Cover paper – Welbourn review of SaHF governance

Introduction and purpose of the review

In summer 2012, the Primary Care Trusts that preceded the CCGs consulted on proposals to improve the quality of healthcare and save lives in North West London. The strategy was called *Shaping a Healthier Future* (SaHF). The Strategy proposed that healthcare in North West London would be improved, both inside and outside hospital, in a number of ways. These improvements include:

- making it easier to see your GP and to have more of the care you need delivered either in your GP's surgery or from a health centre nearby
- making sure that wherever you live in NWL you get the same standard of care
- putting more doctors into our major hospitals so that in an emergency you will be able to see a senior doctor whatever the time of day or day of week
- consolidating more specialist care onto a smaller number of hospital sites so that when you do need to go to a major hospital, you see doctors who are appropriately experienced to deal with your problem.

The strategy is strongly supported by most doctors in North West London, and is based on evidence such as the change to the way stroke patients are cared for in London. This has proved that more people survive a stroke if they are taken directly to a specialist stroke unit rather than to their nearest A&E department. Evidence also shows that approximately 30% of people in a bed in our acute hospitals do not need to be there, and that they could be spending less time in hospital or may even not need to be admitted in the first place. We want to help get people back to their own homes and to support them to stay there.

We have already made a number of changes to improve care for our population. We have made it easier to see a GP outside of normal working hours, we have moved some outpatient services into the community closer to where people live, Urgent Care Centre (UCC) services are now available across North West London and most women will now see a midwife from the same hospital as where they gave birth.

We have also improved the care people receive in our hospitals:

- more women will now have 1:1 care throughout their labour as there are 99 more midwives than a year ago and, if needed, there are more doctors available to look after women during labour
- there are more specialist emergency doctors in the A&E departments at St Mary's and Northwick Park
- more patients attending A&E can now be treated in our ambulatory care units - which means that for many patients they can go straight home after being treated rather than needing to be admitted into hospital for treatment.

However, we recognise that we have more to do and we need to go further and move faster to ensure that we can achieve the vision set out in SaHF. Therefore Professor David

Welbourn was commissioned to undertake a review of the governance of SaHF. Some of the issues that Professor Welbourn was asked to consider were:

1. In the nearly 3 years since the JCPCT made its decision, there has been limited change to the governance structures of SaHF, which focus on a Clinical Board and a Programme Board that recommend changes to the CCG Governing Bodies as the decision making organisations. However the nature of the work has shifted significantly, with the emphasis moving from strategy development to implementation.

2. Over time the activities overseen by the Clinical Board and Programme Board have become increasingly focused on the elements of SaHF relating to acute reconfiguration, rather than the much wider out of hospital strategies that are critical to the successful transformation of services across NWL. This has reduced attendance at the SAHF Programme Board, and also means that acute trusts have less visibility of the work that is going on outside of hospital.

3. The out of hospital work has a strong focus within individual CCGs, and there are two overarching programmes of Whole Systems Integrated Care (WSIC) and Primary Care Transformation. However these programmes are not fully integrated and there are other local developments, such as the Better Care Fund, that need to be joined up with these programmes of change. There is limited visibility of sector wide progress and and there needs to be more learning from different CCGs to ensure the rapid spread of good practice.

4. Both the development of strategy and the implementation of SaHF changes are led by the Director of Strategy and Transformation (S&T), reporting to the Chief Officer of CWHHE as the Senior Responsible Owner for SaHF. The range of activities being led by the Director of S&T is extensive, leading to a lack of capacity to manage the individual programmes, and less accountability to individual CCGs than governing bodies wish. There are few permanent staff within the S&T directorate, and a high reliance on consultants and interims.

5. The level of clinical leadership of the different workstreams varies. There is strong and consistent leadership of the overall SaHF programme and the acute reconfiguration from the 4 SaHF Medical Directors and the Chair of Ealing CCG, and there is also strong local leadership of CCG level changes. However there needs to be more investment in clinical leadership at NWL level for WSIC and primary care transformation in order to address the external view that SaHF is all about acute hospitals, and that there is insufficient focus on out of hospital services.

6. The delivery of out of hospital services, and particularly integrated care, requires a high degree of collaboration with local authorities. However there is limited involvement from local authorities within the SaHF programme and a number have asked to be brought into the governance structures so that they have a stronger voice.

Professor Welbourn was therefore asked to seek views from a range of stakeholders and make recommendations about how we could strengthen the governance of SaHF to ensure that we can successfully implement the strategy and realise the benefits for patients that it aims to achieve.

Approach

Professor Welbourn used a mixed methods approach to gather evidence and provide insight relevant to the review. This included the following methods:

- Document review
- On line survey
- Semi-structured interviews
- Focus groups.

He engaged with stakeholders across the whole of NWL, including CCGs, Trusts, local authorities, patients, NHS England and other partners to get as wide a range of views as possible.

Key recommendations

Professor Welbourn makes 6 key recommendations, which are then explored in more detail and broken down further within his report. They are:

1. Revisit and clarify the shared vision and purpose of the SaHF programme and develop this into a strong narrative, taking full advantage to reflect the changes in [the national] context.

2. Invest in an OD programme for at least the top 200-250 senior managers across partners in NWL.

3. Realign the overall transformation programme into three distinct streams. [acute services transformation, local services transformation and business processes transformation].

4. Redesign the governance structures for the programme to strengthen accountability and support more collaborative working, including stronger representation from Local Authority partners.

5. Identify one (or more) symbolic deliverables that bring all programmes together and can be used as a flagship over the next 6 months to demonstrate real impact at a system level (e.g. consistent performance against winter pressure).

6. Develop the Strategy & Transformation Team into a power house for innovation across NWL that is capable of supporting both the transformation programme and needs for specialist consultancy to support CCG local priorities.

CCG discussions to date

The report has been discussed with individual governing bodies and by the 8 CCG Chairs and some proposed next steps have been discussed. In general the report was welcomed and reflected the views of the governing bodies, and the recommendations were broadly accepted, particularly the proposals to simplify the workstreams within the transformation programme and to bring together the whole systems integrated care and the primary care transformation work. Business processes transformation is not something that we have

currently explicitly considered, but it is implicit in the recent conversations about new approaches to the contracting round. Our key business processes of contracting, BI and finance sit outside of the S&T structures (and should continue to do so) but consideration needs to be given to how these are integrated more effectively with the other workstreams and how they respond to our strategic needs.

The recommendations regarding governance structures recognise that the Programme Board is not fulfilling its role as the sector wide strategic group and instead has been focusing on the implementation of planned changes. By splitting the responsibilities of the Programme Board to create a delivery group to focus on implementation and an advisory group to focus on strategy, we can bring local authorities into the governance structure and reinvigorate membership. In practice the strategy group will not be called the advisory group – this will be the Strategic Planning Group that will be necessary for sector wide planning, including the development of the new Sustainability and Transformation Plan as set out in the planning guidance for 2016/17.

The membership of the delivery group will depend on the implementation activities being undertaken at any point and will be made up of the SROs and project directors for the different implementation workstreams. A matrix approach will be used whereby activities within the 3 key workstreams are mapped and interdependencies identified, and delivery is ensured through events (e.g. paediatric changes) that have appropriate leadership and governance. This will bring out of hospital changes much more explicitly into the delivery governance of SaHF.

In terms of the structure of S&T, Professor Welbourn has made some strong points relating to our reliance on consultants and that we are therefore not developing necessary skills internally. We are also at risk of the loss of organisational memory – while our clinical leaders have remained consistent there has been a high turnover of managers. However, his proposed structure has four key weaknesses:

- While the report is explicit that the clinical leadership of SaHF is one of its key strengths, the proposed structure is not clear how this leadership works with the proposed management roles
- While recognising the need for more director level capacity, the majority of the workload remains with one post (the Director of SaHF)
- There limited appetite within the CCGs to create an internal consultancy arm, which feels too similar to the CSU approach which we rejected
- It is not clear how this improves the working relationship between S&T and individual CCGs, or the accountability of the former to the latter.

Instead, an alternative approach and structure is being developed which is designed to address these points. As well as the management structures, a proposal for clinical leadership is also being considered. The intent of the approach is the following:

- All shared programmes have strong and visible clinical leadership
- Acute reconfiguration changes will continue to be led centrally
- For out of hospital changes, the majority of implementation will take place locally but there will be a core common resource that will be deployed locally to support that

implementation, enhancing local teams, developing core skills and building the working relationship between the local teams and the team working in common across the CCGs

- Stronger common co-ordination and reporting of out of hospital changes to ensure that best practice is shared, visibility of achievement is increased and consistency of offering is delivered, enabling real step change
- Strategy and business processes are brought together through strong and explicit working relationships between S&T, contracting and BI functions
- The requirement for extensive OD is explicitly recognised with a sector-wide OD function
- There is a shift in focus from strategy to innovation, with increased learning from elsewhere in the NHS rather than creating everything ourselves.

Conclusion

The report contains a number of recommendations to strengthen SaHF governance and improve our ability to implement the required changes to improve quality and outcomes for our populations.

The Governing Body is asked to consider the report and approve the proposed next steps.

Next steps

The proposed next steps are:

- Establish the Strategic Planning Group to oversee the development of the Sustainability and Transformation Plan
- Review the function and terms of reference of the SaHF Implementation Programme Board with a view to creating a delivery board, and bring proposals back to GBs for approval
- Produce a new S&T structure in consultation with staff, with funding to be signed off through the NWL financial strategy
- Strengthen the internal programme governance structure for the local care workstream, reflecting the governance already in place for acute reconfiguration
- Develop a detailed action plan to address the other recommendations set out in the report.

SHAPING A HEALTHIER FUTURE:
REVIEW OF ORGANISATION & GOVERNANCE: - FINAL REPORT

1.0 Executive summary

This review was commissioned to provide a critical assessment of the organisationand governance of the Shaping a Healthier Future (SaHF) programme of whole system transformation for the provision of healthcare services in North West London (NWL). The programme has successfully implemented a number of changes to date, but needs to increase both scale and pace of change if it is to achieve the agreed goals. To achieve this, the programme will need to align the key elements of service configuration, capital investment and workforce development in a context of intensifying concerns about the sustainability of high quality services throughout the NHS. The programme also needs to continue forging closer relationships with the Local Authorities to benefit from the growing emphasis on integration, and capitalise on their strengths, experience and political authority.

Programme aims

From its initial concept stage through to the present day, the programme scope and aims have been set by a strong group of clinical leaders, with the specific requirement to deliver safe, high quality, sustainable outcomes for the 2m population of NWL against the growing workforce and financial challenges.

The SaHF programme set three clinical aims: to centre services around the needs of service users, to localise services wherever possible, and to ensure that where more specialist care was required to meet the most complex needs, this was organised to provide safe, high quality care on a 24/7 basis.

Throughout the NHS, there is a recognition that the demands of an increasingly elderly population, and the high levels of long-term co-morbidities can only be met with a radical restructuring of services similar to those defined in SaHF, but when the programme was initiated, NWL was one of the few areas to commit to achieving this at the ambitious scale and pace required. It was also amongst the early areas to adopt the revised policy emphasis of greater collaboration between NHS partners, in contrast to the previous priority for competition, but in this regard, it was able to draw on the valuable learning from London's programmes such as the reconfiguration of stroke services – a major triumph for clinically driven transformation.

As the SaHF programme was initially breaking new ground, it had to overcome a number of barriers, with limited opportunity to learn from peer groups undertaking similar work elsewhere in the NHS. In the early phases, the focus for communications was dominated by external engagement to maintain political and community support against opposition to change. SaHF also became heavily dependent on external advisors for practical experience and evidence of good practice. For many, the SaHF programme name has also become synonymous with the most visible (and potentially most controversial) element: the

reconfiguration of hospital services into fewer sites capable of achieving the higher quality care demanded by the clinical vision. The complementary work of strengthening and broadening access to care within the primary and community setting is less visible and has received less attention. Multiple alternative programme names – out-of-hospital care, whole systems integration, and primary care transformation – add to the difficulty of raising the profile of this vital element of the programme.

Following the publication by NHS England of the Five Year Forward View, there are now several programmes of work being sponsored across England which have a very similar purpose to that driving the SaHF programme, and there is an emerging corpus of expertise, models of good practice and a new shared language is being adopted.

Strengthening purpose

The review confirms that the transformation of care services in NWL continues to be driven by strong clinical leadership, and that the original vision remains appropriate. It also indicates that the translation of that vision into a purposeful narrative has not been adequately maintained or refreshed against the changing context. This makes it harder for those involved in the individual programmes of work to align their contribution with the vision, or to see how all the projects work together to achieve the desired change. Confidence that the vision is correct remains high, but there is less confidence that the vision will be achieved. The importance of refreshing such a purposeful narrative emerged early in the review and the necessary work to recreate this is now underway as part of the five year roadmap, although it still requires stronger engagement with Local Authorities to ensure that it reflects their valuable contribution. As this refreshed narrative is shared throughout NWL, it will help strengthen the common purpose demonstrating clearly how the elements of the programme integrate to achieve the vision.

Whilst restating the purpose of the programme, it will be important to draw on the learning emerging from work on elsewhere in the NHS (e.g. Vanguards) whilst also ensuring that it is expressed in narrative form that can be adopted and adapted so that it is meaningful at both local and regional level.

Strategic leadership

The Rose review of leadership and management in the NHS points to the lack of strategic investment in development of strong management capability, and this review echoes those sentiments. An important characteristic of effective governance is that boards can be very uncomfortable places if they are to underpin difficult decisions with strong assurance. Board members need to be comfortable at being uncomfortable with each other. Governance for the SaHF programme needs to be built around collaborative boards spanning the whole complex system in NWL. Members of these bodies also need to be comfortable at being uncomfortable – in this context some of the conversations will involve conflicts between organisational and system-wide accountabilities, where the solution to wicked problems may involve “cooking the conflict” – allowing the energy of disagreement to fuel innovative thinking.

The trust, respect, willingness to cede power and mature decision-making involved in deeply complex and potentially divisive situations cannot be achieved without investment in organisational development (OD) focused on building strategic relationships, building a common framework of values and shared understanding.

In the same way that organisational boards model the acceptable behaviours and culture, by living and breathing “tone at the top”, the SaHF programme needs to establish a consistent

tone at the top across the whole system, which is then mirrored within each organisation. The OD programme therefore needs to begin with the most senior managers (both clinical and administrative), to shape the culture and space, setting the freedoms and boundaries within which front line staff development can take place. Given the organisational complexity, such a programme needs to involve the most senior 200-250 managers in NWL including partners from London Boroughs, (not simply restricted to Social Care), and Voluntary Sector agencies.

Simplifying the programme structure

Over time, the overall transformation programme should converge towards fewer programme streams. The review identifies three distinct programme streams.

The first of these combines all the programme activities associated with strengthening of localised care, across primary and community care, including home-based care. Local Authority and voluntary sector agencies have an important contribution in this programme and must be more closely integrated into both service delivery and decision making. The dominant characteristic of this stream is one of flat, non-hierarchical structures, highly multidisciplinary workforce exercising considerable professional independence. It is important that this Cohesion and consistency within this stream is achieved through networking, and achievement of large-scale change relies heavily on mobilisation combining empowerment with an inspired invitation to be part of a compelling purposeful movement. Accelerating change in such a movement requires a shift in emphasis from performance measured by process compliance to one built on best professional excellence seeking ever more demanding standards of best-practice, with a much more robust assurance regime.

The second programme stream focuses on developing critical mass across all specialised services to achieve the very best outcomes from services that are consultant-led throughout 24/7. This involves reconfiguration and consolidation of acute services. The focus for this work should continue to be on maximising outcomes for patients and relatives through service models reflecting evidence-based best-practice care. In practice though, this stream is too often judged by the focus on buildings and location of services. This stream differs significantly from the previous stream, because organisational structures for delivery are generally characterised by well-understood management and leadership hierarchies and defined process flows, where there is a greater track record in achieving structured change.

The third programme stream does not currently exist within the programme, but the review has highlighted that the majority of existing business processes related to commissioning, performance and financial flows are predicated on managing commercial relationships between organisations. These processes are generally not fit-for-purpose in the whole-system model of collaboration and partnership that SaHF requires, especially as it progresses towards an Accountable Care Partnership model of commissioning. A recent report from the Nuffield Trust suggests that the current trends of integration will change the nature of commissioning beyond recognition, and this programme stream is required to ensure timely development of the business models and infrastructure processes that will enable the transformation of services to be achieved. Local Authorities have considerably more experience of successfully adapting their approach to commissioning, and could contribute significantly to the shaping of this workstream.

The mental health transformation programme has recently been agreed and is currently managed as a separate programme stream. To avoid disrupting this programme whilst early momentum is gained, it should continue being managed as a distinct stream in the short term. Maximising outcomes for service users depends on better integration between

physical and mental health services, so it is appropriate that at an opportune time, the mental health programme is divided into the local and specialist services and migrated into the relevant workstreams.

The programme currently lacks a single plan integrating all the elements and identifying the critical dependences. A 5-year roadmap has been under development alongside this review, and this should provide the necessary visibility to these critical inter-dependences, but it should be recognised that the scale of the programme is such that inertia and complexity conspire against maintaining a single credible programme plan. The delivery programme should be redesigned around much smaller projects or "implementation events", with a senior owner accountable for successful implementation, with the freedom and resources to resolve issues. Each such project identifies the critical dependences and deliverables drawn from the three programme streams or from other discrete project events. The overall programme is then managed through the interlock of interdependences between the different streams and events, and relies on the accountable owners meeting their commitments. The new delivery board will provide stronger assurance and tighter management control by focusing predominantly on resolving potential conflicts, concentrating on managing risk and anticipating/ responding to policy changes.

Programme governance

The current programme board is too unwieldy to contribute effectively to the decision making processes, but forms a helpful function as an advisory group, enabling all the NHS partner organisations to be aware of and contribute to the broader direction and priorities. The Collaboration Board at which the 8 CCG chairs oversee the joint decision making and provide the strategic commissioning steer to the programme should be retained as a significant route towards achieving authority from the individual statutory bodies.

The Collaboration Board should be complemented by an equivalent body at which the provider organisations (including the newly forming GP Federations as providers) take a collective view on the strategic clinical capacity and capability requirements to meet the demand forecast by the joint commissioners. Care will be required to ensure that this strategic co-ordination by providers avoids anti-competitive areas of detail, whilst progressing areas of mutual responsibility, such as workforce development, common standards and practice, information and intelligence sharing, and research. Imperial academic health partners' network and Health education for Northwest London (HENWL) who both have pan-NWL responsibility should play a pivotal role in developing a mature basis for provider collaboration.

A similar forum for the NW London Boroughs is also recommended so that they can take a considered view of how the proposed programme for the transformation of care interacts with other local authority priority initiatives. Such a forum would also ensure that the Boroughs are more closely involved with the programme and can bring their additional expertise to the programme, especially in the areas of political experience.

With the recommended governance changes, the contribution of these bodies will focus strongly on building the authority and commitment to the aims established by the clinical board. A new delivery board working closely with the clinical board is designed to bring a clear management structure to oversee implementation of the authorised programme. The delivery programme should be structured around relatively small change events with clearly assigned ownership, rather than large scale programmes. It is important that the delivery board and its supporting expert groups draw membership from across the whole network of partners and that the chair of each of these groups has adequate voice in the advisory board.

Programme support

The current Strategy & Transformation Team (S&T) should be developed further into a strategic resource for NWL that is a power house for change. Whilst its primary role will be to ensure that the transformation programme proceeds confidently at pace, it should also act as a professional services and innovation hub, developing a critical mass of expertise and knowledge in all aspects of clinical and business change. Currently, each of the 8 CCGs has a budget available to draw upon the expertise of the S&T team. This provides an essential vehicle for CCGs to call upon an agreed level of expert consultancy to support planning and implementation of their local priorities where these complement the regional transformation programme. Each of the delivery projects should also be able to draw on the design and delivery skills within this hub. This valuable arrangement could be strengthened by better forecasting and co-ordination of local need, access to wider skills. To overcome the current criticism that the S&T team is too centralised with diffuse accountability, members of this virtual team should be collocated with the organisations they are supporting. Instead of the current arrangement of relying heavily on external consultants, this resource should draw heavily on secondment from across all the NWL organisations, creating a dynamic "elite" group of change agents, who cycle knowledge, experience and understanding between the organisations through high profile secondments many of which will be tailored as development opportunities for leaders identified as high potential. This dynamic arrangement should accelerate cultural change and develop the behaviours on which the future of successful collaboration will thrive, and shared ownership will be built.

Consideration should also be given to the way in which Governors and Non-executive directors from across NWL organisations can also be encouraged to contribute, both through the delivery project boards, and in the various advisory groups.

Six major recommendations are outlined in the following section, with a breakdown of more extensive details contained within the report itself.

David Welbourn

2.0 Recommendations – summary

The following table summarises the major recommendations. Appendix 6.2 provides additional detail within each of these, identifying suggested approach and timetable for their implementation.

Recommendations	
1.	**Revisit and clarify the shared vision and purpose of the SaHF programme and develop this into a strong narrative, taking full advantage to reflect the changes in context:**
2.	**Invest in an OD programme for at least the top 200-250 senior managers across partners in NWL.**
3	**Realign the overall transformation programme into three distinct streams**
4	**Redesign the governance structures for the programme to strengthen accountability and support more collaborative working, including stronger representation from Local Authority partners.**
5	**Identify one (or more) symbolic deliverables that bring all programmes together and can be used as a flagship over the next 6 months to demonstrate real impact at a system level (e.g. consistent performance against winter pressure)**
6	**Develop the Strategy & Transformation Team into a power house for innovation across NWL that is capable of supporting both the transformation programme and needs for specialist consultancy to support CCG local priorities**

3.0 Introduction and context for the review

3.1 Introduction

This paper reports the findings from a review of the programme's organisation and governance arrangements for the Shaping a Healthier Future (SaHF) programme of whole system transformation in North West London (NWL). The review was conducted between June and August 2015 with the specific aim of recommending any changes to governance needed to increase confidence and assurance in the programme's ability to accelerate at-scale implementation. The review focused on the importance of aligning the key elements of service configuration, capital investment and workforce development in order to achieve the desired transformation.

A broad definition of governance was adopted, so that the nature and alignment of relationships, behaviours and expectations were considered as well as the structures and processes within which decisions are made. Employing this broad understanding of governance, it is important to ensure that decisions are both well informed and taken at the right time with the appropriate authority. Throughout the report, the term "management" does not differentiate between those in management positions with a clinical background, and those with corporate backgrounds, and successful transformation relies on breaking down these traditional boundaries. One of the most compelling features of the SaHF programme is the extent of clinical involvement in setting the direction and goals of the programme.

The SaHF strategy is designed to transform the delivery of care to the diverse population of approximately 2m people across the eight boroughs in NWL. From its initial concept stage through to the present, the programme has benefited from strong clinical leadership in defining the scope of change to ensure that NWL continues to deliver the very best quality of care sustainably. The principles of SaHF involve localising care wherever possible, developing critical mass in all areas of specialist care where that is necessary and integrating care between the different settings to achieve greater continuity and coordination of care. These principles have been translated into four programmes of work:

- reconfiguring acute care into fewer major centres capable of supporting the highest quality of consultant-led care on a 24/7 basis and other sites capable of delivering excellent specialist, elective and local services;
- transforming primary care and strengthening provision of out-of-hospital care;
- whole systems integration to ensure that care and support is focused on the delivery of outcomes and better co-ordinated around the needs of the person;
- transformation of mental health and wellbeing services to improve outcomes, care and support for people with mental health needs

3.2 The context of Shaping a Healthier Future

Shaping a Health Future sits in a wider national context of changing policy in relation to where and how health services are delivered. It also sits in the context of London-wide changes to health and care commissioning and provision. Since 2010, changes to the commissioning landscape have seen the emergence of clinical commissioning groups (CCGs) commissioning services on behalf of local populations, Health and Wellbeing Boards responsible for local oversight of health and wellbeing services and the move of public health services from the NHS into local government. On the provider side, there have been continued changes to the configuration of acute, community and primary care across the

country in response to the burning platform of ever tightening resources and the burning ambition to deliver services in person-centred, transformative and innovative ways.

The SaHF Programme was initiated in November 2011 by NWL Primary Care Trusts (PCTs). North West London was one of the first areas to adopt a whole health system approach to strategic planning. The eight CCGs took over responsibility for development and delivery of the programme and had contributed whilst still in 'shadow' form during 2012/13. As a major service change programme, a core principle from the beginning has been clinical leadership. The future service models at the centre of SaHF have been developed by a number of Clinical Working Groups.

The 8 CCGs were initially clustered into two groups of 4, with just two management and support teams supporting the whole of NWL, whilst all 8 retained their independently constituted governing bodies. As commissioning plans progressed, Ealing CCG found greater commonality with the central London group and the 8 CCGs are now organised into two collaboratives:

- CWHHE comprising Central London, West London, Hammersmith and Fulham, Hounslow and Ealing;
- BHH, comprising Brent, Harrow and Hillingdon CCGs.

For the purposes of co-ordination across NWL and especially for the SaHF transformation programme, these two collaboratives work together and are supported by the Strategy and Transformation team (S&T).

The aim of SaHF is to improve the quality and safety of care by moving services out of hospital, providing more health services in local, community settings and to concentrate specialist hospital care into fewer major centres, each capable of supporting the highest standards of care with consultant leadership on a 24/7 basis across NWL. The scope of the programme has evolved over the period since its inception to include acute service reconfiguration, whole systems model of care (integrated care pioneer programme), primary care transformation and mental health strategy implementation in its current form. Better Health for London (2014) sets out the aspiration and ambition for healthcare across London, which aligns with the broader vision for the SaHF programme encompassing primary and secondary prevention as well as healthcare services. It references work done in North West London on joint financial strategy development to address inter-dependencies and maintain stability (page 79).

The scale and ambition of the programme has meant that it has faced challenges from multiple stakeholders since its inception. The most recent of these has been the Mansfield review which will be reporting soon on the outcome of its inquiry, having released an interim report in March 2015. One of the strengths of the NWL approach is that it has frequently sought external review and validation of its approach, including the early work on integrated care. The Collaboration Board for NWL CCGs recently commissioned a survey to identify how the Board can strengthen its' impact and effectiveness. This review of the programme's governance arrangements has been commissioned as a timely evaluation of whether the governance could be strengthened as the programme shifts gear from a phase characterised by development of the strategy, into one characterised by large scale implementation.

SaHF set out its vision for changes to acute services, community and primary care services in its Decision Making Business Case in 2013. This vision is in agreement with those published as part of the organisation level strategies by CCGs and provider organisations, though the providers in some instances have raised concerns about some aspects of the

delivery of the vision. The vision is also aligned with most of the priorities of the local health and wellbeing strategies in North West London. An Implementation Business Case (ImBC) is currently being developed by the SaHF programme, to address the investment required in both fit-for-purpose community-based estate, and to improve the specialist acute capacity to support the consolidation. Development of the ImBC continues in parallel with this review.

At its inception, both the aims and scale of the SaHF programme were significantly more ambitious and progressive than most other communities, especially as it drove the agenda forwards throughout the transition of implementing the Health and Social Care Act and dissolving PCTs whilst creating CCGs. The SaHF programme had made significant progress, brokering new ground in some areas, whilst making slower progress in others.

During this period of early implementation in NWL, there has been a significant change in emphasis across the wider NHS, as the majority of communities have come under increasing pressure to continue driving higher quality of care with greater sustainability. The response to Francis' report has placed greater attention on safety and quality of care. Continuing emphasis on austerity measures has seen financial deficits spreading to previously resilient NHS providers. The Care Quality Commission, Monitor and the Trust Development Agency have exercised their regulatory powers for the NHS with increasing concern about the lack of sustainable response to the demographic challenge posed by growing numbers of frail elderly. The policy tension between competition and collaboration has swung in favour of greater collaboration. This swing is epitomised by the new approaches outlined by NHS England in the Five Year Forward View, and the subsequent urgent investment in New Models of Care through the Pioneer and Vanguard programmes. This rapidly shifting national agenda has created a new urgency, new understanding and new language that is essentially driving most communities to adopt principles and programmes that mirror the work already embraced by the SaHF programme in NWL.

The eight CCGs in NWL have sought to respond to the additional opportunities created by the new national initiatives by continuing to work together and submit additional joint bids for consideration under the New Models of Care Vanguard Programme during 2015 (under the first programme covering Primary and Acute Care Systems, Multi-specialty Community Providers and Enhanced Health in Care Homes and the more recent Urgency and Emergency Care vanguard). These applications have not been successful.

3.3 The review process

The review has sought to establish whether the right structures and processes are in place to allow effective decisions to be taken confidently by those vested with appropriate authority, after due consideration of relevant evidence and engagement with affected stakeholders. The most basic consideration underpinning any review of governance is whether there is a clearly defined and agreed purpose driving the decisions and actions that need to be taken.

To explore this basic starting point, it is essential to consider the nature and alignment of relationships, behaviours and expectations as well as the structures and processes within which decisions are made. Experience suggests that in change programmes of this scale, assurance and confidence are more likely to be strengthened by paying attention to these behavioural dynamics when considering the design of governance processes and structures. The review therefore asked a number of key questions related to good governance, gathering evidence through a mixed methods process (interviews, focus groups, surveys and document review). These questions are summarised below:

- is there clarity around the shared purpose? Has it changed?

- where does the authority come from?
- where does accountability sit?
- where are the difficult conversations held?
- how is strategic risk identified and managed?
- where is the neutral system-wide ground where non-partisan conversations are held?
- is the composition of the governance structure right?
- what is the business model to support implementation?
- how does the programme get assurance of delivery against plan?
- how is operational risk identified and managed?

In evaluating the evidence these questions have been used as the basis to offer a qualitative opinion of strengths and weaknesses.

These questions draw on the blend of the review team's theoretical and practical experience of high quality governance relevant to whole systems. During the interviews, it was important to explore individual's understanding of and commitment to the agreed strategy whilst ensuring that any challenge to the strategy remained firmly outside the scope of the review. Where anyone sought to question or challenge the agreed strategy, the discussion was steered towards exploring the mechanisms and fora within which that challenge could legitimately be expressed and suitably resolved.

Appendix 6.1 provides greater detail about the methodology.

4.0 Key messages emerging from the review

This section of the report provides an overview of the important takeout messages that have emerged from the review. They form the baseline for the recommendations.

4.1 Strong clinical leadership

There is considerable respect and admiration for the strength and consistency of clinical leadership involved in creating the original vision for transformed care, and subsequently in developing this into a shared endeavour across the eight CCGs. This has proven to be an invaluable asset in building and maintaining confidence. It has also provided important resilience against opposition to the programme.

It is notable that there has been minimal churn amongst the core clinical leaders of the programme since its inception. This stands in marked contrast to the substantial churn in senior management throughout NWL, both within the programme team and the executive leadership of the provider Trusts.

4.2 Core purpose needs to be refreshed and reinforced

“Purpose” is a collective term that describes the rationale for the programme and should establish criteria that will describe its successful achievement. The purpose articulates the link between the high level, long term vision (or destination of the change journey), and the way this is expressed as aims, goals, or objectives. A strong, clearly defined purpose for any major activity is arguably the most important starting point for effective governance, as it answers the core questions – what is it, why is it important and how will it be achieved?

The programme is especially dependent on clarity of purpose to maximise alignment and traction because of its high complexity, involving extended geography; crossing setting boundaries between voluntary, health and social care; and wide reach across multiple organisations and professions.

Those interviewed provided a reasonably consistent description of the vision for transformed care across NWL, broadly in line with the key principles of localising care wherever possible, developing critical mass in specialist centres where that is necessary and integrating care between the different settings to achieve greater continuity and coordination of care.

Beyond these broad principles, there is a wide variation in understanding and interpretation, especially in relation to the scope of SaHF. For some, SaHF is synonymous with the whole transformation, whilst others see it solely as the acute reconfiguration programme. This confused understanding of the scope of the programme is likely to be one of the root causes behind some of the other important areas (described below) requiring attention from the Collaboration Board.

Many of the interviews showed a strong sense of personal motivation focused on the desire to improve outcomes for patients. This was often accompanied by frustration that too much emphasis was placed on mechanistic views of process and performance. Some views questioned whether there was a danger that the programme’s own rhetoric could begin to dominate aspects of purpose, losing the important perspective that the programme was only an enabler to achieving better outcomes from more appropriate models of care.

4.3 The narrative

For a change of this complexity and scale, achieving change at-pace relies on building momentum throughout the system. When systems are highly dispersed, as they are in

primary and community care, traditional approaches to change management are relatively ineffective and rarely achieved at pace. In such a community setting structures tend to be less hierarchical, flatter and more dependent on principles of networking between peer groups, rather. Change methods similar to those underpinning social movements, focused on creating, mobilising and inspiring individual motivation to change are essential to achieve rapid change in dispersed organisations. Such movements require a highly permissive, empowering environment where most decisions are made in the local teams and alignment with core purpose is achieved through a compelling, inspiring narrative that paints a powerful and attractive picture to which people are emotionally drawn.

A strong narrative is resilient and agile against external changes in context, because it illustrates rather than specifies the journey towards the vision and it is constantly repainted and refreshed by those making that journey real.

The narrative for the SaHF programme was well developed at its inception and created the basis for an exceptional level of agreement amongst the 8 CCGs and amongst the wider group of stakeholders. It was sufficiently compelling in its use of supporting evidence to gain support for a number of sensitive changes, some of which have already been successfully achieved.

As the programme has evolved, and pressures on the NHS have intensified, the narrative has not been sufficiently powerful or relevant to all staff to achieve the prime purpose of empowering and inspiring the workforce to own their part in achieving the vision and drive innovation. A number of factors need to be addressed to strengthen this narrative moving forward:

- the narrative is overly concentrated in the acute reconfiguration element of the transformation, where there is already greatest understanding, most appropriate organisational structures, and relevant experience in delivering change;
- it speaks little to those in the local setting where structures are flatter and rely heavily on professional networks rather than hierarchies;
- arguably it is in this community setting where change the most difficult needs to originate, ideally catalysed through innovative “pull” from front line clinicians, rather than centrally organised “push”;
- the narrative has become dominated by estate, losing some of the strength drawn from the important clinical imperative to drive the change towards adoption of the emerging models of care, with its emphasis on better outcomes and reduced fragmentation of care;
- at the programme inception, the narrative painted a new refreshing picture in which NWL was leading the way, but it has not benefited from continuing to adapt or reflect the vibrant learning being developed elsewhere;
- the narrative does not appear to allow the workforce to make links between their day to day experience, the way it is changing and how this is contributing to achieving the vision
- the narrative and its infrastructure is not adequately owned by those living with its consequences – it is (at least partially) outsourced to central resources drawn from external consultancies;
- the narrative remains NHS-centric, despite the importance of social care, the voluntary sector and the greater importance of self-care and preventative/ life-style measures within the overall vision – there is considerable willingness among these other groups to engage more closely, but many feel excluded or unwelcome.

One of the survey questions invited respondents to choose adjectives from a list that reflected their views of the programme. "Empowering (10%)" and "energising (5%)" were the two lowest scoring from the list, whereas "confusing (53%)" was the second highest.

There is an urgent need to refresh the narrative in a way that adopts the new idiom emerging post the 5-year forward view, provides a more balanced view across the whole scope of change, and connects with front-line realities. This is not about changing the original clinical vision, but about recapturing it in a way that reflects changes in the context since the programme began.

4.4 Confidence & commitment

During the review, we paid particular attention to the levels of confidence about the programme and whether these were changing. We found particularly high levels of confidence in the vision and the work of clinical leadership involved in its preparation. There were some signs in one local authority that further reassurance about the continuing importance of the vision might be required, given the continuation and deepening impact of austerity, but this was a minority view.

Confidence that this vision will be achieved in practice is lower. The majority of those interviewed had some concerns about elements of the programme, especially about the lack of alignment between the different areas, with out-of-hospital care being singled out for lack of confidence in progress. Some expressed high levels of cynicism / scepticism including anxiety that the programme was too ambitious to be achievable, or questioned whether the methodology of a single large-scale programme was the right choice. Most reservations that were expressed appeared to reflect genuine concern rather than political viewpoints though many also questioned the extent of political resolve to support the ImBC given its anticipated requirement for substantial capital.

In the survey, roughly $^1/_4$ to $^1/_3$ expressed a negative sentiment about confidence in the programme, the delivery team or that they will be heard if they need to escalate a matter. Around a quarter did not think that the programme would improve the care received by the service user, but this is consistent with that reported across a few hundred similar, but smaller scale transformation programmes in USA. That external evidence suggests that the number who are very positive about the changes increases significantly once they are directly involved within the new way of working.[1]

A brief poll in each of the focus groups indicated that the S&T team members directly involved in the programme were considerably more confident about both the achievability and its practical achievement then CCG staff. The small numbers involved demand caution in interpreting the significance of this result, though some degree of optimism bias would not be unusual.

4.5 Relationships & culture

The programme has benefitted from the stability provided by the clinical leadership of the 8 CCGs and the joint financial strategy, both of which have recognised the importance of the natural inter-dependences between the NWL boroughs, without losing their independent characteristics. The decision to cluster into the two groups of 5 and 3 CCGs continues the pattern of sub-regional planning long established in London's NHS, and the agreement to collaborate across all 8 for the large-scale transformation also reflects the impossibility of

[1] As reported in The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

isolating change to a single organisational boundary in a dense city, when that change is designed to be transformational.

The pooling of resources in the form of the single S&T team shared across all 8 CCGs has enabled progress that would not have been possible by individual CCGs. Some tension has arisen because the S&T team is perceived to be too centred on Westminster, with limited visibility in the outer boroughs. It is also frequently seen as defining the agenda for the CCGs, rather than following and clarifying the agenda set by the individual CCGs.

Although the aim to localise where possible and centralise where necessary is clearly stated, arguably, the boundary in NWL between what should be local and what central still errs towards over-centralisation. It has not followed the ambition stated by NHS England in the 5 Year Forward View to shift greater levels of control towards increasingly local units. It is possible that NWL has been unsuccessful in recent bids for new Model of Care Vanguard funding because of this perceived over-centralisation – certainly some of the CCGs believe they would have been more likely to succeed with individual bids. The alternative argument that the change agenda in NWL is already highly ambitious and complex, and additional overlay programmes would pose an unacceptable threat to current plans needs to be given greater consideration by the Collaboration Board.

The SaHF programme board at which all major partners are represented serves an important purpose of ensuring that there is a rigorous go-no-go gateway for any major implementation milestone demanding (and gaining) the support of every involved party. Despite this invaluable process of confirming commitment, the membership count of this body renders it incapable of fulfilling the normal purpose of a programme board. Instead it becomes a stage-managed event, with very few difficult conversations and minimal challenge – both essential for strong assurance and transparent accountability. Those difficult conversations that are held tend to be conducted outside the spotlight of governance.

Some views that were expressed admired the achievement of sustaining exemplary levels of executive engagement with the SaHF programme, but suggested that this might be more motivated by fear, instead of engendered by the deepening levels of trust and respect on which successful, sustainable collaborations are constructed.

Several provider organisations commented on the conflicting and potentially paradoxical behaviours required between the SaHF programme which demands investment and commitment to sustainable change based on mature strategic, highly valued relationships, and the increasingly hard line taken operationally on commissioning and performance issues which are increasingly commoditised, price-sensitive and micromanaged.

It is appropriate to maintain separation between the operational world of current performance, and the transformation of services for the future. However, successful collaboration and progress towards accountable-care style partnerships will require new ways of working, more mature and open relationships. Behaviours in these collaborative models will need to be founded on consistent principles that encourage risk and reward sharing. The current national trend towards ever-more punitive performance and regulatory regimes is inconsistent with the need to build strong accountabilities alongside greater transparency and trust, without losing any of their edge in performance.

The earlier section on the importance of narrative stresses how important it is to create a “movement” in which to build pace for change across the dispersed professional networks in community and primary care. Creating the right permissive and empowering culture is just as essential to success as the strength of narrative is in ensuring alignment of effort with the

intended purpose. The creation of General Practice Federations will provide an important foundation on which the new local models of care can be built, but investment of time and energy will be required to develop appropriate trusted relationships and clear demarcation between the GP's competing roles of commissioner and primary care provider.

"Reconsidering Accountability in an age of integrated care"[2], the recently published report by the Nuffield Trust suggests that the role of commissioners is and needs to continue changing to soften the boundaries from the traditional "customer/supplier" relationship with adversarial undertones. This report reinforces the urgency of investing in the development of practices and behaviours that will lead to stronger collaboration. Work is required across all the senior teams to develop deeper mutual understanding, greater openness and agree the principles, behaviours and methods of working that adopt the best understanding of collaborative leadership models.

4.6 Capacity & leadership

The Rose review of NHS leadership[3] highlights the paucity of investment in or celebration of high calibre leadership or management, especially considering the complexity and the scale of the challenge facing most managers. NWL is no exception to this, except potentially the ambition of SaHF places it at the forefront of the challenges of both leadership and management. The report from the first King's Fund leadership summit[4] was subtitled – "No more heroes", signalling the reality within the NHS that pinnacles of success are more frequently the result of heroic leadership, rather than the right combination of ubiquitous strength in both leadership and management[5].

An important finding in that report was that the NHS was under-managed, but over-administered. Despite the evidence of the correlation between clinicians in senior management roles, and the growing importance placed on clinical leadership, it remains common for clinicians to avoid management and leadership roles. Arguments justifying this stance are invariably aimed at dissatisfaction with the administrative content of such roles, rather than at those concerned with leadership or management. As noted in the introduction to the report, use of the term "management" does not differentiate between those in management positions with a clinical background, and those with corporate backgrounds. In all cases management refers to the accountability for decision-making in the optimum use of resources to achieve agreed goals.

In this context, the SaHF programme has been fortunate to be characterised by excellent clinical leadership in setting the agenda, and through the work of the Clinical Board. However, evidence from the interviews supports the above perspective that both the SaHF programme, and the operational relationships between partners across NWL are still characterised by over-administration (too much emphasis on micromanaging performance

[2] Ben Jopp, Reconsidering Accountability in an age of integrated care, Nuffield Trust, http://www.nuffieldtrust.org.uk/publications/reconsidering-accountability-integrated-care

[3] Lord Rose, Better leadership for tomorrow: NHS leadership review, Dept of Health, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445738/Lord_Rose_NHS_Report_acc.pdf

[4] NHS Leadership and Management Summit, May 2011, http://www.kingsfund.org.uk/events/past-events/nhs-leadership-and-management-summit

[5] For the purpose of clarity, the term leadership here refers to the process of encouraging and motivating individuals and teams towards a goal by inspiration and exemplar practice, whereas the term management refers to the organisation and alignment of resources and decisions in a planned, controlled and directed way to achieve a goal. Leadership and management are closely related and interdependent, but both are required to achieve optimum results.

and compliance) and under-management (too little emphasis on ownership of the right decisions in the right place, supported by high levels of trust and strong assurance mechanisms).

One manifestation of this is the absence of fora in which senior leaders spend quality time which is neither focused on crisis nor orientated towards urgent decisions within over-loaded agendas. There is limited opportunity to socialise ideas, develop strong networks and relationships or to spend time to see NW London through the lens of other parties within the system. In particular, none of the leaders from the London Boroughs felt they had been drawn into early conversations to explore options and implications, and the majority thought they had complementary experience and insight to share, and were keen so to do. Even within the NHS "family", the rigid segregation into provider and commissioner was felt to limit understanding and co-development. The high turnover of executive positions throughout NWL has not helped cement key lasting relationships. The powerful patient commitment "no decision about me without me" offers an interesting challenge when quoted by NHS provider organisations back to commissioners when they feel excluded from important conversations.

A number of interviewees commented about there being too few high calibre managers within the programme, with insufficient senior experienced bandwidth, and significant gaps in both capability and capacity between the senior team and those in the critical middle manager roles where sensemaking takes place between strategic plans and operational implementation. In particular, it was felt that the S&T resource is too heavily dependent on external management consultancy, with insufficient links between the thinking/planning and the knowledge transfer or long-term operational impact and consequences of decisions.

4.7 Organisation of the programme

Day to day authority for commissioning decisions about the SaHF programme rests with the 8 individual CCGs, subject to the relevant engagement and involvement of stakeholders including the provider and other partner organisations, and local communities. Through their membership of the Collaboration Board, the 8 CCGs develop shared understanding of the options for and implications of impending decisions, reaching outline agreement about their proposed solution. Each of the 8 CCG Governing Bodies then exercises their authority to reach the decision for their own community, generally fully consistent with the principles and direction approved by the Collaboration Board. Once the commissioning principles have been established for the acute reconfiguration programme, decisions impacting on implementation of service changes have been made at the Programme Implementation Board, where all the relevant organisations are represented.

The Programme Implementation Board is guided by input from highly effective Clinical Board and Lay Representative Groups. These groups form an essential part of the Authorising Regime (see Moore's strategic triangle[6]) to ensure that the programme's legitimacy and credibility is maintained amongst key stakeholder groups.

Where decisions exceed the authority of the individual CCGs, such as that required for the programme business case, the CCGs prepare a joint case following the above process and

[6] Mark Moore identified that there are three important components in defining the appropriateness and viability of strategy in public services: the public value proposition (or what matters), the operational capability (the reality checkpoint of "doability") and the authorising regime (the political, regulatory and public legitimacy of the chosen course of action); see for example Bennington and Moore, "Public value, theory and practice, Palgrave Macmillan, 2011

submit this for authorisation by the relevant body such as NHS England, or HM Treasury, following the normal gateway criteria and review stages.

The SaHF programme has explicit authority recorded in the minutes of Hansard, from a Secretary of State statement in the House of Commons. Even though there may be significant benefits in rebranding the programme to overcome current confusion, it will be essential when considering any future changes to the programme to maintain traceable links to this tangible sign of authority.

There appears to be considerable confusion about the programme structure, particularly in relation to the community based elements involved in whole systems integration, primary care transformation and out-of-hospital care.

This confusion is made more visible given the variation in progress across different localities and the absence of a definitive milestone plan of expected progress in developing alternative community based models as an alternative to continuing growth in emergency admissions. Limited visibility of progress in changes to community-based care provides little confidence within the acute reconfiguration programme that the necessary goals will be achieved to synchronise with expected changes in acute configuration, such as the paediatric reconfiguration as the next major delivery. A master plan showing how the programme elements interdepend and intersect is essential, and is currently being developed.

It is not clear where such a master plan would be owned, or where the work would be overseen to refresh and adapt the vision as it becomes more tangible through the implementation plan. Current programme structures are heavily dominated by NHS commissioners and other groups including social services and NHS providers are keen to contribute more to the wider development of the next stages. Other pan-NW London organisations, such as the Academic Health Science Network and HENWL could also contribute more transparently to the governance, given both their expertise and responsibilities.

The scale of the programme has meant that the Programme Implementation Board is large and cumbersome and does not lend itself to the difficult conversations necessary in exploring the full complexity and impact of decisions that it has needed to make. It has however fulfilled a vital function of ensuring appropriate buy-in and commitment to the “big” decisions. Because all the big decisions to date have arisen in the acute reconfiguration element of the programme, the Programme Implementation Board has not helped to reflect the aims of the programme to strengthen the integration between those services delivered closer to home, and those in a traditional hospital setting. It will be essential for the future governance arrangements to retain the sense of shared commitment to decisions, whilst extending this across the whole breadth of the programme, and enabling a much stronger role for Local Authority partners.

4.8 Risk management

For a programme of this complexity, a healthy approach to risk management should recognise that it is a live and vibrant value-adding process that can be used both to triangulate other knowledge and help focus on success. There are three distinct ways in which risks must be managed:

- at an operational level within each project and delivery area;
- at a strategic level for the whole programme;

- at a strategic level to scrutinise the operational risks so that their cumulative impact can be integrated into the strategic risk process

The latter area is always the most difficult and frequently the most neglected area of risk management because of the difficulty of bridging between the operational and strategic risks without undermining ownership at project level or overloading the strategic process with too much detail.

The review only considered the two elements of strategic risk operated by the programme office team and managed through the appropriate boards. The documented process for risk management addresses the key requirements for effective management of risks. In practice, the review found limited awareness of or engagement in the risk management process, despite a number of interviewees expressing concern about what they perceived as critical risks, suggesting that ownership is perceived to lie with the central team. Explicit consideration of risk appetite and risk tolerance can be a helpful way of developing a greater awareness of and engagement with risk.

5.0 Detailed recommendations

5.1 Clarification of purpose

The vision set for the programme from the outset remains valid, with potentially an even greater need for it to be realised with urgency. For this to be realised (and realisable), it is essential for this vision to be underpinned by clarifying that the purpose of the SaHF programme is to achieve the whole of this vision, with an integrated and fully interlocked approach across each of the current programme areas. There is an urgent need to define both the scope of the programme and the critical timeline for its delivery. This must be in a form which is meaningful and relevant to all those involved in its delivery, irrespective of setting. It must also be in a form that illustrates the implications and benefits pertinent to each stakeholder group.

In creating clarity of the way forward, the programme team should seek both to eliminate the confusion and ambiguity caused by the current multiple overlapping programmes whilst explicitly reflecting the programme's alignment with similar work emerging from the 5yr Forward View. In different circumstances, it would be advisable to undertake a rebranding exercise as the most reliable way of breaking links to the misunderstanding and confusion. However, for NWL the provenance of the programme is a considerable asset and in this instance, the exercise of clarifying purpose should retain the name of SaHF whilst reinforcing its intended meaning. It may however be helpful to retain the SaHF name only in relation to what is currently the acute reconfiguration programme, with which it is most closely associated, but to develop a stronger name for the overall transformation of care, concentrating especially on the clinical aims, rather than the physical location from which service is provided. Whatever course is chosen, it is essential to eliminate the current levels of confusion with a confident communication strategy. There is considerable experience and evidence of best practice available from other industry sectors on which the programme team should draw.

Whilst clarifying its purpose, and if necessary, redefining the scope of the SaHF programme, it will be particularly helpful to develop this purpose in the form of a strong narrative that will act as a compelling illustration of why the transformed model of care offers the best way forward for the communities of NW London. The process of developing the purpose in narrative form can be a powerful technique to engage, empower and inspire a wider group, deepening both the ownership of the solution, and the willingness to take responsibility to adapt and revise the narrative to strengthen resilience against the inevitable changes in context. This will also ensure that the weakness of the current communication strategy will be addressed as a by-product of strengthening clarity of purpose.

Recommendations

1. Revisit and clarify the shared vision and purpose of the SaHF programme and develop this into a strong narrative, taking full advantage to reflect the changes in context :

1a) refreshed vision and purpose to be completed before the 2016/7 commissioning cycle ramps up (October 2015).

Recommendations continued

1b) each partner organisation should take the output from (1a) and develop this into a locally owner narrative illustrating their own contribution to the integrated service, the overall joined-up system, and the revised nature of their critical stakeholder relationships. (November 2015)

1c) adopt a co-design approach to develop the individual narratives from (1b) into a system-wide narrative which has visible connection to the current idiom and NHS-wide learning available from the 5 yr Forward View Vanguards and similar initiatives. (December 2015)

1d.) build a comprehensive communication infrastructure for the programme (October 2015)

1e). co-develop 6-8 clear and bold statements of success by which the programme will be proud to be judged and will embody both the aspiration and commitment to the vision and its positive impact on the communities of NWL.

5.2 Investment in leadership and organisational development

As a transformation programme, a considerable element of the SaHF programme will rely on creating a new culture that is more appropriate to the collaborative style of working required for better integration and co-ordination of care. Diagnostic tools such as the "culture web" point to the importance of understanding some of the symbols and behaviours that not only characterise the existing culture, but also provide it with resilience against change. Unless these symbols are deliberately broken as part of the change programme, the culture will resist the intended changes. Organisations that are successful in achieving transformational change invest heavily in the organisational development (OD) elements of changing culture alongside investment in developing new service models and reengineering processes.

The scale of change required in the SaHF programme involves challenging traditional power bases between professions, rebalancing responsibility, costs and resources between organisations and ultimately changing the dynamic between service user and clinician. An OD programme designed initially to increase understanding, empathy and visibility of different roles and organisations is a precursor to building new levels of mutual trust and respect, itself a precursor to the acceptance of the need to recognise and manage risk in new ways.

Ultimately, a change programme must contain elements relevant to all involved in delivering care in new ways. However, all models of leadership and governance recognise the significance of "tone at the top". Organisations and teams readily recognise and respond to the experience and behaviours exhibited by members of governing bodies or boards. In highly performing organisations, there is a consistency and alignment between decisions, communications and behaviours. Poorer performing organisations often display a dissonance between these, which is easily recognised throughout the organisation.

In collaborative ventures (such as SaHF), it is important to pay attention to "tone at the top" to avoid the destructive effects of dissonance between actions, words and behaviours either within individual organisation or between partner organisations. It is also generally less recognised that the strongest collaborations preserve and even strengthen the individual identity of each partner, emphasising both the uniqueness of that organisation's contribution,

and the way in which collaborative partnership is much stronger because of the combination of these unique attributes, and their mutual commitment to work together.

We believe that it is essential to invest quality time across the most senior leaders of all the partners and key stakeholders in order to generate this consistent "tone at the top" that is very clear about the uniqueness and the value brought by each partner. Such an OD programme should concentrate on behaviours, principles and sharing the different insight developed from different experiences and observed through the different lenses throughout the complex system. This process should not only generate new and deeper understanding and respect, but will also concentrate on developing consistent tools and language associated with the new ways of working together and the new ways of holding each other to account that will bring greater assurance and clearer accountability through stronger management and reduced levels of process administration more focused on value-add. Given the scope of the programme, this programme should embrace a minimum of 200-250 top leaders in NW London to build the depth and breadth required. A suitable programme would involve typically 5 individual development days interspersed with shared project work and action learning sets[7].

A significant part of the curriculum for this learning programme could be designed to meet the needs of other recommendations in this report, including those related to developing new for-for-purpose business processes as well as recommendations 2-5 to reduce the additional demands of the programme. Care must be taken to avoid the OD programme substituting for the operational governance of SaHF.

The current structures are dominated by the NHS agenda, and there are limited opportunities for strategic engagement between the NHS and key local authority interests. Historically, there has been limited appetite or opportunity for London Boroughs to work closely with each other and the NHS on common health agendas. The continued and severe impact of austerity measures on local authorities is forcing joint working across wider agendas to explore shared policy development in areas such as economic development. There is potential to benefit considerably from focusing such joint thinking between the Borough Chief Executives and their NHS counterparts around the whole systems health agenda, especially if that were to focus on the need to change the public attitude towards healthy living, more self care and changing the way care services as a whole are used, alongside changes to the way they are delivered.

Recommendations

2. Invest in an OD programme for at least the top 200-250 senior managers across partners in NWL.

2a) the OD programme to be scoped in Sep 2015, to run to March 2016

2b) the OD programme should be designed to support identification and development of the new enablers and culture to support SaHF, but should not be used as the vehicle to focus on the operational elements of SaHF (i.e. plans, decisions or design of the programme).

[7] Note that case studies of the Total Place initiatives reflected the value of the most senior leaders across different departments spending time working together on both broad strategic topics but also at depth on key wicked issues. The OD programme suggested here reflects the need to develop similar relationships throughout the whole system in NWL.

Recommendations continued

2c) explore potential for closer working relationship between NHS and London Boroughs within the OD programme – e.g. to focus closer working around the implications for public services of the SaHF programme (by January 2016)

2d) consider using Action Learning Sets within the OD programme to co-develop further detail against other recommendations in this report.

2e) ensure that as part of this OD programme, senior leaders regularly host and sponsor multidisciplinary/ multi-agency knowledge sharing / learning opportunities.

5.3 Programme organisation

The current programme organisation under the SaHF umbrella is confusing, with different and occasionally conflicting understanding of the elements amongst stakeholders. Some perceive the programme elements to be organised around reporting accountabilities, rather than the service needs of the population. It will be important to reaffirm that decisions about the organisation of the programme are focused on achieving the desired transformation of clinical outcomes.

The ideal delivery organisation should mirror the key models of delivery, with critical interdependences between the different streams forming the principal units around which accountability and assurance are focused.

The current acute reconfiguration programme remains an appropriate stream of work, subject to stronger emphasis on the key interlocking gateways, though it may be appropriate to strengthen the emphasis on the imperative to create centres of care in which all essential specialisms exceed the critical mass required to sustain consultant led care on a 24/7 basis.

In contrast, “whole system integration”, “primary care transformation”, and “out-of-hospital care” are terms that are often used interchangeably despite having different meanings at a detailed level. The transformation of all aspects of community-based care should be consolidated into a single stream of work within the SaHF programme to avoid the confusion caused by the mixed terminology. Essentially, this stream will focus on all aspects of strengthening of localised services, including improved co-ordination across and integration with centralised services. Progress to date in these relevant elements of the programme is highly variable between localities with fewer standards of best practice to follow and greater local autonomy to decide on pace and uptake.

The dominant characteristic of this stream is one of flat, non-hierarchical structures, with a highly multidisciplinary workforce exercising considerable professional independence. Cohesion and consistency within this stream is achieved through networking. This area of the programme requires a very different approach to maximise pace. Achievement of large-scale change relies heavily on mobilisation based on a combination of empowerment and an inspired invitation to be part of a compelling purposeful movement. Accelerating change in such a movement requires a shift in emphasis from performance measured by process compliance to one built on best professional excellence seeking ever more demanding standards of best-practice, with a much more robust assurance regime. Unnecessary variation in this setting is addressed by strong examples of best practice and clear standards of good outcomes.

The optimum regime for success will be a firm but fair permissive regime with clear standards of accountability and strong assurance – in many ways trending in the opposite direction to current practice. The key priority for the SaHF team is to adopt the best learning available from the Vanguards working with the Five Year Forward View, and with the emerging Practice Federations to secure a stable environment which has closed the gap between the current high enforcement regime, and the ideal environment of greater empowerment. The clearer expectation set within this negotiated position will then provide a more conducive environment within which to innovate, establish and share best practice and clear standards.

The mental health transformation programme has recently been agreed and is currently managed as a separate programme stream. Within the confines of mental health, the current programme is both cohesive and valued by mental health specialists. It is therefore important to avoid disrupting this programme until early momentum has been gained. However, one long-standing criticism of mental health is that it should be much more closely integrated with physical health if the best outcomes and equity of care are to be achieved. It is therefore appropriate that once the programme is established, the specialist and localised service elements should be merged within the appropriate physical health workstreams.

It is also clear from our review that the business processes currently being used to support the collaboration between the 8 CCGs are not fit for purpose to support the SaHF programme. The majority of existing business processes related to commissioning, performance and financial flows are predicated on managing commercial relationships between organisations. Changes are required to the design of contracting to move towards accountable care network models in which responsibility and risk for managing the end-to-end supply chain is vested with a lead contractor, independent integrator or an alliance partnership. Where such contracts migrate towards performance measures defined by broad population outcomes, new approaches will be required to define suitable metrics which in the short term will need to be proxy measures whilst the definitions of suitable outcomes are agreed. Mechanisms to encourage the sharing of risks and rewards will need to be developed with some degree of finesse in the incentivisation and remuneration models to avoid perverse incentives and their unintended consequences. An additional programme workstream should be established to ensure that new business processes are developed as required to support the new collaborative business models.

Recommendations

3. Realign the overall transformation programme into three distinct streams

3a) create a single programme of work focused on the localisation of care wherever possible, by merging the existing integrated care, out of hospital and whole system integration activities, (by December 2015)

3b) create a new infrastructure programme tasked with supporting the introduction of business and management processes orientated towards the collaborative system-wide working environment required by the programme: - to identify, set standards and co-ordinate the development of new processes that reflect the future needs for greater transparency, stronger assurance and accountability, and more distributed decision making. (scope and establish the new programme November 2015)

Recommendations continued

3c) develop the learning and support infrastructure to define stronger standards, encourage innovation and replicate best practice to accelerate pace of change with the localised services. (by March 2016)

3d) strengthen the emphasis on clinical quality and safety within the acute reconfiguration programme so that it is more strongly focused on outcomes, than on location and premises.

3e) pursue the current mental health transformation programme to gain traction, but agree how and when to merge the specialist and local elements into the relevant programme streams.

3f) ensure that there is strong cross-programme engagement between the localisation and the acute reconfiguration programmes to ensure effective whole system working.

5.4 Governance structures

In recommending changes to the governance structures, it is important to retain and build on the very strong sense of clinical ownership at the heart of decisions. It must be grounded in recognition that authority is vested in the statutory bodies, whilst creating an environment of greater collective and collaborative commitment to shared decisions. It must also overcome the difficulties to date of unwieldy arrangements whilst enabling sometimes difficult conversations about the interdependences and potential conflicts between the different programme elements, and constantly build greater trust and confidence.

The proposed governance arrangement seeks to overcome some of the present weaknesses by emphasising that governance involves multiple different relationships. For example, if relationships of authority become conflated with relationships of joint action, the organisational structures are likely to become both confused and ineffective. The description of the proposed design seeks to address the nature of these relationships, as well as the suggested structures.

5.4.1 Lines of authority

The 8 CCG chairs working together through the Collaboration Board have a clear mandate from their respective organisations to oversee the common transformation agenda for NW London through their commissioning duty. It also oversees co-ordination between the CCGs on commissioning matters not included in the transformation programme. It is therefore appropriate to retain the role of the Collaboration board within the programme governance arrangements, whilst clarifying the nature of its role. To strengthen the relationship with both the strategic design decisions and the implementation delivery it should be informed more closely by the Clinical Board and supported by stronger governance around implementation delivery, risk management and communications.

There is currently no formally organised equivalent to the Collaboration Board at which the network of providers (including the newly forming GP Federations as providers, and Local Authority and Voluntary sector partners) meet together to establish a shared understanding of priorities and opportunities. Such a body would enable the provider organisations to take a collective view on the strategic clinical capacity and capability requirements to meet the demand forecast by the joint commissioners. It should progress areas of mutual responsibility, such as workforce development, common standards and practice, information

and intelligence sharing, and research. Imperial academic health partners' network and Health education for Northwest London (HENWL) who both have pan-NWL responsibility should play a pivotal role in developing a mature basis for provider collaboration. Care will be required to ensure that this strategic co-ordination by providers avoids anti-competitive areas of detail.

It will also be increasingly important to draw the Local Authorities more closely into the transformation programme, not only because of the direct impact upon them, but in order to tap into the wealth of experience and understanding they can bring to successful working of complex governance and commissioning arrangements. It may be that the Boroughs choose to establish an equivalent forum (labelled as the Borough Co-ord in the attached figure) to the Collaboration Board and the Provider Board. The main purpose of such a forum would be to receive the considered advice about the programme from the Clinical Board to explore in greater depth how this might support or interact with other specific priorities for Local Authorities.

5.4.2 Programme design and delivery

The Clinical Board has been a great strength for the programme and should continue as the pivotal element of the programme governance, concentrating its focus on strategy and design decisions, whilst ensuring that there is a strong working relationship with the delivery implementation phase of the programme.

As already noted, the changing nature of commissioning and the move towards a more integrated approach will create additional pressure on the one hand for the Health and Well-being Boards to take greater interest, and on the other for the Providers to play a more significant role in defining the priorities. The current Programme Board does not have the authority or the structure to act as an effective system board. It does however fulfil an important role in the final go/no-go decision making prior to a specific implementation. It also provides a forum to maintain awareness and raise key points, though it is doubtful that it is the most cost effective way of achieving this. A structure similar to the current programme board should be adapted into an advisory group on which both commissioners and providers can draw.

The programme currently lacks a single plan integrating all the elements and identifying the critical dependences. The scale of the programme is such that inertia and complexity conspire against maintaining a single credible programme plan. In complex delivery programmes like SaHF, other industries frequently adopt an approach to matrix management in which individual owners are assigned to oversee longitudinal programmes of work, whilst other owners oversee successfully achievement of individual delivery events, drawing together the relevant components from each of the programme streams.

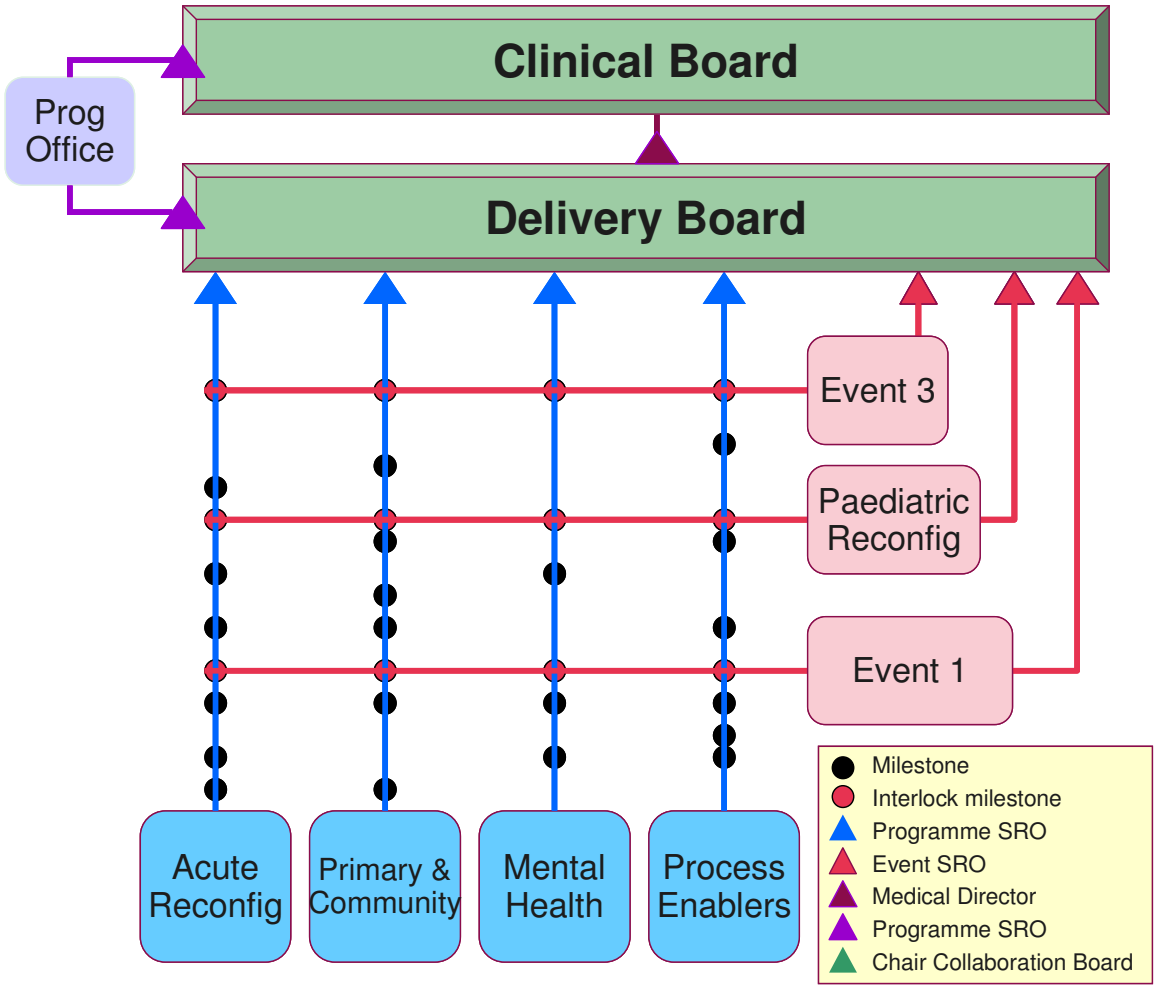
The principles on which such a management structure is built will work well for the SaHF programme, allowing the delivery programme to maintain long range focus through the workstreams previously identified, whilst building the practical implementation around much smaller projects or "implementation events". Each such project should have a senior owner accountable for successful implementation, who is given the freedom and resources to resolve issues.

The overall programme is then constructed from the critical dependences between each project and workstream. It is managed through the interlock of interdependences between the different streams and events, and relies on the accountable owners meeting their commitments, and overseen by a delivery board. This new delivery board will provide strong

assurance and tight management control by focusing predominantly on resolving potential conflicts, concentrating on managing risk and anticipating/ responding to policy changes.

This structure allows a broader distribution and sharing of management responsibility throughout the partner organisations by assigning gateway managers for individual events from across the network of organisations. It also allows the current programme board to be more formally recognised in its advisory capacity. The diagram suggests possible relationships and reporting lines.

The figure below shows how conceptually such a delivery board structure can be organised with appropriate empowered representation from all the key aspects of the programme. The relationship between the clinical board and delivery board is shown schematically for convenience, but the intention is that the clinical board provides leadership on design and strategy decisions and the delivery board provides leadership on implementation, with very close interworking and cross representation.



One of the principles for managing delivery of a complex programme in this way is to allow individual projects to focus strongly on project management and reporting against plan, but for the overall programme to be managed through a strong focus on risk management. A significant deficit in the current programme appears to be the absence of an identifiable approach to the management of risk. At programme level it is important to manage strategic risk and to scrutinise operational risks to assess and integrate the cumulative impact integrated into the strategic risk process. For a programme of this complexity, a healthy

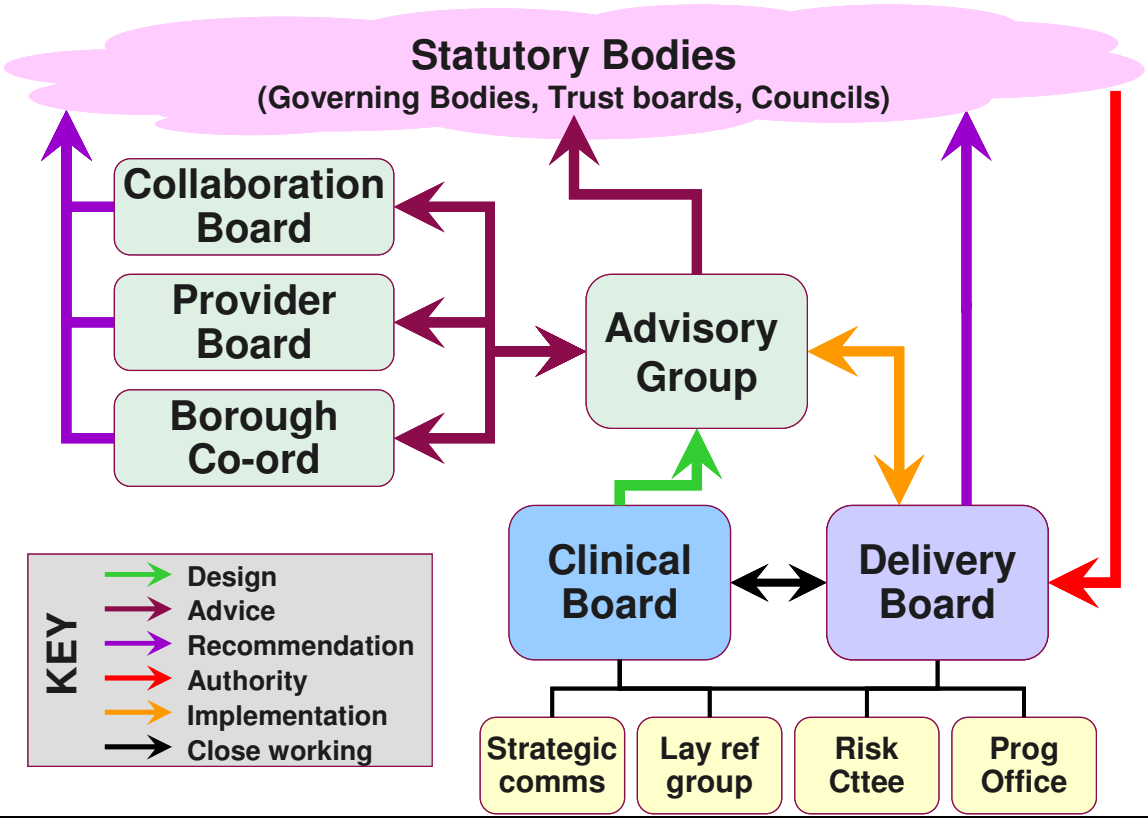
approach to risk management should recognise that it is a live and vibrant value-adding process that can be used both to triangulate other knowledge and help focus on success.

A high quality risk management process will include:

- explicit exploration of risk appetite and tolerance with all key stakeholders as part of a risk policy statement;
- regular review of strategic risks and assessment of both threats and opportunities on the agreed strategy and vision;
- formal consideration of levels of programme assurance, triggered on a frequency determined by the assessed risk severity, reporting against mitigation and contingency plans informed by analysis of sensitivity and resilience;
- scrutiny of the underlying operational risks to determine their potential cumulative impact on and interaction with the strategic risks;
- formal ownership of risk.

5.4.3 Overall programme governance

The figure below shows the proposed relationship between the lines of authority and accountability, vested within each statutory body, and the design and delivery structures. The colour key shows how the technical decisions recommended by the clinical board and shared with the overall advisory group and the sector specific fora (collaboration board, provider board and borough co-ord) are channelled to each statutory body for authority, which is then vested in an approved delivery programme. The delivery board will make specific implementation recommendations directly to the relevant statutory bodies, as well as overseeing this delivery programme in conjunction with the clinical board, supported by the programme office, risk committee, strategic communications and lay reference group.



Recommendations

4 Redesign the governance structures for the programme to strengthen accountability and support more collaborative working

4a reposition the Collaboration Board as part of a network of advisory bodies with responsibility to provide considered recommendations to the statutory bodies, based on the strategic proposals from the Clinical Board and the implementation recommendations from the Delivery Board.

4b) develop a Provider Board to serve an equivalent function for providers to that served by the Collaboration Board focusing on strategic capacity and capability at which providers work together to develop a shared understanding of whole systems working (ideas for the governance and responsibility of this body could also be an output from the OD programme - by January 2016).

4c) establish an equivalent forum at which the NW London Boroughs can work together (described here as the Borough Co-ord) to ensure that the programme can benefit from more effective political leadership in NWL to achieve overall goals that are widely accepted

4d) build the delivery programme around small, empowered task and finish groups reporting into the gateway deadlines. (ongoing)

4e) establish the critical interdependences between the different streams of the programme and important implementation milestones, and produce an overall interlocked programme plan of key "gateway events" by which to manage the programme.

4f) identify independent "gateway" owners drawn from the senior managers throughout NWL, with assigned accountability for all resources involved in successful implementation of that critical project deliverable,

4g) establish a delivery governance regime adopting the principles of matrix management in which the delivery board is populated by the workstream owners, the project owners and key functional roles such as the medical director and OD director (by December 2015)

4h) work with in the OD programme to co-develop a comprehensive risk strategy for system-wide working across NWL (December 2015)

4i) establish a core risk management process and a risk committee with programme level ownership within which to manage strategic risk, and assess the cumulative impact of operational risks. (February 2016)

4j) consider involving NEDs and lay governors in each of the key governance structures

Recommendations

5 Identify one (or more) symbolic deliverables that bring all programmes together and can be used as a flagship over the next 6 months to demonstrate real impact at a system level (e.g. consistent performance against winter pressure) (identify by September/October 2015)

5.5 Redefine the role of S&T

The Strategy & Transformation team (S&T) provides a single, critical mass of the skilled, specialist resource to enable the 8 CCGs to develop and establish their strategic priorities for the future direction. Some other services lie outside the current remit of S&T, but are still centralised and shared across the 8 CCGs. All of these areas of shared expertise should be considered and resourced in a common approach, whether in a real or virtual organisation. Much of this is concentrated into the SaHF programme of activities, but each of the CCGs relies on the resource, both capacity and capability, for some of the detail required to discharge its commissioning responsibility. Each CCG may call upon the skills of the S&T team in areas such as business intelligence, analysis, planning, contracting or economics to support their own local commissioning priorities. These may be related to local initiatives linked to whole system working or out of hospital developments, or to enabling details to prepare for service reconfiguration, or they may be more tactical activities wholly within that CCG's own service plans.

The current organisation of S&T resources centres on the needs of the SaHF programme and individual CCGs express concern that they are unable to receive the support they need for local priorities where these are not wholly related to the SaHF programme. Where the S&T activities are focused on preparing the next stages of the SaHF programme, it is not always transparent to the CCGs that these priorities have been set by the Collaboration Board, because of the duality of their role in advising and guiding the Collaboration Board about options for the next steps, and being their agents to oversee the plans. There is limited clarity amongst the CCGs of how and where the S&T team is held accountable, and how its priorities are set and its effectiveness measured.

The current Strategy & Transformation Team should be developed further into a strategic resource for NWL that is a power house for change. Whilst its primary role will be to ensure that the transformation programme proceeds confidently at pace, it should also act as a professional services and innovation hub, developing a critical mass of expertise and knowledge in all aspects of clinical and business change. Each of the 8 CCGs should be able to call upon an agreed level of expert consultancy to support planning and implementation of their local priorities where these complement the regional transformation programme. Each of the delivery projects should also be able to draw on the design and delivery skills within this hub. To overcome the current criticism that the S&T team is too centralised with diffuse accountability, members of this virtual team should be collocated with the organisations they are supporting. Instead of the current arrangement of relying heavily on external consultants, this resource should draw heavily on secondment from across all the NWL organisations, creating a dynamic "elite" group of change agents, who cycle knowledge, experience and understanding between the organisations through high profile secondments many of which will be tailored as development opportunities for leaders identified as high potential. This dynamic arrangement should accelerate cultural change

and develop the behaviours on which the future of successful collaboration will thrive, and shared ownership will be built.

It is undoubtedly beneficial for NWL as a whole for the 8 CCGs to pool their resources to support the S&T team and allow it to operate at critical mass in the specialist skill areas. NWL could benefit more if a greater percentage of the S&T resource were recruited in-house as part of the long-range investment in critical capacity and knowledge transfer. Areas where specialist expertise is required infrequently can still draw on external consultancy as required.

The portfolio of services provided by S&T is dominated by the broad range of knowledge services, closely resembling those provided by many professional service and consultancy organisations. There would therefore be considerable advantage in modelling the structure and management of the S&T on that used by professional service organisations. Organising in this way, the S&T resources would be aligned in practice areas, with the equivalent of a partner responsible for skills and capacity development in each of these key areas as well as for agreeing the overall resource demands placed on this practice area.

An agreed proportion of the S&T resource would be aligned with the needs of the SaHF programme to deliver both its advisory and its delivery co-ordination roles on behalf of the Collaboration Board. Delivery of the agreed priorities and planning of the demands drawn from each of the practice areas would be overseen by the operational resource manager for the SaHF programme.

Each of the CCGs would also have access to an agreed "budget" of resources within the S&T team to be made available to support the CCG's own local priorities within a level of capacity, skill and response time defined by service agreement. Each CCG could determine appropriate levels of flexibility between practice areas whilst also building specific local knowledge in specific skill areas, whilst still relying on the S&T team to take responsibility for individual team member's professional development and for matching skill and capacity to the aggregated demand.

Such a professional service model would create a more equitable and transparently

accountable balance between the strategic needs of the whole SaHF programme and the local needs of each CCG. Current trends suggest that as the evolution of the 5 yr Forward View progresses, more of the S&T resource should be migrating towards local CCG priorities, and this proposed structure would support this, whilst retaining the benefits of critical mass associated with more centralised planning and capacity building.

A suggested organisation of responsibilities for the revised S&T is shown above. The overall design principles for a new S&T team follow those of organisational design adopted by the majority of professional service organisations, in which resources are grouped into practice areas, but deployed on an assignment basis accountable to the responsible partner or senior project manager.

The head of each practice area is responsible for developing the capacity and capability in that practice area. This includes forecasting the future demand for work in that practice, and the development of the skills, knowledge and experience required to fulfil that demand. It also includes identifying and supporting the development needs of each member of that practice team and managing their performance.

The partners or senior project managers are responsible for meeting the overall requirements of their respective clients – both to understand and agree their priorities and then to deliver agreed outcomes against the negotiated delivery schedules.

Appropriate resource planning tools are essential to maximise the productivity of the overall team and ensure that the right skills are identified and allocated to each assignment. The planning tool also needs to ensure that each individual's work portfolio provides agreed personal development opportunities and captures the relevant information for to support formal performance review processes.

Where the S&T team currently relies heavily on external consultants to provide the necessary expertise, the future arrangement should be designed to create a valued opportunity throughout all the partner organisations to rotate high performing staff on a secondment basis. Such a rotation process will maximise knowledge transfer around NWL, increase the depth of understanding between organisations and accelerate the culture change towards a more collaborative environment.

Recommendations

6 Develop the Strategy & Transformation Team into a power house for innovation across NWL that is capable of supporting both the transformation programme and needs for specialist consultancy to support CCG local priorities

6a) review the organisational design of the S&T team to capitalise on standard business models adopted by typical professional service organisations. (October/November 2015)

6b) build in-house critical mass in key practice areas within S&T, and reduce dependence on external consultancies for all but highly specialist areas. (To March 2016)

Recommendations (continued)

6c) refocus the programme office within S&T to identify a common consistent methodology for all plans and to build support around a programme of gateways at which interdependences are fully interlocked (December 2015)

6d) develop key skills to oversee within a revised S&T team, working in partnership to prioritise and co-design the new process standards. (Agree the key practice areas by Jan 2016 and resource by March 2016)

6e) establish a secondment regime into the revised S&T, designed to support development needs for leaders identified with high potential, as well as to meet the programme needs, and use this dynamic resource to catalyse the cultural change towards a more collaborative working environment.

6.0 Appendices

6.1 Methodology of the review

6.1.1 Approach

The following describes the framework for this review, providing an overview of the technical approach as well as a description of how each of the review questions were addressed. The core questions for the review were as follows:

- Is there clarity around the shared purpose? Has it changed?
- Where does the authority come from?
- Where does accountability sit?
- Where are the difficult conversations held?
- How is strategic risk identified and managed?
- Where is the neutral system-wide ground where non-partisan conversations are held?
- Is the composition of the governance structure right?
- What is the business model to support implementation?
- How does the programme get assurance of delivery against plan?
- How is operational risk identified and managed?
- In evaluating the evidence against both, these questions have been used as the basis to offer a qualitative opinion of strengths and weaknesses.

A mixed methods approach was used to gather evidence and provide insight relevant to these questions. This included the following methods:

- document review;
- online survey;
- semi-structured interviews; and,
- focus groups.

Document review

A review of programme-related documentation was an important part of this work. It helped to inform data collection, through the development of the review tools and refinement of the review questions. It was important for the review team to analyse and understand the plans and activities of the SaHF programme, including the business case for it. This helped ascertain the consistency and complementarity of the plans with the overall programme objectives. In addition, a review of documentation related to the issues that have arisen during the design and pilot stages, which might have had an impact on the implementation stage, helped identify further lines of inquiry to be addressed in the review.

Online survey

An online survey was undertaken in order to gather quantitative data, and used to ascertain participants' views about the SaHF programme. The survey was used to clarify respondents' understanding of SaHF's objectives, their aspirations for the programme and engagement with it thus far. Although the survey responses were anonymous, in order to establish trends across the programme, survey respondents were asked to fill in some basic information about their roles in the programme. A total of 152 responses were received for the survey.

Semi-structured interviews

In-depth interviews were conducted using interview guides. Interviewees were drawn from senior leaders from each of the CCGs, relevant partner organisations, stakeholder groups and members of the programme team. The interviews were used to dig deeper into some of the elements identified by the documents review, and explore perceptions of SaHF's objectives, governance arrangements and the manner in which each party addresses any tensions and conflicts between their individual organisational autonomy and their mutual agreement to work as part of a shared endeavour. The majority of interviews were 1:1, although a small number of the external stakeholder groups involved two or three board members with complementary portfolios (e.g. a chief executive, finance director and medical director). We conducted 62 face to face interviews. These interviews were structured into two groups – an initial group of 5 interviews to clarify our lines of enquiry, following which we reviewed the feedback and revised the topic guide and analytical framework, ensuring that we maximised the learning in the subsequent interviews. Each interview lasted typically 1 hour, with some interviewees giving sufficient importance to the conversation to dedicate up to 90 minutes as necessary. These were confidentially recorded and then summarised to ensure that opinions elicited were accurately captured. All interviews followed the principles documented in a code-of-practise guide based on best practice standards of ethical research. Recording of interviews was also subject to the agreement of the interviewee.

Focus groups

The Focus groups consisted of between six and nineteen participants brought together to discuss the issues raised from the other data sources. The discussions typically lasted around 1.5 hours, during which specific lines of enquiry were delved into. The participants comprised staff from CCGs and partner organisations, service users and other interested groups from the relevant localities. A total of 3 focus group meetings were conducted for this review, the make-up and details of which were agreed upon with the programme team. These were also recorded and summarised to ensure that the opinions elicited were accurately captured. Recording of focus group meetings was subject to the agreement of participants.

6.1.2 Data analysis, triangulation and synthesis of findings

The information collected from the individual review methods described above, were subjected to thematic analysis; the main component of this approach was the "thematic framework", which categorised, organised and presented the data under key themes. This framework was constructed using NViVo software. We summarised the data into the framework to allow comparisons both within and between data sources, therefore enabling us to gain an in-depth understanding of the key issues and current priorities. Once the data was organised and reduced into the framework, analysis take place to establish:

- any differences in interpretation of the shared purpose across the partners;
- any suggested changes to the governance structures that will help strengthen confidence and assurance in future success;
- suggested delivery structures and identification of key leadership roles (including outline responsibilities) required in the delivery team;
- areas where key meetings would benefit from a change in emphasis or membership, supported by recommended revisions to terms of reference;
- areas where levels of knowledge and/or shared understanding need to be strengthened, listing proposed topics for investment in development/training;

- identification of areas where metrics could be improved/ refocused to provide better visibility of progress.

During the course of the review, emerging findings and themes were discussed with the SRO so that they could be clarified, amended or further developed as required. This provided opportunity to target additional evidence gathering, consider alternative interpretations or correct any misunderstanding. In particular, this provided opportunity to ensure suitable balance, agree the appropriate emphasis to be given and avoid the use of unfamiliar language or idiom where this could provide unintended barriers to its acceptance.

6.2 Recommendations – details

Recommendations

1. Revisit and clarify the shared vision and purpose of the SaHF programme and develop this into a strong narrative, taking full advantage to reflect the changes in context:

1a) refreshed vision and purpose to be completed before the 2016/7 commissioning cycle ramps up (October 2015).

1b) each partner organisation should take the output from (1a) and develop this into a locally owner narrative illustrating their own contribution to the integrated service, the overall joined-up system, and the revised nature of their critical stakeholder relationships. (November 2015)

1c) adopt a co-design approach to develop the individual narratives from (1b) into a system-wide narrative which has visible connection to the current idiom and NHS-wide learning available from the 5 yr Forward View Vanguards and similar initiatives. (December 2015)

1d.) build a comprehensive communication infrastructure for the programme (October 2015)

1e). co-develop 6-8 clear and bold statements of success by which the programme will be proud to be judged and will embody both the aspiration and commitment to the vision and its positive impact on the communities of NWL.

2. Invest in an OD programme for at least the top 200-250 senior managers across partners in NWL.

2a) the OD programme to be scoped in Sep 2015, to run to March 2016

2b) the OD programme should be designed to support identification and development of the new enablers and culture to support SaHF, but should not be used as the vehicle to focus on the operational elements of SaHF (i.e. plans, decisions or design of the programme).

Recommendations (continued)

2c) explore potential for closer working relationship between NHS and London Boroughs within the OD programme – e.g. to focus closer working around the implications for public services of the SaHF programme (by January 2016)

2d) consider using Action Learning Sets within the OD programme to co-develop further detail against other recommendations in this report.

2e) ensure that as part of this OD programme, senior leaders regularly host and sponsor multidisciplinary/ multi-agency knowledge sharing / learning opportunities.

3 Realign the overall transformation programme into three distinct streams

3a) create a single programme of work focused on the localisation of care wherever possible, by merging the existing integrated care, out of hospital and whole system integration activities, (by December 2015)

3b) create a new infrastructure programme tasked with supporting the introduction of business and management processes orientated towards the collaborative system-wide working environment required by the programme: - to identify, set standards and co-ordinate the development of new processes that reflect the future needs for greater transparency, stronger assurance and accountability, and more distributed decision making. (scope and establish the new programme November 2015)

3c) develop the learning and support infrastructure to define stronger standards, encourage innovation and replicate best practice to accelerate pace of change with the localised services. (by March 2016)

3d) strengthen the emphasis on clinical quality and safety within the acute reconfiguration programme so that it is more strongly focused on outcomes, than on location and premises.

3e) pursue the current mental health transformation programme to gain traction, but agree how and when to merge the specialist and local elements into the relevant programme streams.

3f) ensure that there is strong cross-programme engagement between the localisation and the acute reconfiguration programmes to ensure effective whole system working.

4 Redesign the governance structures for the programme to strengthen accountability and support more collaborative working, including stronger representation from Local Authority partners

4a reposition the Collaboration Board as part of a network of advisory bodies with responsibility to provide considered recommendations to the statutory bodies, based on the strategic proposals from the Clinical Board and the implementation recommendations from the Delivery Board.

Recommendations (continued)

4b) develop an equivalent Board for providers focusing on strategic capacity and capability at which providers work together to develop a shared understanding of whole systems working (ideas for the governance and responsibility of this body could also be an output from the OD programme - by January 2016).

4c) establish an equivalent forum at which the NW London Boroughs can work together to ensure that the programme can benefit from more effective political leadership in NWL to achieve overall goals that are widely accepted

4d) build the delivery programme around small, empowered task and finish groups reporting into the gateway deadlines. (ongoing)

4e) establish the critical interdependences between the different streams of the programme and important implementation milestones, and produce an overall interlocked programme plan of key "gateway events" by which to manage the programme.

4f) identify independent "gateway" owners drawn from the senior managers throughout NWL, with assigned accountability for all resources involved in successful implementation of that critical project deliverable,

4g) establish a delivery governance regime adopting the principles of matrix management in which the delivery board is populated by the workstream owners, the project owners and key functional roles such as the medical director and OD director (by December 2015)

4h) work with in the OD programme to co-develop a comprehensive risk strategy for system-wide working across NWL (December 2015)

4i) establish a core risk management process and a risk committee with programme level ownership within which to manage strategic risk, and assess the cumulative impact of operational risks. (February 2016)

4j) consider involving NEDs and lay governors in each of the key governance structures

5 Identify one (or more) symbolic deliverables that bring all programmes together and can be used as a flagship over the next 6 months to demonstrate real impact at a system level (e.g. consistent performance against winter pressure) (identify by September/October 2015)

Recommendations (continued)

6 Develop the Strategy & Transformation Team into a power house for innovation across NWL that is capable of supporting both the transformation programme and needs for specialist consultancy to support CCG local priorities

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6e) establish a secondment regime into the revised S&T, designed to support development needs for leaders identified with high potential, as well as to meet the programme needs, and use this dynamic resource to catalyse the cultural change towards a more collaborative working environment.