an agreed system wide funding position. There are already some areas of joint funding between the NHS and local authorities such as the better care fund, with plans agreed by HWBs and minimum contributions pooled in a section 75 agreement²⁶.

There are a number of key challenges faced in developing system financial arrangements. Firstly, many systems will have some or all of their constituent organisations reporting a deficit. Further financial pressures will be faced as NHS organisations recover from the pandemic, particularly as they address the backlog in acute elective care and the increasing demand for mental health services. With finite resources, difficult decisions on where to invest funds will need to be made in the context of conflicting priorities.

²³ HFMA, *The future NHS financial regime in England: recommendations*, December 2020

²⁴ NHS England and NHS Improvement, *Draft NHS standard contract 2021/22: a consultation*, January 2021

²⁵ NHS England and NHS Improvement, *Draft system collaboration and financial management agreement 2021/22*, January 2021

²⁶ DHSC and MCLG, *Better care fund: policy statement 2020 to 2021*, December 2020

Financial decisions are particularly difficult when system envelopes need to be shared between a large number of organisations. Some organisations, such as ambulance trusts, will operate in more than one ICS and therefore system envelope. In some cases, particularly if there is one major acute trust in a system with a large deficit, it may feel like there is only a small proportion of funds left available for other parts of the system.

A further challenge relates to accountability and the disconnect between the system control total and managed organisational performance with regulation based on the financial position of individual constituent organisations. This makes it difficult to move money across a geography of an ICS to change ways of working or address health inequalities. With statutory audits based on individual organisations, there are also potential audit implications of moving funds around.

The HFMA has made a number of recommendations for *Developing system working through changes to the NHS financial regime*²⁷ and further actions, based on experiences across the country, that facilitate system financial arrangements include:

- **Transparency:** there needs to be full transparency over funding, for both capital and revenue. This requires understanding of priorities, an open and honest sharing of financial positions and how decisions are made to allocate funds. There needs to be clarity over what funds are available at system, place and organisational level, so that people can understand how to influence them. In one example, all system leaders have signed up to a system pot of growth funding which is hosted by one organisation and allocated out during the year.
- **Accountability:** recognising the benefit of an action may lie in a different place to its cost and may be realised over a long time period, there needs to be clarity over where the money is, what it aims to achieve and where responsibility lies for it.
- **Agreements focused on the patient:** for many, payment by results has already been replaced with long-term contracts reducing transactional costs. System working can help reduce barriers and make it easier for organisations to do what is in the best interests of patients and taxpayers. Conversations can be had about overall funding levels and how value can be best delivered across the system.
- **Understanding costs:** understanding of the cost base, such as overheads and workforce, will enable a constructive discussion with partners to work out how to improve value. This includes, for example, understanding the recurrent funding needed after an initial period of investment. Using this to feed into an integrated financial plan will enable all partners to be sighted on each other's activities so there are no unexpected consequences for the system.
- **Outcomes based contracting:** delivering quality outcomes, and often making long-term savings, should influence how funds are allocated and subsequently monitored. Examples include providing an outcomes-based allocation to an ICP or a voluntary organisation, alongside key performance metrics, so that the delivery of services is driven by those closest to the citizen.
- **Financial leadership committee:** many systems have found it helpful to have a system wide financial group to drive financial arrangements. Examples of focus include:
 - a financial approach based on system strategy and a joint set of strategic plans
 - an understanding of cost drivers and the impact of changes on services
 - system business case model including impact on fixed costs
 - a plan of what decisions can be made at what level
 - key outcome measures to assess delivery of strategy
 - framework for holding each other to account and dispute resolution
 - communications plan of the relationship between cost, performance and quality
 - staff development and training plan.
- **Agreed financial principles:** many have a memorandum of understanding (MOU), across part or all of the system setting out their agreed purpose and principles. Building on this, risk share agreements are increasingly used to support agreed plans. These are explored further in HFMA's briefing, *How do you ensure robust system risk management arrangements?*¹¹ To ensure senior leadership owns the MOU, some examples include each organisation being required to provide email confirmation, from the chief executive or finance director, of their approval of the agreement. Collaborative working will only happen if the individuals involved agree and act on the spirit of the principles. However, writing these down helps form an agreed view and is particularly helpful as staff changes occur. The NHSE&I *Collaboration and financial management agreement*²⁵ should be built upon to develop a tailored set of principles for the system. An example of the MOU principles one ICS has developed are set out in **figure 4**.

²⁷ HFMA, *Developing system working through changes to the NHS financial regime*, December 2020

Figure 4: Example financial principles

Clinically led: Focus is on the patient and our populations, minimising the impact of Covid on planned and unplanned services (physical and mental health) across the ICS and reducing health inequalities.

Collaborative approach: We're all in it (proportionately) together and all organisations will act reasonably. Active use of peer review.

Transparency: Open-book approach using consistent assumptions. Prima facie assumption is that each organisation's financial plan is reasonable and provides value for money, that no organisation has included anything extreme or unusual (and if so, to be explicit about this). New investments not directly related to clinical priorities should be met from funding streams ring fenced for that purpose or through offsetting CIPs/ waste reduction/ savings.

Simplify: Processes should be simple whenever possible and appropriate, using 'fair shares' not bidding.

Comprehensive and inclusive: Financial forecasts need to be based on overt activity/ service levels and capital investment. Clinical prioritisation must be clear and decided by the relevant clinical and operational colleagues.

Deliverability: Ambition must be tempered by an honest assessment of what can be done in time.

Fairness: Distil the spirit of the national guidance, (what it is they are trying to achieve) into a clear framework that deals fairly with patients and feels fair to all organisations. We do not want to disproportionately affect the population of one place over another.

Consistency: The new allocations and rules should not create 'windfall' gains and losses. We would expect that the resulting position for each organisation to be broadly similar to that reflected in previous plans to meet financial improvement trajectories.

Specialised commissioning: Any shortfall or gain on these services should not be borne by the CCG that 'hosts' the relevant provider. Where these services are provided for populations outside of the ICS, a proportionate share of any shortfall should be borne by the relevant ICS.

Future proofing: When agreeing 'trade-offs' between organisations for the year, need to also agree annual accounts treatment and onward consequences for future years. Need to retain visibility of underlying position.

Source: West Yorkshire and Harrogate Integrated Care System

In your system:

Are the financial arrangements, and expected outcomes, agreed and simply documented?

Is there an agreed understanding of both system funds and system costs, now and aimed for?

Have all partners been involved in setting system financial principles and signed up to them?

Sharing financial information

Financial data from across the system needs to be able to be pulled together into useful information to enable effective system decision-making. To achieve this, an open book approach is required across all system partners. Ideally this will include NHS organisations; local authority adult social care, children's services and public health; and the VCSE sector.

Applying the principles set out in system MOUs, finance teams should work together to share data. The default position should be to share financial information unless there is a good reason why not. However, there are a number of practical and cultural challenges faced in doing so. Trust can be fragile with historic behaviours leading to a culture of protectiveness and secrecy over data. The Covid-19 pandemic has accelerated data sharing across organisations and this needs to be maintained. As set out in the white paper, 'the forthcoming data strategy for health and care will set out a range of proposals to address structural, cultural/ behavioural and legislative barriers to data sharing and a more flexible legislative framework to improve data access and interoperability, including enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system.'

Individual organisations hold a wealth of financial data in different formats, from different sources, and available at different times. For some organisations, such as ambulance and mental health trusts, finances can span more than one ICS. It takes time to identify and consolidate data into a system format and resources to do this may be limited. Comprehensive information needs to include triangulation with non-finance data such as performance and workforce.

The HFMA has previously explored approaches to aligning resource plans in a system¹². Further thoughts shared from across the country include:

- **Capacity:** pulling together financial information takes time and examples where this has worked well include defined resources allocated to pull together ICS-wide information. In some cases individual organisational returns are shared for an individual to pull out key information (but not shared more widely) and in others templates are shared for individual organisations to complete.
- **Use existing data:** the aim should be to get as much information from existing reports as possible, such as various activity data (SUS, SLAM, primary care); efficiency data (model hospital, GIRFT and RightCare) and budget reports. The data systems of each partner need to be understood to identify any gaps in information needed by the ICS.
- **One version of the truth:** numerous reports provide different data for different audiences, but they must reflect one version of the truth. It helps to share a system finance report with Boards of constituent organisations. As raised within *One NHS finance*²⁸, participants want greater consistency in systems, processes and the application of policies so that there is less differentiation across organisations especially within an ICS footprint.
- **Review system assumptions:** undertaking an exercise to understand assumptions across a system financial plan such as pay, inflation, prescribing and financial reporting will support greater understanding and consistency. Not all will be the same but the review will allow individual organisations to understand and explain any different approaches. It is also a helpful exercise to get all parties together to collaborate around a one-off initial system exercise.
- **Finance reports and dashboards:** system reports need to be tailored according to what they will be used for and who will read them. It is common for reports to be reviewed in detail at a system finance committee and then recommendations taken to the ICS board. Reports may include overall financial position, activity, workforce, services, efficiency programmes and risk assessments. Finance reports commonly include: key messages; current and forecast financial position (revenue and capital); and risk scenarios. Figure 5 provides an example.
- **Service level reporting:** for many systems one meaningful way to review data is by segment, such as frailty, enabling a discussion that clarifies how much is being spent on a service and by which organisations. This also helps wider system understanding and aligns more closely with the local authority budget book principle. Some systems are testing this on one area initially as a proof of concept, recognising it will take time to build the data.

²⁸ FFF, *One NHS finance – report of the first online workshop*, December 2020

Figure 5: Common finance report headings

Adjusted (surplus)/deficit (£m)	Year to date plan, actual and variance	Forecast plan, forecast outturn, variance	Risk including mitigation and current and predicted net risk
Provider A			
Provider B			
Total providers			
Commissioner A			
Commissioner B			
Total commissioners			
Intercompany mismatch			
Local authorities			
System (surplus)/deficit			

In your system:

Have you identified what is needed in an overall system financial report and who it is aimed at?

Have you considered other financial reports that will be helpful such as at place level or service line?

Have you agreed how reliable information will be practically pulled together from all partners?

System governance

Governance framework

Governance is defined as ‘the system by which companies are directed and controlled’ and covers how they are run, structured, led and held to account²⁹. System governance consists of the arrangements put in place to support partnership working and to embed a collective model of decision-making and accountability to deliver a shared purpose. The arrangements need to add value by working with, rather than acting as a barrier to, existing organisational governance arrangements. They need to enable decisions and represent all organisations without creating lots of additional meetings involving large numbers of people. If effective arrangements are in place, they can be used to drive the right behaviours to enable new ways of thinking and working to address system-wide issues such as inequalities in health.

As system working has increased over recent years, governance arrangements have evolved in different ways. In some areas the current frameworks are relatively informal, based on unwieldy structures that can make it difficult to enable things to get done. As set out in *Next steps to building strong and effective integrated care systems across England*, ‘ICSs now need to put in place firmer governance and decision-making arrangements for 2021/22, to reflect their growing roles and responsibilities’. The aim is to balance a consistent framework with flexibility to match local needs. **Figure 6** sets out the core requirements of the ICS governance framework.

Figure 6: ICS core governance requirements

‘The *NHS long term plan* stated that all ICSs should develop their system level governance arrangements, stating the importance of multi-professional leadership within it. It stated that every ICS will:

- establish a Partnership Board, drawn from constituent organisations
- have a non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving organisational nonexecutive members of boards/ governing bodies
- have sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes
- fully engage with primary care, including through a named accountable Clinical Director of each primary care network
 - clearly articulate the links between the neighbourhood – place – system, including robust reporting and escalation processes which link all tiers of the system
- build a culture of improvement and development across the governance groups.’

Source: NHS England and NHS Improvement, Governance guidance: mechanisms to support the work of integrated care systems³⁰

There are a number of challenges faced when developing an effective system governance framework. Firstly, it is important to recognise that governance is as much about behaviour, values and attitudes as about structures, systems, processes and controls. There is no point having a comprehensive governance framework if no-one is committed to it or understands why it exists and what it is designed to achieve. For many, system governance is not very clear beyond ICS board level and is complicated further by continuous change.

Arrangements are currently based on voluntary consensus. Statutory requirements on the constituent bodies of a system will continue to cause difficulties for boards who are legally required to act in the best interests of their organisation, rather than the wider system, should there be a conflict. Currently a key issue is that if a partner doesn’t agree ‘play jointly’ there is no mechanism to address it. There are also legal constraints on the ability of organisations in an ICS to make joint decisions. Although the white paper aims to remove barriers to integration, this will remain a challenge until new legislation is in place.

For many ICSs there is both a large geographical spread and number of different organisations from different sectors - NHS, social enterprise, private sector, primary care, local authorities and VCSE - which makes it difficult to create simple, robust and transparent governance arrangements. For example, how do you integrate a large number of different sets of motivations and hear all voices? It can feel an unmanageable structure to work within and one individuals can feel removed from. Practically this can also lead to there being insufficient time to follow good governance practice to get proposals signed off.

²⁹ HFMA, *Introductory guide: NHS finance*, September 2016

³⁰ NHS England and NHS Improvement, *Governance guidance: mechanisms to support the work of integrated care systems*, July 2020. Available via NHSfuture collaboration portal System operating framework workspace

Recognising that different arrangements are required to suit different systems, NHSE&I has signalled key elements they expect to see in their *Next steps to building strong and effective integrated care systems across England*. These include a focus on place leadership, provider collaborative leadership and individual organisation accountability within the system governance frameworks. A resource pack³⁰ has been designed to help systems think through what type of governance arrangements they might need.

Based on experiences from across the country it is important to build governance arrangements that support a collective mindset and system plans. Changes in governance should not purely add layers of bureaucracy or be at the expense of existing excellent arrangements. Key lessons include:

- **Matching structure to purpose:** ICS structures are often a complex set of sub-systems which need to be designed in partnership with those in the system. This should focus on what the role and responsibility of each partner is and how all relevant voices can be heard at the right place. This needs to also include organisations that may be small, and often span a number of ICSs, such as ambulance and mental health trusts. Whatever structure is established, it is important to ensure the following functions are covered:
 - engagement
 - strategic vision
 - operational
 - co-ordination.
- **Understanding governance arrangements:** as demonstrated in the example at **figure 7**, it is helpful to ask a series of questions to understand the role and workings of key groups within the structure.
- **Transparent decision-making at the appropriate level:** different decisions will need to be taken at different levels. For example, system wide changes to delivering maternity may best sit with the ICS, while a business case for an additional consultant may sit better at 'place' or organisation level. In all cases, the principle of subsidiarity (closest to the patient as possible) should be applied and arrangements documented. It can be helpful to separate decision-making from engagement so that a range of options can be gathered and then objectively considered. Further tips are set out in HFMA's briefing, *How do you support effective system decision-making?*¹⁰
- **Senior level:** with committees generally not set up with delegated authority, it is important to have people attend meetings with delegated authority from their own organisation so that they can commit to actions, such as pathway changes or financial movements.









Figure 7: Governance structure fundamentals

	Partnership Assembly	Partnership Board	Partnership Executive	Partnership Coordination Group
What it is	The Partnership's representative or democratic council, akin to a shareholder AGM	The governing body of the Partnership	The team that executes the strategic plan of the Partnership	An ad hoc operational group to coordinate efforts in response to C-19
Why it exists	Without it there would be no scrutiny of the Partnership Board & possibly narrower interests represented	To set the strategic framework of the Partnership & monitor performance against it; gives authority for expenditure & policy decisions where appropriate	Both to deliver & help Partners to deliver the vision & mission of the Partnership	To improve efficiency across the C-19 response, & to provide additional resource
Where it fits	At the top, as the body of last recourse. Provides the context in which the Board works	Accountable to the Partnership Assembly. Holds the Partnership Executive to account	Executive arm accountable to the Partnership Board	Temporary arm of the Partnership Board
Who's on it	Partnership Board, reps of all Partner orgs, stakeholders (open to public as auditors not contributors)	Chair, representation from LAs, CCGs, Trusts, VCSE, Public Health, PCNs, NHSE/I & Partnership Executive	Chief Officer, Dir Finance, Dir Workforce, Dir Strategy & System Development, Dir Performance & Delivery, Dir Comms & Engagement	As per approved constitution
When it meets	Three times a year	Monthly	Weekly	Weekly

Source: Cheshire and Merseyside Health and Care Partnership

- **Facilitator role:** one of the key functions of the ICS is to act as a facilitator to improving services. For some systems, this is helped by having a lead for each element such as finance, digital and estates, often from different organisations, and brought together by a programme director. For some, an independent facilitator is used to ensure individuals, from all sectors, understand system impacts and system governance so that their focus is on improvement.
- **Clear documentation:** whichever model is selected, the impact on the governance arrangements of all the existing statutory bodies needs to be considered. Significant work will need to be undertaken to determine arrangements, with much of the benefit gained from the conversations had in developing them. Whatever is agreed, the accountability of an ICS needs to be clear, specifically how it connects with, and meets the needs of, the local population, so that all parties understand how things work and why.
- **Reflection:** system governance arrangements will need to be adaptable, particularly as relationships develop, financial frameworks evolve and service patterns change. For 2021, many systems will be testing out arrangements. In some cases, systems are establishing a six month or annual reflection process to consider what is working well, whether there are any unintended consequences and what might need to be refined. Programming this in up front, including what will be evaluated and how, can make the exercise feel less adversarial. Internal audit is an valuable source of independent input into this. **Figure 8** is one example of questions that can be used to evaluate how the system is progressing.

Figure 8: Partnership evaluation questions

Questions the Partnership must ask itself	
 1. How far is people's health improving?	1 2 3 4 5
 2. How far are health inequalities reducing?	1 2 3 4 5
 3. How strategic are we being?	1 2 3 4 5
 4. How effectively are we collaborating?	1 2 3 4 5
 5. How much value are we adding?	1 2 3 4 5
 6. How smart are we being with money?	1 2 3 4 5
 7. How well are we learning?	1 2 3 4 5
 8. How usefully are we impacting on C-19?	1 2 3 4 5

Source: Cheshire and Merseyside Health and Care Partnership

In your system:

Is there a clear governance framework in place which sets out structures, people and processes?

Are decision-making arrangements clear?

How will governance arrangements be reviewed and refined?

The role of non-executive directors

NEDs and lay members provide an invaluable role in terms of engagement, leadership and challenge in the NHS and are vital in developing effective new collaborative arrangements. They are able to take the lead in ensuring constructive challenge from a position of experience, independence and focus on the whole picture, particularly as seen from a patient perspective. NEDs are often governance experts so are ideally placed to contribute to developing arrangements.

However, the NED role is currently firmly grounded within statutory organisations and it can be unclear to them how they fit into the new system arrangements. In some cases, NEDs feel isolated or unheard, particularly if it seems that an ICS is taking a greater decision-making role with no formal NED challenge until proposals are presented back to organisational boards. It can be difficult to manage communications and representation with such a large number of NEDs in some systems. In some cases, ICSs are trialling a system audit committee or NED group, but the challenge is to avoid creating another layer of bureaucracy.

Some examples that have helped across systems include:

- **System role:** as set out in the King's Fund paper³¹, NEDs need to 'think system', recognising that individual organisations cannot meet the challenges facing the NHS on their own. NEDs should consider how they see their system role and how it can be delivered. In one example, NEDs and local authority members agreed together the arrangements that suited them.
- **Engagement:** particularly at the initial stages, it is helpful to invest the time to engage with all NEDs to identify their concerns, views and priorities. Examples of engagement include system-wide NED meetings or audit chair groups; ensuring NED representation at ICS meetings (possibly with a rotating chair); attendance from ICS executives at organisational meetings to engage with NEDs; matching NEDs from different system organisations; matching a NED with a system executive; and attendance at other organisations' NED meetings.
- **Transparency:** set out what information is needed for transparency of arrangements and decisions to enable NEDs to hold the ICS to account for delivery. For example, it is good practice for the ICS finance report to go to organisational finance committee meetings. Transparency over how system work links to individual organisation objectives, as well as over the assurances expected and how they will be achieved, will grow confidence.
- **Place/topic alignment:** it may be helpful to consider aligning NEDs to place, which can often link well to alignment with local authority members. In some examples, a NED has been allocated roles within specific ICS working groups. In one example, the meeting of finance committee chairs has been integral to understanding the system financial pressures and increasing pace on working together to solve financial management issues.
- **Independent ICS NEDs:** independent NEDs for an ICS can avoid conflicts of interest issues.

In your system:

Have NEDs and local authority members been involved in developing system governance arrangements?

What mechanisms might work best locally to ensure NED oversight is applied to the system?

How are NEDs kept up to date with system strategies and plans?

³¹ The King's Fund, *Non-executive directors and integrated care: time to think system*, May 2018

Conclusion

The need for collaborative system working is clear but the finance and governance arrangements to enable it can be complex. Significant progress has been made over recent years, although it can often feel fragile. As set out in the white paper and *Next steps to building strong and effective integrated care systems across England*, further changes - accelerating this move to system working - are expected.

No one system would claim to have addressed all the challenges faced and no one approach will suit all systems. If it was easy to do it would have been done by now. Despite the challenges, greater system working presents huge opportunities. Many argue that now is the time to be ambitious. System finance and governance arrangements will continue to evolve as system working becomes the new normal. There will be a lot more to explore over the coming year in terms of legislative implications, risks and opportunities.

This paper explores the challenges faced, along with guidance and tips to help address them. It provides some key questions that systems can use to aid conversations they are having to tailor arrangements to suit their systems. Whatever arrangements are developed, it is clear the key cornerstones to these must be a patient focus, flexibility, trust and transparency.

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HFMA Governance and Audit Committee

HFMA System Finance Special Interest Group

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The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For nearly 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.

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