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NHS ENGLAND – BOARD PAPER

Title:

Progress on delivering joint working between NHS England and NHS Improvement

Lead Director:

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Purpose of Paper:

This co-authored paper sets out the work we are carrying out to strengthen and build on joint working between NHS England and NHS Improvement and our proposed next steps.

The paper:

- sets out the context of NHS England and NHS Improvement's future approach to joint working;
- sets out the design principles we have been using;
- seeks the Board's agreement for functionally integrated regional teams;
- seeks the Board's agreement to run national programmes and activities on an integrated or more closely aligned basis;
- seeks the Board's agreement to initial proposals for governance and accountability arrangements for integrated functions; and
- sets out the key enablers for further models of collaboration and joint working.

The Board invited to:

Review and agree to the proposals set out above, and endorse the next steps.

Background

1. There is a growing movement towards commissioners and providers working together across local health and care systems, to agree how best to use their collective resources to meet the needs of their populations and improve quality of health and care outcomes.

2. Over the past year, both NHS England and NHS Improvement have been working with a number of emerging integrated care systems (ICSs) that are going further in joining up health and care services to meet the changing needs of local populations. To support NHS commissioners and providers to work more closely together in the way envisaged in the *NHS Five Year Forward View,* and *Next Steps on the Five Year Forward View,* we have set ourselves the ambition of providing increasingly cohesive leadership for the NHS.

3. We also need to make changes to the way we work together in light of growing evidence of duplication between our two organisations. We know from our engagement with local health and care systems that our parallel systems, data and information flows, and in some cases, conflicting messages, can create considerable, and often unnecessary, complexity.

4. It is within this context that we are developing closer joint working between our two organisations to ensure that we speak to systems with one voice and to streamline, where possible, the oversight and support we provide.

What have we achieved so far?

5. The way forward set out in this paper builds on multiple existing examples of joint working to date, covering both national programmes and regional teams. These include:

   - Since September 2017, we have had **joint regional directors in the South region**, covering the South East and South West.
   - Since March 2017, we have had a **joint national director overseeing work on transforming urgent and emergency care and improving A&E performance and winter planning**, with the eight Regional Directors each (on behalf of both organisations) overseeing system performance for a set of STPs.
   - There are two **joint Regional Chief Nurse posts**, in London and the South.
   - We have appointed **a joint Chief Information Officer and a joint Chief Clinical Information Officer**.
   - There are also examples of **joint programmes** of work across areas such as mental health, cancer services, and support and oversight for STPs and ICSs.

6. From these examples, and other cases of collaboration to date, we have seen strong levels of support across our organisations for greater joint working. However, feedback has also indicated that to fully realise the benefits of joint roles, we need to more effectively align our organisations through supporting governance and accountability arrangements and by developing a shared culture

and set of values and behaviours. Detailed lessons learned are set out in **Annex A.**

Next steps for agreement

7. To deliver joint working across our organisations, we have agreed a shared set of design principles, set out in **Annex B**. In addition, we have been using a taxonomy framework, also set out in **Annex B**, to inform decisions as to where it is most effective to align our collective functions and activities.

8. In designing this work, we have been considering the following key questions:

   - **Opportunities for efficiency:** Could we take out costs and inefficiency by removing duplication or simplifying processes?
   - **Opportunities for effectiveness:** Could we improve our effectiveness by delivering a certain function or activity together?
   - **Legal considerations:** What legal constraints do we need to be aware of? (e.g., we know we need to retain separate Boards and that some specific functions, such as commissioning, may only be delegated to an NHS England employee)
   - **Organisational capability:** What is our current level of organisational capability in relation to a certain function or activity and could this be optimised by coming together?

9. We have agreed a series of priority areas where we believe that making changes to the way we work together will have the most impact in ultimately improving patient outcomes. These changes are set out below.

Changes to regional teams

10. Since September 2017, we have had joint NHS England and NHS Improvement Regional Directors in the South region, covering the South East and the South West. Both of the joint Regional Directors in the South and the local health and care systems that they work with have been positive and clear about the benefits of joint regional working, noting how the changes so far have enabled a more aligned voice to local systems and a reduction in duplication. The move to joint working in the South has also been challenging in many ways, and has generated significant learning (set out in more detail in **Annex A**) around the further work required to align our respective organisations, specifically in relation to developing less duplicative governance and accountability arrangements, as well as improving the interface between regional and national teams.

11. In other regions beyond the South, NHS England and NHS Improvement Regional Directors and their teams have been working together in multiple ways, including through adopting more aligned approaches to oversight and assurance of urgent and emergency care, supporting STP and ICS development, and adopting aligned approaches to quality surveillance (particularly through the two joint regional directors of nursing in London and the South).

12. In light of this learning and our broader engagement with local health and care systems, we are now proposing a new integrated regional model across all footprints, the details of which are set out below.

<table>
<tr><th colspan="2">PROPOSED CHANGES TO REGIONAL TEAMS</th></tr>
<tr><th>Area</th><th>Detail</th></tr>
<tr><td>Integrated regional team</td><td>This new integrated model will involve:
Joint regional teams led by a joint Regional Director, working for and reporting into both NHS England and NHS Improvement in a particular regional footprint.
The functions within regions will be integrated – e.g., there will be one Regional Finance team, reporting to a Regional Finance Director. These teams will in some places contain specialist functions more closely allied to one ‘parent’ body or the other (e.g., direct commissioning), but these roles will still be part of one integrated regional team with a single reporting line. This will serve to minimise complexity in the regional teams, and facilitate integrated working with integrated care systems and STPs.
Professional functional relationships will continue to be managed by the national teams, organised in line with the parallel changes we propose making to national teams (subject to Board approval) as set out in the following section of this paper.
The work of the joint regional teams will be overseen by a joint governance mechanism (details of which need to be developed further) made up of a subset of Executive Directors from NHS England and NHS Improvement.</td></tr>
<tr><td>Role and functions</td><td>As part of a new integrated regional model, we are proposing changing the way in which regional teams work by moving to a more aligned approach across the following five key areas:
Assurance & intervention of:
Finance
Quality
Operational performance
Improvement and intervention capability
Leadership development and support
System leadership and development of STPs and ICSs
Change management
Beyond these areas, there are many further existing regional functions including direct commissioning and Emergency Preparedness, Resilience and Response (EPRR) which will need to continue to be carried out within the new regional model.
Through this process, we want to strengthen the role of regional teams and their responsibility and accountability for the five key areas listed above. As such, under this new model, the role of the Joint Regional Directors will need to combine the ability to oversee and support both providers and commissioners, in addition to providing leadership to enable local health and care systems to work more jointly together. This role therefore requires very advanced relationship management skills, an ability to handle complexity and manage outside organisational boundaries, an extensive technical understanding of the system, and an ability to manage both strategic and delivery functions.</td></tr>
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<table>
<tr><td>Footprints</td><td>Based on learning from our current regional model and the complexity of supporting systems across large geographies, we are also proposing splitting the current regions into seven:
• North – region to be split into two
• Midlands and East – region to be split into two
• London
• South East
• South West
We are currently working with the regional teams to explore different options for the proposed new footprints and will provide further detail within our next Board update.</td></tr>
<tr><td>Timeline</td><td>• Subject to Board approval, we propose moving to this new regional model from September 2018.
• We are developing more detailed plans for how to make these changes (subject to Board approval) in time to manage next Winter effectively.</td></tr>
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Changes to national programmes and activities

13. There are several priority areas where we believe better alignment and in some cases, integration of national programme teams and activities will reduce duplication and enable us to make better use of our collective resources to better support local health and care systems.

14. Learning from the South region and other examples of joint working indicates that it is not possible to fully realise the benefits of an integrated regional model without making parallel changes to the way in which national programmes and activities are organised and governed. Therefore, we will need to ensure that joint or aligned national functions are set up in a way that provides the right support for regional teams and gives sufficient time for them to focus on the activities that will add the most value to local health and care systems.

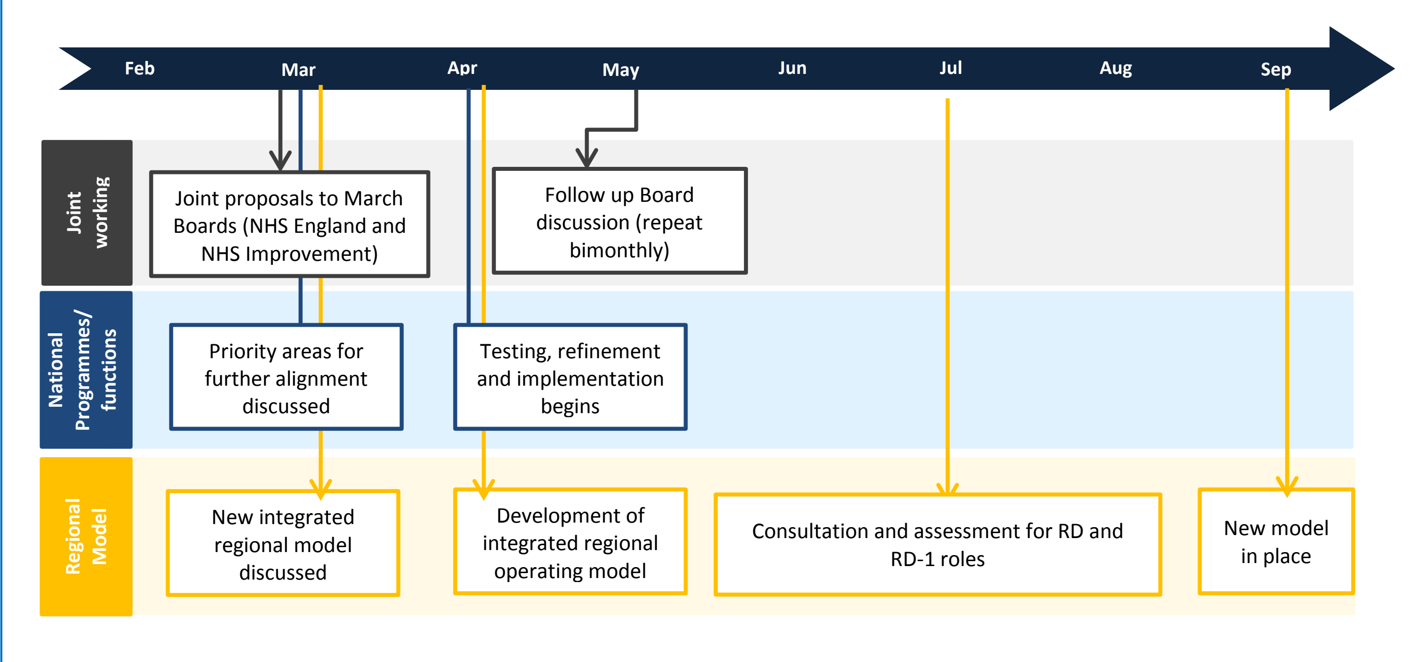
15. As such, we have a draft proposal for some of the national functions and programmes that should be delivered through either one team across the two organisations or through separate teams who work in a more aligned way. We are currently refining this by working function by function across our two organisations to identify how to develop a more effective operating model, which ensures we are adding value through our activities at every level.

16. We would appreciate input from our Boards into our thinking at this stage. Our initial proposal (not comprehensive) is set out overleaf.

DRAFT ORGANISATION OF JOINT OR ALIGNED NATIONAL FUNCTIONS			
	Operational arrangement		
	One team	**Aligned team**	**Separate, involvement if needed**
Operating model	• Both organisations agree objectives and work programme. The head of the team is accountable to both organisations and the team works as a single team regardless of employer • In joint regional teams, Regional Directors will report equally into the two organisations. • For other functions, to avoid overcomplicated governance, we will work function by function and agree a 'lead organisation' for each. For example, the Efficiency and Productivity function will have a lead report into NHS Improvement.	• The relevant teams work within their 'own' organisations but work to a single overarching plan. Joint goals/processes/ accountabilities are used to ensure activities are coordinated and consistent. • Might also consider co-location and/or connection building through professional networks to reinforce alignment	• The relevant teams work within their 'own' organisations to deliver a separate function. • They consult and involve each other within agreed joint forums or other mechanisms to align overarching goals or relevant aspects of delivery.
Example general functions	• Clinical programmes, regional teams, transactional HR processes, national clinical roles, IT, information and analytics, estates, efficiency and improvement programmes, Five Year Forward View programmes	• Communications, strategy, strategic people functions	• Emergency Preparedness, Resilience and Response (EPRR), specialised services commissioning, medical revalidation • Considering complaints about procurement
Example Finance activities	• Regional finance teams, financial reporting and analysis	• Pricing	• National finance leadership, financial recovery and intervention

Timeline for implementation

17. Subject to Board approval, the high level timeline for implementation of this work is as follows, with regular Board updates and discussions to be scheduled over 2018/19:



Proposed governance and accountability arrangements

18. Achieving the right governance arrangements and avoiding duplicative, parallel processes will be key to success. We will need to set up a number of joint governance mechanisms to enable the joint oversight of operational performance and national priority programmes, a fully coordinated approach to finance and to ensure the joint oversight of clinical quality.

19. In designing these new arrangements, we must avoid a fragmented approach where oversight of one function happens completely in isolation from another (e.g., a solely operational discussion without oversight of quality or finance). We are also working to ensure that the new arrangements allow national and regional directors to have the necessary line of sight into these areas, whilst also being manageable in terms of time commitment.

20. There is more work to do to review the two organisations' Board oversight structures to ensure that both Boards can discharge their independent responsibilities as well as encourage appropriate collaboration. Initial steps have already been taken in this direction, particularly with the appointment of Associate NEDs and the creation of the Joint Finance Advisory Group, co-chaired by the Deputy Chairmen of NHS England and NHS Improvement. As we look to develop a more detailed governance proposal, we would welcome the Boards' input and direction on further steps we might take to strengthen Board-level governance arrangements.

21. We are currently working across both of our organisations to agree the detail of how these arrangements will work in light of our design principles (in **Annex B**) and our commitment to avoid duplicative or complicated reporting structures. We will provide more detail in our next Board update.

Managing change well: supporting future models of collaboration and joint working

22. To ensure the success of this work we will focus on the following key enablers:

- **Communicating and engaging with staff** – We have set up a joint communications and engagement steering group to ensure that staff are informed and engaged and we will be developing a detailed communications and engagement strategy to enable staff to inform and shape the implementation of this work.
- **Communicating and engaging with local systems** – Early feedback from local health and care systems regarding this potential direction of travel has been overwhelmingly positive. We will be developing an engagement strategy to enable local health and care systems to inform ongoing work.
- **Resourcing and managing change** – The proposals outlined in this paper will not affect all staff but will bring significant change to some individuals and we are working to understand how many staff will be closely impacted. It is clear that change on this scale needs significant leadership attention and resource. To ensure we progress this work appropriately:
    - **We have established a joint oversight of this work**: The development and implementation of these changes will be jointly overseen by our two Chief Executives who have appointed a lead Executive Director from each organisation – Emily Lawson, National Director for Transformation and Corporate Operations is leading this work for NHS England and Ben Dyson, Executive Director of Strategy is doing so for NHS Improvement.
    - **Established a joint virtual change programme team:** To date, the early thinking to support these proposals has been generated and co-ordinated by a small virtual programme team, working across our organisations as a flexible resource. Since the implementation of the proposals in this paper will require a significant change programme, we will ensure that this team is resourced appropriately and has both the capacity and change management capabilities to deliver this work effectively.
    - **We will, as necessary, commission additional resource** – We have started to map out the timeline and implementation plan for this work. Once we have completed this, we will likely need to bring in more additional expertise to help support key areas of work (e.g., integrating information systems and processes across regional teams). We are currently working closely to ensure that the design and development of this work is also shaped by and benefits from the parallel organisational development work that we currently have in train across both organisations – the Transforming NHS England programme and the NHS Improvement Operating Model development work.

23. We will provide further detail on these areas and an update on progress at the next Board meeting.

Next Steps

24. Subject to Board approval of these proposed changes, our next steps over the next month will be:

- **Integrated regional teams** – We will work with Regional Directors, regional teams and relevant national colleagues to further develop the detail on what functions an integrated regional team should carry out, how it should be structured, how it should operate and the supporting enablers (e.g., data and information, alignment of IT systems, change management support, staff training and development) that need to be in place to support this. Once agreed, we will develop a detailed plan and timeline for implementation.
- **Integrated or aligned national programmes and functions** – We will agree the design of integrated (or aligned) national programmes, functions and activities and the supporting enablers required. Once agreed, we will develop a detailed plan for implementation.
- **Communicating with staff** – We will develop a joint communications statement to be shared with all NHS England and NHS Improvement staff detailing any changes agreed by the Boards of our two organisations. We are currently working out the most appropriate timing of this in light of the Easter holiday period.
- **Detailed governance proposal** – We are working to agree the detail of how the governance of these proposals should work. We will come back to both Boards with a detailed governance proposal in our next Board update (May 2018).

ANNEX A

LESSONS LEARNED FROM JOINT WORKING TO DATE

The following learning on joint working to date has been gathered through discussions with those carrying out joint roles, their senior teams and evidence collected through related reviews. This learning primarily covers the move to two joint Regional Directors in the South and the two joint regional Nursing Directors in London and the South.

Area	Learning
Benefits and opportunities	Across these different examples of joint working it has been felt that joint roles provide the following benefits and opportunities (if more fully realised with the enablers listed below): • Providing a clear 'system lead' for local systems, including commissioners and providers on operational, finance and quality issues • Speaking to the sector with one voice • Providing national teams with a local 'system' view of a particular area e.g. urgent and emergency care • Enabling local issues to be more readily resolved by viewing them through a system, rather than a solely commissioner or provider-focused lens • Being able to deploy the collective resources of both organisations in our support, oversight and intervention with local systems • Empowering staff to work more holistically with whole systems and reduce duplicative work across both organisations
Operating model, data and information	• **Operating model** – There are different systems and processes across the two organisations which means that existing activities, roles and operating models are often not easily aligned through joint working. For joint roles and activities to be successful, there will be multiple activities and processes that required simplification and alignment. For some areas this will involve making changes to existing systems and processes, whilst for others this will require designing new and bespoke systems and processes. • **Data and assurance** – There are currently significant demands for information in both organisations. There is a clear need to simplify and align these so that information is being requested once, with sufficient notice, and for clear reasons. Depending on the extent of integration, we will need to align data sources and definitions to support 'one version of the truth'. Effective joint working to date has often been limited by the lack of access to each organisation's data sources. • **Information systems** – Those in joint roles have been required to work across duplicate technical infrastructure – with two IT systems and organisational processes leading to wasted time and effort. • **Regional/National interface** – We need to become clearer about the interface between national and regional teams so that we remove the need to manage duplicative and sometime contradictory requests for data and assurance. •

Aligned governance and accountability	• **Reporting lines** – Those currently carrying out joint posts have described the complexity of working across two different organisations where their roles are the only integrated role. This context creates significant bureaucracy, with multiple reporting lines and the logistics of parallel executive and senior management meetings to manage each week. This many reporting lines can create a disproportionate administrative and logistical burden. • **Decision making** – Decision-making can be slowed and in some cases can become confused by needing to be taken through parallel accountability structures across the two organisations, which are not necessarily synchronised in terms of timing or membership.
Culture, values and behaviours	• **Aligning culture and style** – Learning to date has highlighted that there are two (or more) quite different operating models and styles in each organisation. To make joint teams work, we will need to work on aligning these and creating a single, new operating style, with an agreed set of leadership competencies, values and behaviours. To achieve this, it will be important to work closely with staff to better understand how each organisation can learn from the other and how we might build on the best of both of our operating styles and cultures.
Change management	• **Investing in change management** – Learning to date has highlighted that more emphasis is needed on bringing everyone along with a new way of working, including developing a clear vision and programme plan, and ensuring that organisational design and development activity involves staff and therefore creates a model that works ‘in the real world.’ • **Uncertainty for staff** – Moving towards models of joint working requires us to be sensitive to the ways in which organisational changes can create a sense of vulnerability and uncertainty for staff, often articulated through fears about losing their jobs or a sense of perceived ‘merger through the back door’. • **Clarity and pace** – Staff have told us that they appreciate clarity and pace in dealing with change, as it can be difficult and cause uncertainty when changes are drawn out unnecessarily. • **Managing geographical changes well** – Learning from the regions has indicated that alongside managing changes around joint working appropriately, we need to ensure that any geographical change to regional footprints and therefore to the makeup and location of teams is equally managed well.

ANNEX B

DELIVERING A NEW APPROACH TO JOINT WORKING

To deliver joint working across our organisations, we have agreed a shared set of design principles and the following taxonomy framework to help guide this work:

Design Principles	
Simple	• Wherever possible, we have a single point of accountability for any responsibility • Where not possible, the processes and structures for carrying out any activity involve the minimum number of steps, of handovers between functions, and everyone involved is clear about how to get things done in their area
Cost-effective	• Wherever possible we do things once • Where not possible, we streamline processes and combine forces to make sure capabilities are deployed against our most critical activities
Aligned	• We speak with one voice • We ensure our messages are consistent, internally and externally
Practical	• We engage with the broader healthcare system to ensure our approaches work for those delivering care to patients
Collaborative	• We work as joint and equal partners, learning from each other and creating the right shared vision, culture and behaviours • We actively seek input and feedback from each other and from our stakeholders on our policies and activities • We agree on joint plans of work and share resources to get them done in the most effective way
Adaptive	• Our structures and processes are designed to adapt to changing circumstances • We build learning into all our major processes

Taxonomy Framework			
Category 1	**Category 2**	**Category 3**	**Category 4**
One team	**Aligned, separate function(s)**	**Separate, involvement if needed**	**Separate and distinct**
• Delivering a function once, through one team working on behalf of both organisations	• Joint governance to ensure the two teams work to a single aligned plan	• Delivering a function separately with aligned overarching goals and collaboration at key points	• Delivering a function completely separately, either due to legal reasons or where joint working does not add value
Proposed operational arrangements			
Integrated delivery	*Aligned delivery*	*NHS Improvement led* *NHS England led*	*NHS Improvement led* *NHS England led*
• Everyone who works for the team is employed by or seconded to the same organisation <u>*Or:*</u> • Some members of the team work for NHS England and some for NHS Improvement, but in practice they are a virtually integrated team with shared leadership. • Both organisations agree objectives and work programme. The head of the team is accountable to both organisations	• The relevant teams work within their 'own' organisations but work to a single overarching plan. Joint goals/processes/ accountabilities are used to ensure activities are coordinated and consistent. • Might also consider co-location and/or connection building through professional networks to reinforce alignment	• The relevant teams work within their 'own' organisations to deliver a separate function. • They consult and involve each other within agreed joint forums or other mechanisms to align overarching goals or relevant aspects of delivery.	**Key** NHS England NHS Improvement Joint accountability Function Reporting to Board Influence