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.