



Making local health economies work better for patients

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Introduction from the programme chair

As stated in the 'NHS Five Year Forward View',¹ there are a number of challenges facing the NHS today – increased demand from a growing and ageing population, management of long term conditions and increased treatment costs. In many local communities these challenges are even more pronounced due to the service and clinical issues particular to them.

The tripartite partners – NHS England, Monitor and the TDA – came together earlier this year to undertake an exercise to identify the most challenged local health economies (LHEs). These were the areas whose healthcare organisations were in most need of intensive support in order to develop robust strategic plans that were both clinically and financially sustainable over the next five years. We agreed to jointly fund some additional help for the 11 areas we had chosen in developing their five-year strategies.

We were confident that by investing this additional time and resource these areas could focus on the scale of current challenges and future opportunities, consider the local health community-wide strategic solutions and models of care that would deliver sustainability, and plan to adopt them collectively and as individual organisations. We believe these LHEs are now better placed to deliver high quality services to their patients in the medium and longer term.

All the partners recognise that there is no one size fits all solution for every local health economy, however there are common barriers and solutions which have emerged during this project. This programme of work has also highlighted how effective LHE-wide planning processes can be in building the strong working relationships between multiple organisations needed to uncover and solve long-standing issues, ultimately for the delivery of better care for patients.

We developed this report in the hope that it will provide useful lessons and insights into common challenges being faced by other LHEs, as well as giving a springboard to others in developing, or further developing, sustainable solutions for the future. Often those solutions start with a clear vision, being able to talk to each other honestly. Most importantly, they put the needs of the patient first. Our hope is that it will help all providers and commissioners improve how they work together to deliver better quality healthcare services for all patients, both now and in the future.

Sarah Pinto-Duschinsky, NHS England, Chair of the Intensive Planning Support Project Board

¹ NHS England (2014) 'Five Year Forward View' www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Executive summary

A need for radical change in healthcare services

The NHS is facing a significant financial challenge. Current trends in funding and demand will create a gap which projections² suggest could grow to £30 billion a year by 2021 if nothing is done to address it.

In order to help address this challenge, Monitor, NHS England and the NHS Trust Development Authority (the national partners) launched co-ordinated planning guidance in December 2013 requesting commissioners and providers to develop five-year strategic plans by June 2014. They asked NHS commissioners and healthcare service providers in designated areas, referred to as local health economies (LHEs)³ in England, to develop five-year strategic plans and detailed two-year operational plans, rather than the annual plans they had produced previously.

This move to a longer term planning horizon is to enable commissioners and providers in each LHE to plan and carry out radical structural changes in local health services, so they can meet patients' diverse, changing and growing healthcare needs within the limits of the available funding. However, the strategic planning process is just the start of the journey. Implementing such complex change and delivering improved results for patients is an ongoing process.

The Intensive Planning Support Programme

The national partners had concerns about the ability of commissioners and providers in a small number of LHEs to submit sufficiently robust and aligned plans by the June 2014 deadline. As a result, the national partners decided to appoint external advisers to support 11 challenged health economies with their planning processes. By working together, the national partners drew attention to the need to address the structural problems across the health economies.

As part of the work to improve these plans the national partners developed the Intensive Planning Support Programme (IPSP) to deliver additional support where it would have the greatest impact. The support was designed to identify solutions that fixed the problems within the health economy and helped ensure commissioner and provider plans were aligned and deliverable. The plans were submitted to the national partners in late June 2014.

The national partners believed that lending additional support to these 11 areas during the planning process would mean that these areas would be more able to

² NHS England (2014) 'Five Year Forward View' www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

³ A health economy is a designated geographic area containing multiple healthcare organisations that between them have numerous financial and clinical interactions.

head off any potential problems that might occur in the years ahead, avoiding costly major intervention further down the line.

The work so far has already helped the healthcare organisations in the 11 LHEs achieve a common case for change, and improved working relationships and progress towards sustainable services. The work has also shown how important it is to maintain momentum for improvement and to harness the skills and efforts of everyone involved.

The 11 LHEs, which include around 40 providers of NHS services and over 35 commissioners, were: Cambridge and Peterborough; Cumbria; Devon; Eastern Cheshire/Southern Sector; East Sussex; Leicestershire; Mid Essex; Northamptonshire; North East London; Staffordshire; and South West London.

The external advisers worked with local commissioners and providers across each health economy to explore the options for the future shape of healthcare services within the area and to reach consensus on a clear way forward.

What we found across the 11 challenged health economies

The programme had a number of positive effects, for instance the plans submitted by the health economies were, in most cases, aligned and had quickly made significant advances. The majority of the challenged health economies still need to develop their solutions further if patient services are to be clinically and financially sustainable into the longer term.

In most of the LHEs, the five-year plans are not yet sufficient to meet the scale of the local challenge and there is further work to do to close the financial gap fully. Either this means the proposed cost improvement programmes need greater definition to ensure they are deliverable, or there is still a financial gap to bridge and further solutions are needed. If the plans already include all reasonable efficiency improvements, then increasingly radical changes need to be considered.

All 11 LHEs need to put in place more robust arrangements to deliver the necessary changes. Establishing effective cross-LHE working is crucial to making sure the plans are delivered successfully. The majority of the challenged LHEs still need to finalise and implement strong governance and leadership arrangements to drive forward their change programme. They also need to build greater local capability and capacity to support the change programme.

The scale and complexity of the challenges mean that organisations across the LHE will need to work together to make the changes happen and for most this will involve some changes to their current ways of working. This represents a significant leadership challenge which cannot be left solely to the most senior leaders. Everyone has a part to play.

Lessons for the national partners

On a number of occasions throughout the IPSP the national partners received feedback that their working together on this issue added additional urgency and weight to the strategic planning process across the LHE. It was helpful for the LHEs to have, in effect, singular, joined-up national oversight.

The national partners can encourage improvement in strategic planning by forming stronger links with local area teams and LHE leaders at the front line, developing clearer measures of performance, clearly setting out the joint regulatory and oversight approach and processes, and by providing additional support to developing LHE leaders.

Lessons from the programme show successful LHEs will be those that:

- understand the challenges in securing clinical and financial sustainability
- articulate a clear case for change, based on the benefits for patients
- engage extensively with patients, the public, stakeholders and staff during both the design and delivery of change programmes
- enable clinicians to take a leading role in the design and delivery of change programmes
- prepare robust implementation plans and provide the appropriate resources for the delivery of change
- ensure the right capability and capacity are in place for managing complex changes
- promote the right leadership behaviours to drive change forward, putting the interests of patients and carers above the interests of individuals and organisations.

1. The characteristics of a challenged health economy and the need for change

A number of common themes and trends were identified across the 11 LHEs that defined them as 'challenged'.

1.1. Structurally unsustainable healthcare services

All 11 health economies have a pattern of healthcare services that is unsustainable in its present form. This could be due to a wide range of factors, such as the distribution of clinical services across sites, the inherited costs of capital investments, services operating at a scale that is insufficient to meet quality standards or skill gaps that cannot be filled. Whatever the historical reason, the structure of current

services means that operating costs are greater than the income and the funding gap cannot be bridged by efficiency savings alone.

1.2. Solutions that will need a system-level response

In order to address the sustainability challenge, providers and commissioners within the health economy need to work together because changes will be needed across the whole patient pathway. This requires the involvement of everyone who plans for and provides health services, including commissioners, local authorities and providers. In essence, the solution cannot be found at individual organisational level, rather it can only be found by agreement at LHE level. Often this involves changing the way health services are delivered, and possibly, who delivers them. Without agreeing these tough decisions the services will remain unsustainable.

1.3. Difficult decisions that have been deferred for many years

In challenged LHEs there is often a history of deferring the resolution of structural issues. This has resulted in short-term or one-off fixes rather than making difficult decisions to reach sustainable, long-term solutions. This is one of the reasons that the three national organisations set out a longer term planning horizon, enabling LHEs to address these difficult and complex structural issues over several years.

1.4. The scale and complexity of the challenge

As a result of the structural problems with existing services, all 11 LHEs require significant change to provide services that are clinically and financially sustainable. The scale and complexity of the challenge mean that external planning support of varying degrees is needed to help develop solutions and prepare for the major changes ahead.

1.5. A history of reliance on external financial support

The history in challenged LHEs shows that deferring decisions about change has meant they have become reliant on external financial support. This approach of looking to the rest of the NHS for financial support is no longer sustainable, particularly given the financial outlook over the next five-year period.

1.6. Lack of consideration of the implications of the Better Care Fund

The Better Care Fund (BCF) is an attempt to help integrate services, giving patients a more seamless journey through the NHS and social care while also helping to create higher value and radically different ways of delivering care. Plans for the (BCF) are a critical element of strong five-year plans. In challenged LHEs, it is not always obvious that the service reorganisation and financial implications of the Better Care Fund have been considered in local healthcare organisations' preparation of their five-year plans.

2. How strategic planning has created the foundations for change

Co-ordination between the long-term strategic plans of commissioners and providers is essential in addressing the structural issues that define a challenged health economy and help it to deliver quality sustainable healthcare services for patients. The commissioning strategy sets the agenda for change, but local providers, and all the other stakeholders in the LHE, must be involved in developing it. Providers can then align their strategies with the future direction of commissioning and deliver any necessary service changes.

2.1. Commissioners to set the agenda

Commissioners are tasked with buying healthcare services that meet the needs of the public they serve both now and for the long term. In order to do that, they need a clear, long-term commissioning strategy that defines the best ways of buying services to attain maximum value for patients, introduce new high value care models, and reconfigure services if need be. In the 11 challenged LHEs the IPSP found commissioners making rapid progress in developing commissioning strategies including all three elements.

2.2. Maximising value for patients and taxpayers

Maximising value for patients and taxpayers means buying services so they achieve better patient experience and outcomes for the same or lower amount of the local NHS budget, funded by taxpayers. To maximise value for patients, commissioners need to be pro-active in determining the types of services they want delivered in their LHE. Their greater certainty in turn creates greater certainty for providers, allowing them to plan to introduce new models of service that will deliver what commissioners want.

2.3. Reconfiguration and new care models

The models of care developed by LHEs include approaches to integrated care, with more person-centred, co-ordinated care to reduce duplication and gaps in services for people with complex needs that span multiple providers and care settings. This will mean expanding the roles for primary care, social care and self-care. In many LHEs this has resulted in the recognition that significant development of their primary care strategy and social care strategy is needed.

In some LHEs, the impact of a shared vision on individual services means that significant changes are needed to improve clinical adjacencies, manage patient flow through the system and strengthen the integration of care. This may mean that service reconfiguration is needed between settings of care and sites of delivery in order to secure the benefits for patients.

2.4. Providers can deliver increased efficiency savings and new organisational forms

Together commissioners and local providers need to tackle complex structural problems that require innovative solutions. The providers have to support change and this means their significant involvement in co-creating commissioners' strategic plans. That said, there are a number of areas where individual commissioners and providers can take steps to maximise value for patients and taxpayers, pushing forward innovative new approaches. They include:

- **Increasing organisational productivity and efficiency:** For example, merging administrative processes such as back office functions and outsourcing processes can both save money, increase the quality of delivery and increase economies of scale. This is true for commissioners and providers.
- **Improving service efficiency:** While it is recognised that challenged LHEs are likely to need structural change in order to become sustainable, there remains significant scope for improved efficiency within existing service provision. It is important that strategic plans include an expectation of reasonable efficiency improvements in each year of the plan.

The areas identified by LHEs for improved service efficiency include:

- moving towards best practice benchmarks for quality and productivity in areas such as emergency admissions, referrals from primary care and length of stay in hospital
- reducing duplication by sharing clinical support functions such as pathology and administrative support functions such as financial, estates and human resources services
- improving the utilisation of assets by optimising the space used for services and rationalising the estate in line with local needs
- increasing commercial income, which could include partnerships with industry on clinical innovation, on-site business activities and collaborations with other local service providers.

3. Overcoming the barriers to long-term strategic planning

Effective long-term strategic planning is part of the solution to the structural and efficiency problems putting the sustainability of patient services at risk, but not all LHEs are doing it well enough. Challenged health economies generally have a history of failed initiatives, plans and strategies to address the various concerns and problems associated with the location. This significantly undermines confidence

across the health economy and introduces weariness when it comes to yet another attempt to fix long-standing problems.

The IPSP identified and implemented a number of behaviours and processes that are helping the challenged LHEs to overcome these barriers.

3.1. Honest debate with clear communication channels

Understanding the challenge within the LHE requires open and honest debate that provides clarity about the size of the problem, the urgency of the situation and the shape of the solution. A shared understanding of the challenge helps to define the single vision that sets out the need for change. Honest communication also underpins positive engagement with patients, public and the media.

However it has been flagged at the local level that there is a perception by organisations within LHEs that being open and honest will disadvantage them in negotiations around service change, including with national partner organisations. The national partners can help to address this by increasing their own transparency and consistency, and by intervening to broker in negotiations.

3.2. Leveraging existing local agreement

The IPSP often saw organisations within the LHE not working together, not recognising a common problem and not taking ownership of either the problem or the solution. It also found difficulties with some organisations within the LHE not regarding themselves as part of a system. On occasion there was a tendency for the less financially challenged partners to want to remain on the periphery of finding solutions. In particular, the IPSP found financial disparity between NHS trusts and foundation trusts brought added complexity.

Where the challenged health economies already had ongoing programmes of work the IPSP made progress more quickly than in others.

The most effective elements of existing programmes were:

- an existing LHE agreement on strategic direction – a clear vision
- clear diagnosis of the challenge at hand based on a structured methodology and robust financial analysis agreed by all partners. Agreement around the underlying data provides a solid baseline to develop a set of standards and assumptions for modelling solutions and delivering appropriate options for change. It also provides clarity on the LHE challenge and aids options analysis
- a collective (health economy wide) and individual organisational ownership of the challenge

- existing good working relationships between individuals and partner organisations across the LHE
- governance arrangements already in place from an existing or previous programme.

3.3. Working closely with stakeholders, particularly clinicians, patients, politicians and the public

Being clear at the start of the process how these particular groups will be involved in the process of creating new ways of delivering healthcare services is fundamental to making services work for patients.

The IPSP noted some inability to gain political and public agreement and support for service change that begins to fix the LHE's problems. This creates a perception which leads to organisations within the LHE putting aside or delaying necessary changes and a bias toward short-term thinking – characteristic of working in a challenged health economy.

Engaging well means engaging early and often, with a clear and documented structure for feeding views into the LHE planning process. Organisations in LHEs should be looking, where possible, to co-create service change, share evidence and take tough decisions in partnership.

There is a legal obligation to show how the public's views are being taken into account and included in the options development. Close working promotes a speedy and effective consultation process that limits the risk of judicial review.

3.4. A clear shared vision across the LHE

Individual organisations within a health economy may have a clear vision for their future direction but these may not be aligned across the health economy. Conflict between competing visions has negative effects on the LHE's ability to tackle long-term structural issues.

Under the IPSP, LHEs were more successful when they were able to articulate a shared vision of how to address the structural problems affecting their healthcare system. This was achieved by agreeing the predicted financial gap, setting a clear understanding of the health services their populations need now and in the future, and aligning their individual organisational visions. By agreeing a vision, providers are given the certainty that allows them to deliver more organisationally radical and higher value services.

3.5. More effective shared governance structures

The process for developing a five-year commissioning plan includes outlining an LHE vision that could include necessary service change. Organisations in a challenged health economy are less likely to be able to agree a way forward as they

tend not to have effective health economy-wide governance structures, and lack trust and strong relationships between organisations and personalities. All of this hampers their ability to work together.

The changes needed to make services sustainable will clearly have an effect on staff and organisations, with some feeling as if they are 'winners' and others, 'losers'. Sometimes a service change or a change of location will be seen as a disadvantage to one organisation or team and an advantage to another. This means that leaders will need to challenge themselves and their colleagues, to put the interests of patients above the interests of individual organisations and professions.

Governance structures that reach across the LHE are necessary to agreeing a shared vision and in delivering the outcomes of the strategic plans post submission. They also help to define the leadership structure, offer credibility to system leaders and define the roles of commissioners and providers in delivering the plans.

The three national partners working together has drawn attention to the need for local organisations to work together and develop a system-wide response to addressing any structural problems. This form of national working has given a boost to overcoming LHE process fatigue.

3.6. Supported leadership and increased capability

Across the 11 challenged LHEs, the IPSP often saw a lack of teams with the right skills to take on the challenges. We found that chief executives were often pulled into dealing with day-to-day problems, giving them very little capacity to think creatively about the future. Another challenge is to find leaders that are credible with both providers and commissioners. There are without doubt excellent leaders within individual organisations but the difficulty is in stepping up to bridge the traditionally separate spheres.

In addition, the NHS structure of clinical commissioning groups (CCGs) is new and CCGs are still coming to terms with their remit. Challenged health economies may have new leaders who are getting to grips with their organisation while the planning process is under way.

The problems faced by these LHEs are growing more complex and so are the solutions. The processes involved in drawing up a long-term commissioning strategy and aligning provider strategies are difficult and can be misunderstood. Providers and commissioners have to take on national guidance across a range of different areas, further increasing the complexity of planning for both groups. At the same time the NHS is having to deliver increasingly tough efficiency savings year on year.

Not only is it difficult to find enough people with the right skills mix to be leaders across the health economy, these posts may be less attractive due to the high risk and time commitment associated with cross LHE leadership, especially within an LHE known to be challenged.

The IPSP found that providing support such as leadership development masterclasses and expert support in developing financial and clinical modelling, as well as establishing transformational cross-LHE teams helped to address some of these problems.

The national partners have set a clear direction of change for the NHS in the 'Five Year Forward View'⁴ which should, alongside updated planning guidance, help clarify the changes needed across LHEs and give LHE leaders a platform on which to deliver change.

3.7. Clear implementation plans

Most five-year commissioning plans will not reach the point of naming sites and the services to be delivered. This tends to be the point at which relationships carefully built up over the course of the planning process, for example between healthcare organisations, politicians and the public are perceived as likely to face the most challenge.

Clear implementation plans help maintain momentum and give confidence to those responsible for delivery. They set out the implications for individual organisations and the actions that each need to take to deliver the changes to the wider system of care.

They can also provide clarity around the role of national NHS organisations within the process, providing an opportunity for regulators to combat misunderstanding of rules (especially around competition).

4. The Intensive Planning Support Programme design and next steps

The IPSP was designed to facilitate health and social care organisations to work in partnership to diagnose the underlying causes of the problems they face, build a case for change and design sustainable services to meet the needs of patients in the medium to longer term.

The key phases arising from each stage of the programme are set out below.

4.1. Diagnosing the problem

The first phase of the work with challenged LHEs was to carry out a brief diagnostic review of the work already in place to enable organisations to prepare their strategic plans. The diagnostic reviews considered the existing position on demand assessments, the current pattern of service provision, the benchmarking of efficiency opportunities, and local capacity and capability.

⁴ NHS England (2014) The NHS Five Year Forward View www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

As a result of the diagnostic reviews, it was possible for LHEs to identify the strategic challenges, the barriers to sustainability and the opportunities. A summary of their findings is shown in Table 1, Appendix 1.

The strategic challenges identified by LHEs highlight that significant change will be needed in the care delivery system for it to be sustainable.

Nonetheless, significant opportunities have been identified; not least a strong desire for improvement, many examples of good practice and improved working relationships.

4.2. Developing solutions and preparing for implementation

The second phase of the work with challenged LHEs was to develop solutions and the third phase was to prepare for implementation. The results of the work in Phases 2 and 3 have been used as the basis for five-year plans by the constituent organisations. An extension to the programme, Phase 4, was also agreed in order to develop continuing governance arrangements for delivery.

The solutions were expected to include the agreed option for the future pattern of service provision, the impact of any proposed service configurations on the LHE, including financial and activity projections, and the results of engagement with patients and the public.

The preparation for implementation was expected to include support for commissioners and providers to develop a detailed implementation plan.

The continuing governance arrangements for delivery were expected to enable each LHE to maintain the momentum built up during the project and ensure that LHEs could continue to implement the solutions and actions agreed as part of the IPSP.

The types of solutions identified by challenged LHEs, their preparations for implementation and plans for continuing governance are summarised in Table 2, Appendix 1.

4.3. Taking forward the delivery of strategic plans for sustainable services

The national partners were determined that the investment in support for strategic planning should be followed by clear next steps for each LHE in taking forward their strategic direction. In addition to the preparation of five-year strategic plans, the next steps and further work required are being set out for handover to regional tripartite teams, so that there is continuity and follow up.

The IPSP has maintained a regular review of the risks to delivery, which will need to be managed effectively in the period ahead. The key risks are identified in the local plans for each LHE and are also being discussed during the handover of the national programme to regional tripartite teams.

It is important that the lessons from this round of strategic planning are learned not just by the challenged LHEs, but are available for the wider NHS. Hence, each LHE programme was asked to share the lessons learned during the past six months.

Table 3, Appendix 1 includes a summary of the overall risks, next steps and lessons learned, based on the reports and feedback received by the national programme.

The biggest near-term risk for this programme is loss of the strong momentum that has been developed over the past six months.

The most immediate next steps are, therefore, to ensure that the change programmes are picked up locally now that the external support has finished. This will be the focus of the handover discussions with regional teams.

4.4. Next steps for taking forward strategic plans

In the light of the conclusions above, the next steps in taking forward strategic plans in the challenged LHEs include:

1. **Taking forward the full design and implementation of the solutions identified.** There is a danger that the momentum for change will reduce now that the IPSP has been completed.
2. **Completing further work in the LHEs where clearly defined solutions have not yet been agreed.** Where the work in neighbouring LHEs has resulted in overlapping solutions being proposed, decisions need to be made about any realignment of their approach with neighbouring LHEs. Where a clearly defined pattern of services for the future has not yet been agreed, continued momentum is needed to ensure that strategic solutions for sustainability are completed.
3. **Strengthening the approach to patient and public engagement.** In most challenged LHEs, significant changes are needed to current services to put them on a sustainable footing. These changes will need to be taken forward with the full and inclusive engagement of patients, the local community, clinicians, other staff and stakeholders. The well-established good practice for managing service change (<http://www.england.nhs.uk/2013/12/20/gd-practice-guide/>)⁵ needs to be adopted by all those involved in taking forward strategic plans.
4. **Further developing leadership capability and capacity to support the change programmes.** The complexity of the changes highlights the importance of strong leadership, with clear and consistent communications about the vision and benefits for patients, alongside behaviours that put the needs of patients

⁵ www.england.nhs.uk/2013/12/20/gd-practice-guide/

and clinical services above the interests of particular individuals or organisations.

5. **Strengthening the approach to partnership working in each LHE.** This includes building the confidence of commissioners, stakeholders and providers to work together, while retaining their respective roles and ensuring senior commitment to the arrangements for partnership working.⁶
6. **Strengthening the practical support for partnership working,** including the agreement of lead responsibilities for programmes across the LHE and the establishment of programme management resources.⁷
7. **A minority of health economies have for some years been in significant difficulty,** and have struggled to develop and implement credible plans to recover their position. NHS England, Monitor and the TDA will continue to work together in 2015/16 to offer further support for these systems.
8. **National partners need to support LHEs** in communicating the benefits of change to politicians so they in turn can advocate for change

Appendix 1. Summary of results from each phase of the Intensive Planning Support Programme

See the three tables on following pages for a summary of the results.

⁶ NHS England (2014) 'Five Year Forward View' p. 25 www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

⁷ NHS England (2014) The NHS Five Year Forward View p.29 <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

Table 1: Challenges, barriers and opportunities identified by LHEs in the diagnostic reviews

Strategic challenges	Barriers to sustainability	Opportunities
<p>Re-balancing the care delivery system</p> <ul style="list-style-type: none"> • Patient pathways do not maximise the benefits of integration • Emergency care is an increasing proportion of activity compared to elective care • The balance between acute and community services is sub optimal • The quality of primary, community and social care is sub optimal <p>Creating a fit-for-purpose service infrastructure</p> <ul style="list-style-type: none"> • The scale of services is sub optimal • Additional costs are incurred to run services across several sites • High estates spend due to private finance initiative (PFI) contracts and the estate not fully used • Loss of elective work to other providers • Impact of change in other LHEs • Skill shortages and recruitment difficulties • A need for service re-configuration 	<p>The environment for sustainability</p> <ul style="list-style-type: none"> • Effect of geography on recruitment and retention • Complexity due to the number of stakeholders • Uncertainty about the impact of tendering for services • Uncertainty about the impact of specialist commissioning plans <p>Reaching agreement about future direction</p> <ul style="list-style-type: none"> • Absence of an overall clinical vision and model of care • The need to clarify supply-led issues (change within providers) versus demand-led issues (to reduce avoidable admissions) • Case for change not fully understood • Limited capacity and capability for strategic planning and delivering a major transformation 	<p>Ambition to rise to the challenge</p> <ul style="list-style-type: none"> • Ambition, desire and determination to address the challenges • Stakeholders have a clear view of the challenges faced <p>Improved working relationships</p> <ul style="list-style-type: none"> • Relationships across the organisations have improved • CCGs and providers coalescing around a key set of programmes such as integrated care <p>Knowledge of how to recover</p> <ul style="list-style-type: none"> • Productivity changes in the hospital • Resolving concerns with the urgent care pathway • Primary care transformation • Acute reconfiguration plans <p>Good practice achieved to date</p> <ul style="list-style-type: none"> • Areas of good practice including the integration of services, personalisation of services, single point of entry and multidisciplinary teams

Strategic challenges	Barriers to sustainability	Opportunities
<p>Optimising service performance</p> <ul style="list-style-type: none"> • Variable performance on key quality indicators • Integration has not yet yielded the necessary savings • Inefficiencies and low productivity in certain clinical services • Sub optimal lengths of stay in hospital <p>Strengthening leadership capability and capacity</p> <ul style="list-style-type: none"> • Focus is on hospitals rather than the wider system • The Better Care Fund is not yet fully targeted on the priorities • Solutions not radical enough to meet the challenge 	<p>Communications and engagement</p> <ul style="list-style-type: none"> • Solutions may destabilise individual providers • Previous failed attempts at service change have delayed progress • Public acceptability of potential solutions <p>Leadership capability and capacity</p> <ul style="list-style-type: none"> • A need for more visible clinical and organisational leadership • A lack of alignment between organisations • Limited track record of successful delivery of change programmes • Focus is currently on short-term problems only • Limited focus on execution and delivery of plans 	<ul style="list-style-type: none"> • Some foundations in place to help deliver system change as demonstrated by recent service reconfigurations

Table 2: Solutions identified by LHEs and preparations made for implementation

Proposed solutions	Preparing for implementation	Governance of delivery
<p>Re-balancing the care delivery system</p> <ul style="list-style-type: none"> • Prevention: maintaining independence; healthy living and wellbeing initiatives; early access to screening and prevention; raise 111 public profile; supported self-care and prevention in all pathways • Out of hospital care: pro-active care for people with long-term conditions/frail elderly/end of life; rapid response; admissions avoidance; enhanced primary care; improved use of community hospitals, mental health and outpatient services • Elective care: greater use of ambulatory care; theatre efficiency; enhanced recovery; greater day case delivery • Urgent and emergency care: improve patient education on best use of urgent care; single points of access; implement national strategy/ pathways • Specialist services: rationalising services into fewer specialist centres to improve quality <p>Creating a fit-for-purpose service infrastructure</p> <ul style="list-style-type: none"> • GP practice options to merge, federate or network on a locality basis to create physical or 	<p>Creating the environment for sustainability</p> <ul style="list-style-type: none"> • Communicating the case for change, considering quality and population health gaps and the projected financial position • Anticipating and managing the politics; and creating an environment where compromise is possible • Extensive engagement of clinicians in developing the strategy and implementation • Extensive public, patient and stakeholder engagement during design and delivery <p>Implementation planning</p> <ul style="list-style-type: none"> • Further development of the strategic solution • Detailed design of models of care • Recommended future service configurations, with travel time modelling and implementation plans for the next 9 months up to statutory consultation and beyond 	<p>Agreeing governance systems</p> <ul style="list-style-type: none"> • Define governance, leadership and support requirements for the transformation programme • Establish cross-LHE governance, with decision-making arrangements agreed by key organisations • Develop further details on existing interventions, helping to mobilise the programme and drawing out the critical path over five years. • Condense plans into a short public-facing report • Identify how health and wellbeing boards will be involved • Show how changes to governance and resourcing will accelerate delivery • Establish programme structures, a roadmap for implementation, programme milestones and an approach to resourcing the programme

Proposed solutions	Preparing for implementation	Governance of delivery
<p>virtual community hubs</p> <ul style="list-style-type: none"> • Integrated working: of acute and community care; health and social care • Joint commissioning of nursing and residential care (via Better Care Fund) to increase the number of over-75 patients returning to their place of usual residence • Hot/cold split of elective and emergency care • Consolidation of services on fewer sites to improve co-location of clinical services • Greater use of shared services across the LHE, including pathology, back office, procurement and other clinical support functions • Improved asset utilisation (estates, workforce and information management and technology) • Improved use of technology; telephone/email consultations and follow ups <p>Optimising service performance</p> <ul style="list-style-type: none"> • Address primary care variability: variation in A&E attendances, prescribing spend and referral variances • In-hospital efficiency to reduce length of stay 	<ul style="list-style-type: none"> • Modelling of the financial and activity impact • Forecasting capacity requirements • Agreeing a clear financial bridge showing the savings year-by-year for the LHE to remain financially sustainable • Identify investment required for interventions • Define Better Care Fund investment in social care • Develop detailed implementation plans • Develop primary care strategy • Ensure alignment with NHS England specialised commissioning strategy • Ensure alignment of commissioner and provider plans • Work with providers outside of the LHE • Commence pilot programmes to kick start delivery. • Ensure clinical testing and public engagement. • Carry out 'proof of concept' to provide assurance that the plans will work 	<p>Building capability</p> <ul style="list-style-type: none"> • Identify capacity and capability gaps • Agree a clear resourcing structure to manage the programme • Support the Programme Management Office (PMO) in establishing the programme governance, provide guidance on the key documentation required and the processes which need to be in place • Build capability in the PMO team to develop key programme documentation, such as approvals processes, change control processes and a benefits framework • Identify best practice turnaround methods <p>Culture and behaviours</p> <ul style="list-style-type: none"> • Communicate the vision for the patch, articulate who is accountable for driving each of the transformational programmes, and provide an update on progress of each programme. • Identify the responsibilities of each individual organisation while maintaining collaboration • A series of honest conversations with

Proposed solutions	Preparing for implementation	Governance of delivery
<ul style="list-style-type: none"> • Improving discharge and reducing delayed transfers of care • Reducing costs using benchmarked efficiency opportunities including medicines optimisation; reduced agency and locum spend; order communications and product rationalisation <p>Providing enablers for improvement</p> <ul style="list-style-type: none"> • Enterprise and innovation zones, allowing budgets to be used more flexibly • Workforce transformation • Estate changes • Use of innovative technology • Incentives aligned to encourage change • New commitment of the leaders to work as a system • Building a strong coalition of clinical leaders to drive the strategy forward 	<ul style="list-style-type: none"> • Support development of capacity for delivery • Pathway re-design (approximately six months) • Implementation (approximately six months) • Benefits realisation (approximately one year) <p>Leadership of change</p> <ul style="list-style-type: none"> • a 'concordat' for change which sets out how the parties will work together • Development of communications plan for all stakeholders • Facilitation of collaboration between leaders of organisations to develop new delivery models • Decide the contracting approach • Visible and united leadership behaviour • Effective communication and engagement 	<ul style="list-style-type: none"> • stakeholders to improve capability and behaviours within the LHE • Promote alignment of plans across the LHE • Carry out organisational development • Identify the style of intervention, robust leadership and active engagement needed to drive change • Maintain momentum and sufficient pace in line with the direction of travel agreed • "The key issue is clinical engagement"

Table 3: Taking forward the delivery of strategic plans: key risks, next steps and lessons learned

Key risks	Next steps	Lessons learned
<p>Robustness of plans</p> <ul style="list-style-type: none"> • Clinical sustainability – the clinical model and the leadership of change are not owned and led by clinicians • Financial sustainability – the solutions do not provide sufficient financial benefit to close the forecast gap. <p>Engagement</p> <ul style="list-style-type: none"> • Consensus – the LHE is not able to obtain sign off to the preferred solution with all key stakeholders due to the contentious nature of the solutions. • Public and political pressure make the implementation of the preferred solution difficult <p>Capability and capacity</p> <ul style="list-style-type: none"> • There is insufficient capability and capacity in the system to fully develop and deliver the plan 	<p>Agree implementation plans</p> <ul style="list-style-type: none"> • Prioritise initiatives to take forward • Develop cross-LHE communication and engagement plans • Develop the financial case, showing implementation costs and detailed timing of savings for the initiatives • Further develop plans to fill gaps in long-term sustainability plans • Develop granular plans for cross-LHE transformational initiatives • Agree the implementation plans <p>Establish programme governance</p> <ul style="list-style-type: none"> • Embed cross-LHE governance • Agree lead responsibilities for cross-LHE transformational initiatives • Confirm the role of each workstream • Agree a clear resourcing structure to manage the programme 	<p>What went well</p> <ul style="list-style-type: none"> • More cohesion, coherence and collaboration across the LHE • Extensive clinical engagement in the design of the future solutions • A new governance structure that brought the LHE together • Joint national partner support helped leaders prioritise the issues and secure alignment • Resources for facilitation to enable problem-solving between partners, • Rapid pace helped buy-in: “you needed to be there so as not to miss anything!” • ‘Honest broker’ external support helped shift perspectives and build momentum • The creation of ‘one version of the truth’ to define the scale of the challenge has been a key catalyst for change

Key risks	Next steps	Lessons learned
<p>Culture and leadership</p> <ul style="list-style-type: none"> • Focus — lack of focus on longer term initiatives due to fire-fighting of short-term performance issues • Alignment – misaligned incentives as a result of winners and losers from change • Culture and behaviour – the silo way of working and unwillingness to co-operate may limit progress • Leadership – insufficient momentum and drive for change 	<p>Build capacity for delivery</p> <ul style="list-style-type: none"> • Continue cross-LHE focus and support • Identify how to build capacity for delivery • Commence pilot programmes to kick-start delivery • Build leadership and governance of the programme • Establish a substantive PMO with capabilities for major programme management 	<p>What could be improved</p> <ul style="list-style-type: none"> • Commissioner and provider plans less well aligned than expected • Earlier engagement of other LHEs with linked service reconfigurations • Information was less willingly shared due to tendering processes • Split responsibilities between national partners for project management caused complexity • Greater transparency of outputs by national partners would have built more trust • Clearer communication with local teams at the start would clarify the approach

Appendix 2. Equality and health inequalities statement

Equality and diversity are at the heart of our values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to:

- reduce health inequalities in access and outcomes of healthcare services
integrate services where this might reduce health inequalities
- eliminate discrimination, harassment and victimisation
- advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.