



# Health Select Committee inquiry into Sustainability and Transformation Partnerships (STP)

Written evidence submitted by the Good Governance Institute (GGI)

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## The inquiry

Sustainability and Transformation Partnerships (STPs) cover all of England. In each STP area, local NHS organisations and councils have drawn up proposals to improve health and care in the areas they serve.

The NHS England document Next Steps on the NHS Forward View, published earlier this year, says

STPs began life as pragmatic vehicles for enabling health and care organisations within an area to chart their own way to keeping people healthier for longer, improving care, reducing health inequalities and managing their money, working jointly on behalf of the people they serve. They are a means to an end, a mechanism for delivering the Forward View and the key national priorities in this Plan. (p.32)

Bearing in mind the role of STPs described in Next Steps, the Committee invites written submissions addressing any or all of the following points:

- How effective have STPs been in joining up health and social care across their footprints, and in engaging parts of the system outside the acute healthcare sector, for example primary care, local authorities, public health, mental health and voluntary sector partners? How effectively are they engaging local communities and their representatives?
- How reliable are the ratings in the Sustainability and Transformation Partnerships Progress Dashboard, and what do they tell us about the state of the plans and the relationships that underpin them?
- What do the available evidence, and experience so far, tell us about the deliverability of STP plans given the financial and workforce pressures across the NHS and local government? Are the demands being made of STP plans through the NHS Mandate and the NHS Shared Planning Guidance deliverable, and can STPs ensure the fulfillment of the requirements of the NHS Constitution?
- Looking across all STPs, are there any major areas where the content of the plans needs to be tested for credibility and realism? Are there any major gaps? For example, are proposals in some plans to reduce bed capacity credible?; are the NHS efficiency estimates in STPs robust?; is the workforce available to enable the implementation of STPs?; or is the timescale for the changes proposed in STPs realistic?
- How will the development of STPs into Accountable Care Systems (ACSs) change the delivery of care in an area?
- What governance, management and leadership arrangements need to be created to enable STP planning and implementation to be carried out effectively? Are additional, or different, arrangements required for areas which are developing ACSs?
- What legislative, policy and/or other barriers are there to effective STP and ACS governance and implementation, and what needs to be done by national bodies and national leaders in the NHS to support the implementation of STPs and ACSs?
- What public engagement will be necessary to enable STPs/ACSs to succeed, and how should that engagement be undertaken?

## Response from the Good Governance Institute (GGI)

GGI is a well respected research and review organisation. Initially set up by the NHS in 2008 following the launch of the Integrated Governance handbook, GGI is now an independent consultancy which has advised commissioners, providers and suppliers, government agencies and regulators. GGI publications and events have scrutinized and informed governance arrangements in the NHS and with partners for 10 years. We believe that good governance is a means to delivery and is characterised by both good systems and behaviours – the mechanics and dynamics of governance.

STPs are an important attempt to align planning and delivery of health and care support for local populations. They have no statutory authority and are dependent on the leadership and goodwill of their constituent partners. As with the early days of CCGs there is no single template for their activity and they are evolving differently around the country. This is good for innovation but creates weaknesses where the fundamental principles of good governance have been neglected. There are many STPs working effectively especially where partnerships and plans were already well developed, relationships and confidence had been established and joint working in particular between the NHS and Local government was the norm rather than the exception (such as Dorset, where coterminosity of boundaries is also a factor).

GGI do not favour imposing a rigid structure for STPs but do recommend urgently the creation of a single set of guiding principles to allow governance to be established and mature. GGI have been influenced by the work of Professor Mervyn King, lead author of the South African models of good governance contained in the Series of King reports started in 1994, the most recent King 4 published by the SA Institute of Directors in 2016.

The codes are non-legislative and are based on principles and practices. It also espouses an apply or explain approach, unique to the Netherlands until King and now also found in the 2010 Combined Code in the UK. GGI favour an apply and explain approach which focuses on doing the right thing rather than rigid compliance. It requires boards and practitioners to think.

The philosophy of the code consists of the three key elements of leadership, sustainability and good corporate citizenship. It views good governance as essentially being effective, ethical leadership. King believes that leaders should direct the enterprise to achieve sustainable economic, social and environmental performance. It views sustainability as the primary moral and economic imperative of this century; the code's view on corporate citizenship flows from a company's standing as a juristic person and should operate in a sustainable manner. The enhancement in the new code make King IV more accessible to public service entities (see [https://c.yimcdn.com/sites/www.iodsa.co.za/resource/resmgr/king\\_iv/King\\_IV\\_Report/loDSA\\_King\\_IV\\_Report\\_-\\_WebVe.pdf](https://c.yimcdn.com/sites/www.iodsa.co.za/resource/resmgr/king_iv/King_IV_Report/loDSA_King_IV_Report_-_WebVe.pdf)).

King has also promoted the principle of integrated public reporting adding value to a set of social and economic capitals which can include health and wellbeing, quality outcomes, well trained staff, innovation and productivity. (<https://integratedreporting.org>). The concept of adding value to key capitals provides a developmental route for the STP progress dashboard which is too static at present and needs more recognition of planned development over time.

Areas developing ACS require different models of governance but the same principles will apply. To become an ACS, a local health and care system must show its partnership is advanced enough to make shared decisions, improve services for the public and manage resources collectively. GGI have found it helpful to distinguish between decision making, the process of engagement, developing options and clarifying assumptions; and decision taking when the various partners actually confirm a decision. In governance terms this is when responsibility for an action becomes accountability for its outcome.

All of the new groupings will need a design model based on population health which is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. STPs will need to develop effective frameworks to optimise outcomes through a golden thread of analysis, engagement, prioritisation, planning and delivery. Whilst STPs will have significant footprints, there will also be the need to understand flows and arrangements beyond their boundaries. STPs will need to recognise accountability for outcomes delivered by neighbours for their own resident populations. This will require agreements on sharing information and assurance of putting things right when they go wrong.

What are the principles of good governance? These were set out in the HQIP Good Governance Handbook in 2012 and then developed in 2015 for application from ward to board setting out how they should operate at departmental, division and board level:



From Good Governance Handbook, HQIP, GGI Jan 2015

<https://www.hqip.org.uk/public/cms/253/625/19/39/Good%20governance%20handbook%202015-1-1.pdf?realName=7ZZ76z.pdf&v=0>

The Nolan Principles are usually quoted as the mainstay of good governance. We applaud these but would encourage colleagues to adopt the additional two principles used in Scotland viz respect and public service. Holders of public office must respect fellow members of their public body and employees of the body and the role they play, treating them with courtesy at all times. They also have a duty to act in the interests of the public body of which they are a board member and to act in accordance with the core tasks of the body but we also feel the rigid application of fiduciary duty - to look after the interests and continuation of the institution - is too narrow an understanding of public duty. We prefer an appreciation of continuing to provide the best quality outcomes rather than the survival of an outmoded model of service delivery perhaps by an institution with volumes too small to deliver safe care or a lack of capacity to improve beyond mediocrity. We have advocated a best value model of service redistribution to those who can deliver better outcomes.

## Risk Appetite

Developing good governance in new disparate organisations is tricky. We found when CCGs were established there was an aversion to formal governance arrangements but a preparedness to consider risk appetite which provided a means for GPs in particular to embrace principles of good governance. Our guide with a matrix developed from the Treasury guidance was further developed in Scotland with the help of Jonathan Passmore, now Chair of Aberdeen City Health and Social Care Partnership IJB as a guide for the new integrated health boards (Oct 2015). This is possibly where it has greatest value in understanding not only our risk appetite but also that of our partners and stakeholders. Aberdeen City Health and Social Care Partnership (ACHSCP) was established through the Public Bodies (Joint Working) (Scotland) Act 2014. The combined entity is tasked with integrating health and social care services in Aberdeen city, working with the partner bodies of Aberdeen City Council and NHS Grampian to deliver fundamental changes to how acute and community health care services, as well as social care services, are planned, funded and delivered. This required an appreciation and sharing of risk across and beyond the geographical and organisational boundaries.

The foreword to the operating framework for the NHS in England 2010/11 reinforces this view:

*'In order to achieve the transformation required, we need to focus on how we share risk across the system and re-balance the risk between providers and commissioners...it is vital that NHS organisations do not respond by just trying to transfer risk to another organisation. We will not succeed if we have islands of success in a sea of failure. We have to recognise that we have a zero-sum game. If risk is transferred elsewhere in the system, it doesn't take the risk away. The people who pay are patients. They don't recognise organisational boundaries. What they recognise are services that are joined-up across the system.'*

### Culture & Language

An issue for partnership working is the differing cultures and language in use both within NHS organizations and between health and local government and charities and private providers. GGI working with Centre for public scrutiny (CfPS) have developed a guide for prospective partners setting out an etiquette for joint working and scrutiny.

## Etiquette principles

### 1. **Agree common outcomes, values and metrics**

The new partnership board must seek to determine its common purpose and it might best be able to do this by agreeing what will be different as a result of the collaboration. Story telling such as 'what will this be like for the patient being discharged? or the care worker receiving a referral?' might be an effective means of doing this.

The new arrangements will bring together different cultures so an early discussion of agreed values, unearthing variations in working practice and language will be important. Co-location will help avoid 'us and them' feelings and improve communication. Once outcomes and values have been agreed, alignment of system and metrics will be important to ensure common reporting back to 'parent' bodies.

### 2. **Ensure separation of executive delivery and scrutiny review roles**

Most partnership arrangements involve officers and elected or lay members and it is important to unravel respective roles so there is no ambiguity between executive delivery and scrutiny review roles. In practice, the new partnership board will need to be taking executive decisions with delegated authority from their respective hosts. Lay and elected members must determine if they are there as members for the new board or are representing the parent body who has elected or engaged them. If the former, the parent body will need other means of scrutinising decisions and progress.

### 3. **Re-establish and share engagement principles**

Good governance is about taking the best decisions based on good insight. Insight exists inside and outside of organisations and developing shared engagement principles can help executives and people with a scrutiny role talk to the right people at the right time to influence strategic direction and operational performance. Executives can use engagement principles to understand risk and help develop resilience. People with a scrutiny role can use engagement principles to check how services are performing and suggest future improvements.

### 4. **Allow stakeholders to engage early enough to influence strategy and plans**

All organisations will have stakeholder engagement models in place, some with statutory force. The new partner body will need to share and where possible align these allowing stakeholders to engage early enough to influence strategy and plans. We are developing this theme with Healthwatch England. This means going beyond legal duties to inform and consult, but making sure that the Guiding Principles remain central.

### 5. **Ensure attendees have delegated authority to take decisions**

Those attending joint board meetings should come prepared with delegated authority when decisions are required. They may have this as an agreed element of their role or may need to seek on an ad hoc basis depending on the item under consideration. Board papers need to be explicit when decisions are required to allow members to seek authorisation to act, so as to avoid constant reworking of issues. If not attending, the preferred action should be conveyed to the chair of the board so as to encourage progress rather than delay.

### 6. **Log, share, and track agreed decisions inviting each sovereign body to provide assurance of delivery trajectories.**

Decisions taken should be logged and explicit in what they will achieve, sharing with parent bodies intended outcomes and progress against these. When progress is at risk of running off agreed trajectory, reference should be made to delegated tolerances for escalating to parent bodies. Audit should be commissioned to check this operates as planned. Others with a scrutiny role can also check that levels of ambition for outcomes and progress are reasonable.

### 7. **Understand each other's risk appetite to allow for shared costs and risks**

A shared approach to risk and resilience is vital to successful partnership arrangements so that planned actions are not de-railed by unexpected circumstances. This means developing a common understanding about respective performance management and regulatory frameworks which can impact on the realities of joint working.

## **8. Delegate to partners and suppliers within agreed risk tolerance**

Parent bodies should be clear of their own and partners risk appetite for change to allow for informed risk sharing of costs and reputation. Agreed tolerances will help those representing them at partnership meetings to know when variations in expected performance need to be referred back to the parent bodies for additional effort, prioritisation, or resources.

## **9. In scrutinising papers focus on improvement rather than opposing**

Scrutiny should focus on improvement of outcomes rather than simply opposing decisions that have been taken. Where executives and those with a scrutiny role have a different view about actions to be taken, asking the question 'are executives doing what they said they would do?' can help take 'heat' out of difficult conversations. Scrutiny should always be positive rather than dismissive, seeking to improve the outcome for service users and carers.

## **10. Aim for 'what goes around, comes around' rather than win-win**

It will not always be possible for partners to be equal gainers from decisions so rather than seeking only bilateral win-win outcomes, a 'what goes around, comes around' approach will help remove log jams, recognising that different partners will secure different benefits at different times.

## **11. Recognise that our boards and stakeholders must police governance and scrutiny before regulators**

Good governance is not demonstrated only through compliance with external rules and regulations, but by adopting a transparent, inclusive and accountable culture within and across organisations. Boards and those with a scrutiny role must take governance seriously, recognising that good insight is required to take the best decisions. There are lessons from the past about what can go wrong when good governance is not fully understood.

## **12. Seek alignment of scrutiny, audit, inspection and regulation within and between different agencies to provide mutually reinforcing systems**

The combined boards should aim to develop their own assurance that intended standards and outcomes are being achieved. This should be shared with parent bodies on a no surprise basis. It is the combined boards role to achieve this rather than rely on external regulators.

In addition, combined boards should support their auditors, inspectors and regulators to work together to develop a holistic pathway or place based approach to audit and regulation. This should gradually replace the many institutional based reviews which fail to tell the whole story (Scrutiny: the new assurance?, Good Governance Institute / CfPS, September 2017, available at <https://www.good-governance.org.uk/services/scrutiny-the-new-assurance-a-good-governance-discussion-document/>).

## In summary, we believe:

1. STPs and other groupings need to be guided by a set of principles that all can sign up to.
2. Collaborative models need to understand the extent to which they are unravelling the 2012 Act, the duty of CCGs to commission on behalf of patients and the thorny issue of patient choice. A lighter touch joint commissioning based on principles of intelligent funding and focused on outcomes might be the answer.
3. Transformation will need investment and disinvestment. Combined authorities should set out their principles of disinvestment in advance and follow these lest they fall foul of judicial review. Best value reviews might be the best way to demonstrate the need to create new forms of provision.
4. The combined authorities will need to take decisions, some of these will be unpalatable to be internal partners and stakeholders. It would be prudent to establish a formal arbitrator in advance; it is much more difficult to agree on a name after the battle lines have been drawn.
5. Combined decision making needs a new kind of leadership which can rise above self interest but still command support from disadvantaged players including the organisation the leaders represent.
6. We need to establish a fundamental principle of subsidiarity recognising that accountability starts with clinical practice, is the responsibility of the board, then the commissioners/funders, and only then with regulators/agencies who cannot assure but only exhort. This is doubly important when decisions are being taken by partner groups. Accountability still rests with the individual statutory bodies. They cannot outsource these accountabilities to quasi bodies. To give such bodies room to analyse and debate their relative accountabilities, they must be unencumbered by issues rightly dealt with at operational level within respective partner institutions.
7. Scrutiny must be recognised as an important lever to secure both accountability and improvement but one that needs development. NHS boards and others seeking to operate effectively in complex partnership arrangements must not only understand their own roles and accountabilities within but also recognise their responsibilities and obligations beyond their organisational boundaries.
8. Transformation plans will need effective stakeholder engagement on a much higher level of competence than has been the norm. This needs to be ethically rather than PR driven with genuine and early involvement of stakeholders if it is to be credible. On the plus side, patient / user/ staff / partner engagement and support will trump negative political/press perspectives.
9. Public reporting needs to break out of the prescribed annual report debacle and move to a model more akin to Professor Mervyn King's Integrated Reporting albeit within a friendlier language.
10. Some standard shibboleths need sorting and moving mainstream with a common understanding. These include induction, clarity of roles, annual reporting, cycles of business, board assurance, scrutiny, risk appetite, delegation, escalation, etiquette.
11. There needs to be national planning framework with proper accountability to cover progress on investment, training and recruitment, inspection and review and national audits. If the Department of Health or NHS England/Improvement cannot, or will not, do this the NHS and its representative bodies should themselves establish a collective model.
12. There should be effort placed on developing a coherent and credible national quality framework and improvement methodology.
13. Clarity should be given to auditors on expectations on them to develop offerings that can cover clinical as well as system / financial audit and cross boundary as well as organisationally focused audits.

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