

Governing for transformation:

STPs and governance



Introduction by Chris Hopson, Chief Executive of NHS Providers

Effective creation and delivery of the local system Sustainability and Transformation Plan (STP) is now a key task for any healthcare leader. There is a clear consensus that creating effective governance for the STP process is vital but it's not something we have collectively done well enough up to now. The difficulties here are compounded by the existence of lots of different perspectives and advice on what constitutes good STP governance.



What makes our joint publication with Hemptons distinctive is that it sets out the context for STPs in a typically forthright foreword by Professor Paul Stanton; it identifies the challenges for organisations as they look to shape and implement STPs in their area; it examines the role of the board in the context of STPs and addresses the constraints that current legislation imposes on those seeking to work collaboratively. Perhaps most importantly it provides practical guidance on governance for those leading and directing STPs, which can be found in section 2 of the document. Hemptons have also helpfully included a template memorandum of understanding which STP partners may wish to adapt for use in their local area.

We hope you find it an interesting contribution. But, more importantly, we hope that you will find it useful in helping you address a potentially complex issue.

A handwritten signature in black ink that reads "Chris Hopson". The signature is written in a cursive, slightly slanted style.

Chris Hopson
Chief Executive

Foreword by Professor Paul Stanton

The challenges for those who govern NHS bodies - both centrally and locally - have never been more intense. In an increasingly turbulent global context the collision in England between protracted public sector austerity and inexorably rising demand has generated unprecedented and potentially destructive strains, not only within the NHS but within the health and social care system as a whole. Doing more of the same - within the existing resource envelope - is not possible.

We have now arrived at the second anniversary of the publication of the 'Five Year Forward View' which argued powerfully that, if the NHS was to become 'fit for 21st Century purpose', new care models needed, urgently, to be developed. It also made clear that a sustainable NHS was predicated upon action on three fronts: "Managing demand; delivering care more efficiently; [and] securing additional funding". Presciently, it warned that "Less impact on any one of them will require compensating action on the other two". In the intervening years, much has changed, much remains obscure and a few things now seem more starkly clear. As Simon Stevens himself concluded, in the wake of post Brexit turmoil, "It would not be prudent to assume any additional NHS funding over the next several years" (July, 2016). Little wonder then that pressure (on commissioners and providers alike) to "deliver care more efficiently" has been ramped up by NHSE and NHSI, as NHS deficits have continued to spiral, year on year. Which brings us to "managing demand". It has long been obvious that, while some levers of demand management do lie within the gift of some parts of the NHS, most do not. Even of those levers that are directly responsive to NHS control, few, if any, are in the sole hands of NHS Trusts or Foundation Trusts – whether secondary, tertiary, mental health or ambulance.

It is increasingly clear that action to address underpinning drivers of demand - heightened expectation, life style associated illness and/or social and economic deprivation - requires more sophisticated analysis of root cause, honest

social discourse and targeted long term investment from central government. These have, hitherto, been either absent or abandoned with a change of administration.

Even more crucially, there has been almost no open national recognition of, no co-ordinated planning for and no substantial investment to manage the primary and inexorable escalator of NHS demand - the radical and ever more steep change in the age structure of the population of England. "People are living longer ... demands for services are directly related to age and, because of the strong association between increasing incidence and increasing age for most diseases (like cancer, heart disease and dementia), population change will be the biggest single driver for health and healthcare over the next decades" (NESHA, Our Vision, Our Future, Our NHS, 2008). More than 90% of people aged 85 and above suffer from at least one long term condition with more than half of them having three or more inter-current long term conditions that generate complex and interactive health and social care needs (Barnett et al 2012; Melzer et al 2012). At the same time the proportion of frail elderly people who die in a hospital bed has risen, year on year for the last decade – with the result that "should this trend continue, fewer than 1 in 10 people will die at home in 2030" (Health Select Com2014). This would be financially catastrophic and ethically scandalous.

In 2013, the House of Lords Committee on Public Service and Demographic Change had concluded that "England has an inappropriate model of health and social care to cope with the changed pattern of ill health from an ageing population" (Ready for Ageing?) and called for "an honest debate about the implications" and urgent action to avert a catastrophe. No such debate and little concerted action has, to date, occurred.

In fact, that 2013 analysis (based upon ONS population projections to 2030) significantly underestimated the true

scale of demographic change. Revised ONS projections, to 2039, show that England will see a 57% increase in those aged 75 and above between now and 2032 and an overall 85% increase by 2039. So far as those aged 85 and above are concerned there will be an 82% increase by 2032 and an overall 127% increase by 2039. Most dramatically, the number of people aged 90 and above will increase by 116% by 2032 and by 193% by 2039 (ONS 2016). It is hard to think of any public debate on the impact of these changes on the NHS and on society as a whole.

It is important to emphasise that these are average figures for the 350 plus districts of England. The variance between districts is extreme. For example, so far as people 85 and above are concerned, there will be, by 2039, an overall 230% increase in Basingstoke & Deane while Barking & Dagenham will see a decrease of 50%. When planning for the future, place matters.

Few things could more dramatically and more concretely emphasise that, while NHS and wider system transformation is essential if a catastrophe is to be avoided, 'one size does not fit all' so far as local 'fitness for purpose' and thus local 'sustainability and transformation' initiatives are concerned. The nature, scale and pace of local transformation must be determined by local realities – not by national financial abstractions nor by a national template derived diktat.



Section 1: The sustainability & transformational planning process: local reality

There now appears to be a broad consensus across the NHS commissioners and providers and local government that 'doing more of the same' within the existing financial envelope is neither affordable nor appropriate. An overall direction of travel aimed at ensuring the transformation and thus financial sustainability of the NHS itself and of welfare provision deserves to be supported. However, as is so often the case, a distinction needs to be drawn between a commonly desired end and a centrally mandated means.

The proposal for STPs arose from a recognition that "England is too diverse for a one size fits all" uniform solution. NHS England therefore proposed 44 geographical planning 'footprints' to aggregate coherent health and social care 'communities of common interest' and to permit 'place specific' approaches that could drive local change at 'pace and at scale'. Dealing with the footprint's size, composition and boundaries has been a challenge and alongside this there has been a lack of clarity around the STP purpose and some have felt that the process has not been sufficiently attuned to local reality. In many cases, the swift timetable, driven by the centre, has compelled some local health economies to submit plans that constituent organisations or partners believe to be imperfect, poorly evidenced and/or undeliverable.

For many STPs their cost reduction targets for 2020/21 appear to be unrealistic and unachievable, with the targets being pre-defined without engagement with the players in each footprint. Prioritising seemingly quite arbitrary cost reduction targets has significant potential to undermine the ability of partner organisations within the footprints to work together to deliver the sort of transformation that will lead to cost reduction in the medium term.

Where STPs involve a radical redesign in models, patterns and locations of services there is a very real danger that a

severe shortage of capital to redevelop local infrastructure will slow down or even prevent the implementation of plans. Early indications are that capital funding will be limited and that only those schemes that provide the most beneficial impact will receive funding. In this context it would be prudent, therefore, for all parties to local STP submissions to consider carefully how capital intensive changes can be appraised and prioritised.

Inclusivity

The Five Year Forward View envisaged an inclusive and whole system approach to service transformation. However the need to identify multi million pound cost reductions within five years has, in many cases, led to an almost exclusive focus on structural reconfiguration of the acute sector with scant attention to the pro-active and comprehensive changes needed to minimise and better manage the demand that ultimately is the source of secondary healthcare cost.

Radical changes needed in primary, community, social and end of life care – upon which the appropriate and cost effective use of acute beds should be predicated – often seem to have been marginalised or ignored. There is little evidence of the pro-active involvement of ambulance services in the planning of transformational change. Similarly, with a few notable exceptions there has been little emphasis on closer integration of mental health and learning disability provision with physical healthcare.

This failure of inclusivity has increased the potential to overlook the unintended impact of cost driven change with potentially divisive consequences for wider collaboration. A number of local authorities and local Health and Wellbeing Boards have already felt detached from a process that many see as 'NHS centric'.

At the same time the fact that STPs have only just started to be debated openly and in public has postponed rather



than avoided a challenging and highly sensitive period of public engagement and consultation. NHS organisations and their partners will need to ensure real involvement of local communities before final decisions are taken to implement changes – not least so that the process itself is not flawed in relation to the statutory duties of public involvement and local authority consultation.

Finally, it is clear that for the most part the STP process has not involved or engaged with front line staff, yet their active commitment to and participation in transformational change is an essential pre-condition to the seamless, safe and effective delivery of services to patients through periods of structural upheaval. Provider Boards will therefore need to proactively secure genuine clinical and staff involvement in the planning and delivery of change itself.

Developing clarity in relation to governance

In some cases the link between the STP process and previous work on developing new organisational forms for providers of NHS services is clear, in others it is less so. So it is worth reiterating that the STP approach can be entirely consistent with organisational forms for new care models identified in the 2014 Dalton Review ‘Examining new options and opportunities for providers of NHS care’. The STP process can also be consistent with the first principle defined by Dalton to underpin new collaborative endeavours, which was that ‘one size does not fit all’. Dalton emphasised the primary responsibility of provider Boards. He made it clear that he had expected that ‘trust boards should consider their response to the NHS Five Year Forward View ... and consider whether a new organisational form may be most suited to support the delivery of safe, reliable, high quality and economically viable services for their populations’.

As yet there are no definitive figures, but indications are around one third of acute and specialist trusts have

already entered into one or other form of ‘collaboration’ with an NHS provider peer since the Dalton review was published. As ‘one size does not fit all’ implies, the nature of such collaborations has varied quite significantly. In some cases the STP process has lent weight to work that was already taking place, but in others it has prompted a reappraisal.

A number of trusts have entered into agreements to share a CEO while retaining their own board and, in some cases, have a chair common to both boards. For example, most recently, as an integral part of their STP three acute hospitals in one footprint are considering “unified leadership, management and operations across all three hospitals”. Whilst the trusts do not plan formally to merge, the STP indicates that they intend to create a conjoint “trusts’ joint governing vehicle” – though the specific nature of such a mechanism has not as yet been defined. Others are actively pursuing full merger or acquisition while others are looking at how to network more effectively. While the mechanisms for governance of organisations coming together through transactions is clear, the governance of a group of organisations that share a management team, but have separate boards is less so. How boards will exert ‘grip’ over executives or exercise a choice to part company with executives when those same executives are not wholly answerable to them will be a dilemma that will require a solution in the medium term. Whilst the extent of collaboration and the spread of best practice across some health communities has already been impressive and the formal consolidation of some services has promoted significant improvements in quality and efficiency, progress has not always been easy or linear. Two proposed hospital mergers recently have been abandoned. Sharing chair and CEO arrangements will be reversed.

The impact of pursuing changes that eventually are not followed through can be substantial and this will in

turn have an impact on the amount of risk boards are prepared to take on in pursuing change. Collaborative developments are costly of both executives' and non-executives' time, and will stretch the capacity of all but the best resourced of senior teams. At the same time analysis of high profile governance failures in the NHS shows that the impact of co-incident internal and external pressures can cause boards and executive teams to lose a grip on the organisation and the wellbeing of patients in their care. So the pursuit of change is no guarantor of success and can divert scarce resource, all of which suggests the need for robust local appraisal of STPs.

Equally, it is arguable that new forms of collaborative arrangement have outpaced the capacity and capability of the regulatory apparatus of the NHS. Notwithstanding the fact that TDA and Monitor responsibilities have been

subsumed by NHSI, the weight of regulation and CQC inspection and oversight still impacts heavily on individual organisations. Both the time that regulation absorbs and the nature of it can act as an obstacle to the generation of new forms of provision. While the perspective that more lean and unified integrated quality and financial regulation could evolve, is welcome, this is for the future, not the present. Similarly, medium term proposals to allocate funding on a programme basis across populations with the agreement of all the organisations involved may mark a new radicalism and flexibility on the part of NHSI and NHSE, though experience on the ground lags a considerable way behind this.

What is unequivocally clear is that, as Robert Francis made clear in his second report, provider boards must maintain a persistent and unrelenting focus on the safety, quality and cost-effectiveness of the care provided by their own organisations and for which they are accountable in law.



Section 2: Leadership, control and STPs: getting the governance right

This section examines the continuing role, responsibilities and liabilities of boards and issues of organisational altruism and local accountability. It also addresses the limits of footprint-wide decision making and suggests means by which decisions can be made in a way that is both collaborative and lawful.

The STP approach is not addressed in law. The executive or more rarely mixed executive and non-executive groups that are assuming a leading role in the STP footprints are not in themselves legal entities and have no status in law. Because STPs do not legally exist as corporate bodies, they have no legitimacy other than that of the individual participants and have no legal powers. Executives and boards will therefore need to check whether they need to take a step back from treating STPs as if they were entities. At least one partnership is examining whether there is merit in establishing their STP partnership vehicle as a company. This might confer status as a corporate body, but it will not have the effect of conferring authority because the body will still lack powers in respect of the governance of NHS services.

In the context of the above use of language is important. Certain terms such as ‘board’, ‘committee’ and ‘partnership’ have meaning in law. Their use could imply a standing in law that an STP leadership group does not actually enjoy, so participants are advised to take some care in deciding what to call these groups to avoid misunderstanding. Furthermore it would be wrong to assume commonality of meaning and understanding between NHS and local government organisations. For example elements of what the NHS calls ‘commissioning’ local government refers to as ‘contracting’, with ‘commissioning’ meaning the identification of means to meet a defined need.

The role of provider boards

The role, responsibilities and liabilities of boards are unchanged by STPs. If they are not to become defensive and risk averse, boards need to review the strategic

direction of their organisation, in the light of a 360 degree appraisal of the current and future needs of the populations that they serve. They will need to seek a common purpose with all of their stakeholders and agree a direction of travel that will facilitate long term whole system sustainability and transformation. To this end they should identify and seek to rectify any weaknesses in their local STP plan in collaboration with their health and local authority partners, with NHSE and NHSI. They will then need to revise and prioritise those elements of the STP that can be safely implemented locally in a timely and cost effective manner, to improve the overall quality and cost effectiveness of care.

It should be noted that directors of provider organisations, individually and collectively as boards, have specific legal duties to patients, the public and their own organisations. Exhortation from elsewhere, no matter where or how forceful does not alter this. Directors also have a duty to exercise independent judgement and to use the skills and knowledge necessary for their role as well as any other skills and knowledge they may have.

Boards are not able to agree to ‘pool sovereignty’ because legal responsibility and liability lies with the board and cannot be assigned elsewhere. Agreement for the sake of compliance is also not an option that is open to boards no matter how uncomfortable that might be. It must be accepted therefore that in the current format it will not be possible to progress elements of STPs in some cases. Similarly it must be expected that boards will sometimes wish to review decisions taken under delegated authority. In fact it is quite likely that early in the STP process boards will wish to exercise a strong grip to ensure that nascent risks are identified and managed by the appropriate organisation.

The existence of a footprint-wide STP does not absolve boards from developing and seeking to implement a strategy for their organisations. In many cases this strategy will be aligned to the STP and reflect the organisation’s

part in delivering the STP. But many boards will have strategies that reflect broader ambitions, perhaps to deliver services outside their STP footprint or to diversify, transform and grow within it. Organisational strategies can and should accommodate such ambitions. However, transparency in sharing and debating the impact of such strategies (whether with other STPs or with local partners) is important if trust is to be maintained and if the wider impact of one organisation's ambition is to be managed so as to avoid or minimise unintended negative impact on the system as a whole.

The necessity of local decision making on footprint-wide proposals suggests the need for those participating in STP groups to have a continuing formal and informal dialogue with their own organisation to check that projects in development continue to command support. Given what was first envisaged when system working was proposed it is perhaps surprising that the role of the board at organisation level is as important as ever if not more so.

What can STP leadership groups do?

STP leadership or partnership groups depend entirely on the delegations given to each participant in order to reach agreement. For NHS foundation trusts, if the participant is not an executive director this presents a particular problem because foundation trust boards can only delegate to executive directors or to committees of the board of directors. Delegating to committees opens up the possibility of forming committees in common for STP footprints, an approach covered in more detail in the next section on the content of memoranda of understanding. Where boards are delegating authority the delegation of authority should be written, limited to named individuals and explicit in what it covers.

An alternative is for STP leadership groups to seek prior approval of proposals in advance of meetings of the group or retrospective agreement after the group has reached agreement on a suggested approach. 'Decisions' reached by these groups by any other means are not binding on the participants and are likely to be ultra vires if implemented

without proper authority at organisational level. Nor is it possible for these groups to oversee or project-manage the implementation of STP proposals other than through delegations to individual executive directors.

What NHS trust and foundation trust members of an STP cannot do is to cede or share their decision making powers by delegation or devolution to other organisations or the STP leader. But what they can do is to align their decision making with other STP members so that they work constructively together to agree coherent planning and implementation.

Not every organisation within a footprint will be affected by each of the proposals in an STP. In some cases the proposal will affect only a proportion or even just one or two participants. Such proposals might be approved by way of a bi-lateral or multi-lateral agreement. However parties to the agreement need to be aware of, and take account of, health economy-wide implications.

Discussions and continued dialogue at footprint level will no doubt be indispensable and add value. However we advise caution; some of the content of STPs is likely to be contentious and the scope for challenge will increase if the legal footing of decisions is unclear.

Organisational altruism

One of the key reasons for bringing organisations together is so that they are able to rationalise services to the benefit of the patient. This will require organisations to put the broader interest of patients and service users first even where this is not ostensibly in the short term interests of the organisation. Section 152 of the Health and Social Care Act 2012 adds a paragraph 18A to Schedule 7 of the National Health Service Act 2006, so that it reads: "The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public." This has been taken by some to mean that foundation trusts cannot engage in organisational altruism because such steps



would not promote the success of the corporation. Others take the view that the duty to maximise benefits for the public requires a broader approach. Section 152 mirrors the duty to promote the success of the company set out in Section 172 of the Companies Act 2006. It should be noted that there is no consensus on what this section of the Companies Act means in practice, so it is understandable that there will be doubts about the meaning of the equivalent section of the Health and Social Care Act. It would not be unreasonable however to draw the conclusion that NHS organisations are able to act in the long term interests of the communities they serve, and should, in any case, always weigh this consideration as a factor in all of their judgements.

Involving foundation trust governors

If we are to avoid overly interrogating the meaning of 'significant transaction' it should be reasonably plain that STPs will involve some quite significant change for foundation trusts and that their governors will need to be consulted. If that consultation is to be meaningful it will mean a substantial and open engagement that allows for the possibility of plans being changed as a result of the consultation process. Objectively it is probably already quite late to invite governor input, even if there is the very good reason that boards themselves have not always been engaged to date. Boards should consider involving their councils of governors at the earliest opportunity.

Learning from elsewhere

As David Walker's 2009 'Inquiry into Governance Failures in UK Banks and Financial Institutions' warned "In times of major turbulence and change in external environments, a board's collective risk oversight must be strengthened. Different & potentially much more difficult issues arise in the identification and measurement of risks. Past experience can be an uncertain or potentially misleading guide". We are now experiencing a time of major turbulence and we can expect new governance challenges. Meeting them will require vigilance and flexibility, but also a preparedness to accept and work within the current legislative envelope.

Section 3: Memorandum of understanding

This section provides advice on issues that we recommend are included in a memorandum of understanding between the parties involved in an STP.

It would be prudent to set out in writing how organisations within STPs are going to work together and this will probably take the form of a memorandum of understanding (MoU). The MoU will need to be both precise and explicit and all participants will need to have signed up to it via their boards of directors. It should also be clear that the accountability of each participant is to the board of their own organisation.

The following paragraphs identify issues to be addressed in the MoU:

Objective – scope and clarity of purpose

There needs to be a shared understanding of what falls within the scope of the STP, which also means being explicit in the MoU about what falls outside the scope if there is any possible ambiguity. There also needs to be clarity about what the STP is attempting to achieve.

While it is to be expected that the scope of the STP will be ambitious, it is important that participants do not commit their organisations to overly ambitious plans that stand little chance of being implemented. Ambitions need to be tested so that they are limited to what is likely to be achievable in the context of timescale, resources and the capabilities and capacities of the participants.

Agreed principles

Any group of individuals that works together to a common end will develop its own culture. If that culture is to be the right one it will need to be planned and managed. This applies just as much to a grouping of chief executives as it does to any other group. The culture of these groupings will also need to be in keeping with the culture of the organisations that make up the STP. The MoU should

therefore address agreed principles for ways of working and culture.

Governance for decision making

STP members are not able to share decision-making and they will not have shared or collective accountability. But they can set up a governance model for aligned decision-making. They can do this by establishing an 'STP board'. This will not be a board in any formal sense and it will not be able to make decisions for or otherwise commit the members. Instead, it will be a group which can allow the members, through their representatives, to make aligned decisions.

The STP board can act as a meeting forum and single communication channel with stakeholders and for applications for transformational funding. It can produce options, recommendations, proposals for ratification by the members. Terms of reference for the STP board should be included in the MoU. These will set out the role and remit of the group, its membership and mechanics such as the process for calling and conducting meetings.

Alternatively the boards of foundation trusts and NHS trusts have powers to establish committees of the board made up of board members and to delegate powers to those committees. It would be possible for each foundation trust and NHS trust in an STP footprint to establish a committee, each with the same terms of reference and delegation. All of these committees could meet at the same time, in the same place with a common agenda and the same reports. Clearly memberships would need to be small if the combined meetings are to be manageable. Also each separate committee would need to reach its own decisions, but the ability to hammer out issues in person should make reaching a shared decision easier. Foundation trust and NHS trust boards may feel inclined to give a broader delegation to a committee than to an individual. Local government would

not be able to participate on the same terms because of legal constraints, but local government colleagues could participate as members, albeit that they would need to rely on delegations to individuals. Committees in common might be particularly useful in providing detailed oversight of risks that require the input of more than one organisation to manage effectively.

This methodology could not be applied to full boards because each board member would have a duty to attend and participate turning a meeting into a conference.

Disagreements and disputes

To a very large degree STPs will depend on the unanimity, however enthusiastic or reluctant, of the organisations within the footprint. There is no legal mechanism for majority voting or for compelling organisations to submit to plans that their boards in all conscience cannot endorse. However there are also likely to be disagreements as projects progress on matters of detail and these disagreements will need to be resolved. It would be prudent for the MoU to anticipate such disagreements from the outset and to agree how they will be addressed and resolved.

Opting out

The STP, right or wrong, is not a viable option given the legal duties of directors and boards to the communities they serve. Nor should it be taken for granted that STP groups will be anything more than task and finish groupings. Participants should therefore be anticipating the circumstances under which organisations can withdraw and also how eventually the STP grouping will be wound up. This should be in writing in the MoU and be agreed by all participants so that there can be no surprises.

Subsidiarity

The STP initiative is an acceptance of the fact that there are some decisions that are best made by individual organisations, but taking a regional or sub-regional

perspective because those decisions have broader implications. But this does not negate the need for many decisions to as close as possible to the people affected by them. This means that many decisions will be made at single organisational level or within units of organisations. The MoU needs to acknowledge and respect the principles of subsidiarity.

Risk and assurance

Implementation of STP projects is likely to generate risks that affect and could impact on more than one organisation. Many financial risks can effectively be pooled with each participant responsible for finding financial resource to cover their share of any cost should the risk not be successfully managed and become a reality. Risks to quality of care cannot easily be subdivided and the consequences of something going wrong with an STP project will impact on the reputation of each of the participants as if they were the sole organisation involved.

Clarity about ownership and management of risks is particularly important in inter-organisational projects. Each organisation must satisfy itself that risks to the strategy in their totality are being managed effectively, not just those risks that the organisation itself has agreed to own and manage.

Similarly boards will want to be assured in respect of the risks owned by their organisation and of the risks owned by partner organisations if there are consequences across the partnership. Where external assurance is sought for footprint-wide risks there is the possibility using committees in common to oversee management of risks. The pooling of resources to commission external assurance may also be of use in dealing with footprint-wide risks. But each board will still need to take a view on the value of such assurance and act accordingly. The MoU should acknowledge and respect the agreed arrangements for managing risk.

External advice

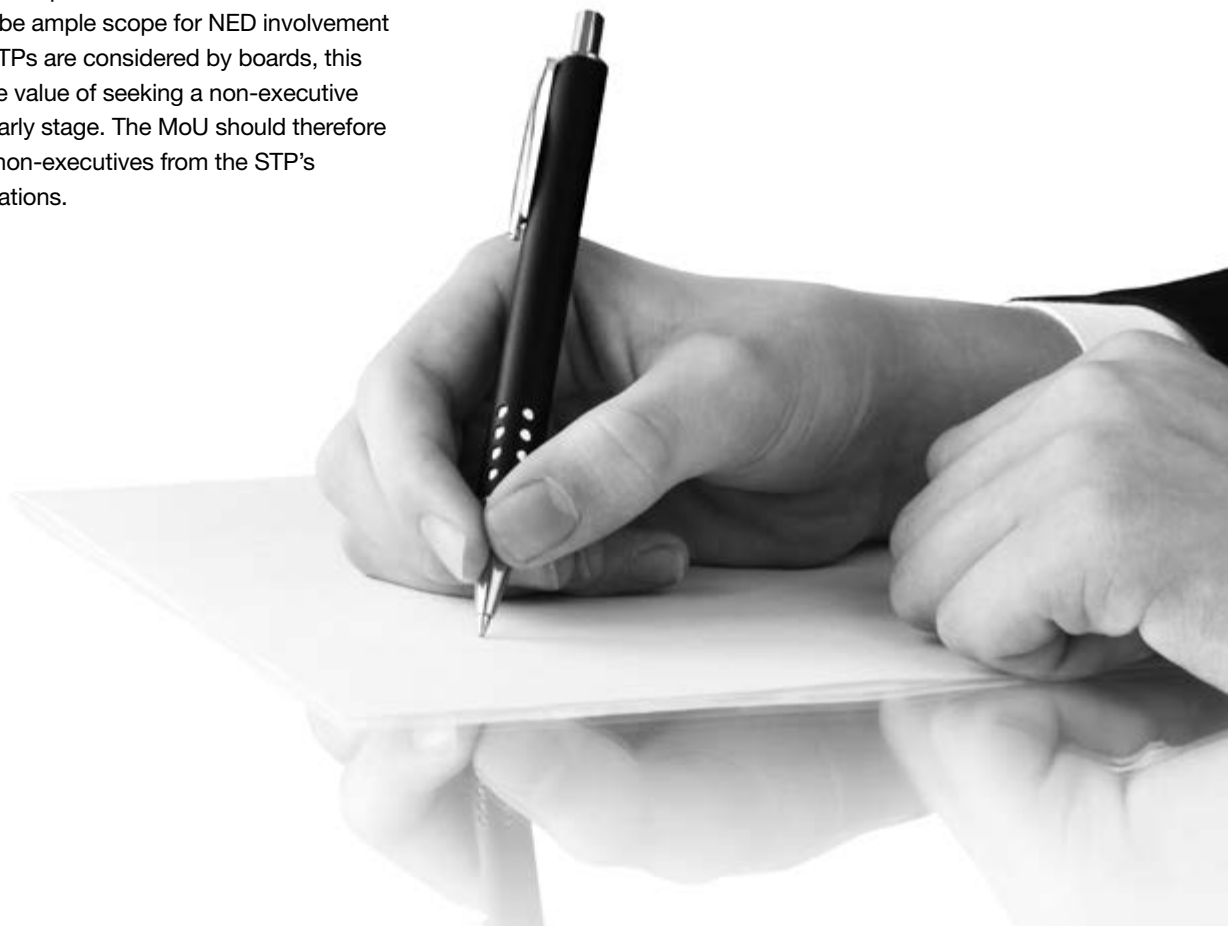
Where organisations have commissioned and paid for external advice, whether on their own or in agreement with others they should be prepared, and able, to rely on that advice. The MoU should address how the need for external advice will be sourced and financed at footprint level. Generic advice commissioned without the input or knowledge of organisations must be viewed with a degree of caution and organisations need to understand that there is an increased risk in relying on advice that is not owned by your organisation. The MoU should not therefore seek to limit the ability of each of the organisations in the STP footprint to commission its own external advice.

Non-executive perspectives

Those charged with devising the strategies that make up STPs have for the most part been executive directors. While there should be ample scope for NED involvement and challenge as STPs are considered by boards, this does not negate the value of seeking a non-executive perspective at an early stage. The MoU should therefore consider a role for non-executives from the STP's constituent organisations.

Transparency, communication and consultation

What happens as a result of STPs will play out in the public arena. While it is understandable that there will be a reluctance to set hares running about proposals that might not progress far, it is equally understandable that the public has a legitimate interest in influencing what happens to health services in their area. High quality consultation coupled with transparency and clarity of communication will be essential and needs to be planned for as soon as possible. However the legal duty to consult lies with individual organisations. The MoU should describe the role to be played by the STP leadership group in overseeing, or co-ordinating actions to fulfil this duty.



Template / memorandum of understanding for STP governance

This memorandum of understanding is made on [] 2016

1 Parties

The parties to this MoU are the following NHS commissioners and providers and local authorities in the [Footprint name] footprint:
[Insert names of parties.]

2 Background

- 2.1 NHS Shared Planning Guidance for 2016/17 – 2020/21 asked every local health and care system to come together to create their own Sustainability and Transformation Plan (STP) for accelerating the implementation of the Five Year Forward View (FYFV).
- 2.2 [Footprint name] footprint was identified as one of the STP footprint areas in which people and organisations will work together to develop robust plans to transform the way that health and care is planned and delivered for their populations.
- 2.3 The Parties have agreed to work together to enable transformative change and the implementation of the FYFV vision of better health and wellbeing, improved quality of care, and stronger NHS finance and efficiency.
- 2.4 The Parties have agreed and submitted their STP in the current form as set out in Schedule 1 but agree that it is a living document that may be varied and updated from time to time.

3 Leadership

- 3.1 [Insert name] has been designated the STP Leader within [Footprint name].
- 3.2 The STP Leader's role and remit are set out in Schedule 2.

4 Duration of the MoU

- 4.1 This MoU will take effect on the date it is signed by all Parties.
- 4.2 The Parties expect the duration of the MoU to be for the period of 2016-2021 in line with the duration of the STP or otherwise until its termination in accordance with Clause 13.

5 Objective

The Objective of this MoU is to provide a mechanism for securing the Parties' agreement and commitment to sustained engagement with and delivery of the STP to realise a transformed model of care in [Footprint name].

6 Agreed principles

The Parties have agreed to work together in a constructive and open manner in accordance with the agreed principles for ways of working and culture set out in Schedule 3 to achieve the Objective.

7 Effect of the MoU

- 7.1 This MoU does not and is not intended to give rise to legally binding commitments between the Parties.
- 7.2 The MoU does not and is not intended to affect each Parties' individual accountability as an independent organisation.
- 7.3 Despite the lack of legal obligation imposed by this MoU, the Parties:
 - 7.3.1 have given proper consideration to the terms set out in this MoU; and
 - 7.3.2 agree to act in good faith to meet the requirements of the MoU.

8 Governance

- 8.1 The Parties have agreed to establish an STP Board to co-ordinate achievement of the Objective.
- 8.2 The Parties have agreed Terms of Reference of the STP Board in the form set out in Schedule 4.
- 8.3 In particular the Terms of Reference describe arrangements for aligned decision making of the Parties which they agree is necessary to achieve the Objective.
- 8.4 Each Party will nominate a representative to the STP Board and notify the STP Leader of his or her name and a deputy who is authorised to attend for him or her in his or her absence. [Alternatively describe any other arrangements, eg committees in common.]
- 8.5 The Parties agree that the STP Board will be responsible for co-ordinating the arrangements set out in this MoU and providing overview and drive for the STP.
- 8.6 The STP Board will meet at least [monthly] or as otherwise may be required to meet the requirements of the STP.
- 8.7 The STP Board does not have any authority to make binding decisions on behalf of the Parties.

9 Subsidiarity

- 9.1 The Parties acknowledge and respect the importance of subsidiarity.
- 9.2 The Parties agree for the need for many decisions to be made as close as possible to the people affected by them.

10 Risk management and assurance

[Describe what arrangements, if any, the parties have made to share ownership, management and assurance of financial and other risks.]

11 Resources

- 11.1 The Parties have agreed to commit their own resources to achieve the Objective in accordance with the arrangements set out in Schedule 4.
- 11.2 The Parties have further agreed the arrangements set out in Schedule 5 for engaging external resource and advice.

12 Openness and transparency

- 12.1 The Parties agree that they will work openly and transparently with each other and with other stakeholders including non executive directors, governors and councillors of the Parties and other local health and care organisations.
- 12.2 [Describe the role that the STP Board will have to oversee and co-ordinate the Parties' compliance with their duties of public involvement.]

13 Termination

[Insert here the circumstances under which organisations can withdraw and also how eventually the STP grouping will be wound up.]

14 Dispute resolution

- 14.1 The Parties will attempt to resolve any dispute between them in respect of this MoU by negotiation in good faith.
- 14.2 [Insert here terms for dispute resolution that the Parties consider appropriate.]

15 General provisions

- 15.1 This MoU will be governed by the laws of England and the courts of England will have exclusive jurisdiction.
- 15.2 The Parties agree that this MoU may be varied only with the written agreement of all the Parties.
- 15.3 [Insert here any further general provisions that the Parties may consider desirable.]

Signed by the parties or their duly authorised representatives on the date set out above.

Signed by
duly authorised for and on behalf of)
[PARTY 1])

Signed by
duly authorised for and on behalf of)
[PARTY 2])

[SCHEDULES TO BE CONFIRMED]

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