



NHS Improvement and NHS England

Meeting in Common of the Boards of NHS England and NHS Improvement

Meeting date: Thursday 24 May

Agenda item: 01

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Report on: **Next steps on aligning the work of NHS England and NHS Improvement**

Progress on delivering joint working between NHS England and NHS Improvement; specifically proposals for:

- a) Joint governance and accountability
- b) Integrated regional teams and new regional geographies
- c) Aligning appropriate national functions
- d) Managing change well

Request: The Boards are asked to consider and endorse the proposals

Introduction

1. The National Health Service is turning 70 on 5 July 2018. Over the last seven decades the NHS has helped transform the health and wellbeing of the nation and in turn has earned the enduring support of the British people. Through a process of continuous evolution and modernisation it has delivered huge medical advances, improvements in population health and innovations in patient care.
2. Now, as the NHS moves into its next decade, local health and care systems across the country are rising to the challenge of a growing and ageing population by collaborating across organisational boundaries to develop more integrated models of care. In line with the vision of the NHS Five Year Forward View, we are seeing a growing movement towards commissioners and providers focusing on population health supported by local system-wide action. This means working together to mobilise community assets and collective capabilities to improve quality of care for individuals, health outcomes for populations, and wise stewardship of taxpayers' resources.

Working Together for the NHS

Rationale

3. Faced with that challenge, NHS England and NHS Improvement now need themselves to evolve and adapt, to transform the way we work to provide a single system view that supports and enables integrated care.
4. In March, our Boards agreed ambitious proposals to transform the way we work together to provide more joined-up, effective and comprehensive system leadership to the NHS. This paper sets out our next steps in moving from fragmentation to coherence, to create an operating model that best supports local health systems and the patients and public they serve. This reflects both our organisations' duties to co-operate with each other in the exercise of our functions; to exercise those functions economically, efficiently and effectively; and to facilitate, where beneficial, integrated provision of healthcare services
5. For NHS Improvement, this will represent a shift from regulation to improvement in order to protect and promote the needs of all those who use the NHS over the next period of its history. NHS Improvement will focus more clearly on the areas that will bring greatest value in driving improvement and transformation both for the provider sector and for local health systems – see more detail in Appendix One. This will include a significant change in the senior organisational structure in NHS Improvement to enable it to deliver its refocused purpose.
6. In designing this new approach to joint working, we recognise that the statutory framework established by Parliament assigns NHS England and NHS Improvement (Monitor) some distinctive and non-shareable functions, and that primary legislation implies separate board governance, chairs and CEOs for the two organisations. The statutory framework also establishes distinct functions for clinical commissioning groups (CCGs) and NHS trusts and foundation trusts, which are also reflected in part in the functions of each organisation, including those Secretary of State functions delegated to the NHS Trust Development Authority (TDA).
7. That need not, however, stand in the way of enhanced joint working in many areas where the NHS will benefit from our doing so. Specifically, we want to:
 - a. Move from a world where local health organisations (trusts, CCGs) sometimes receive different and conflicting messages from the national bodies, to one where – through our integrated regional teams – we have a single conversation with them.
 - b. Take a more holistic view of NHS resources across commissioners and providers, both locally and nationally, better aligning financial incentives and architecture for whole-system improvement.
 - c. Leverage NHS England's and NHS Improvement's distinctive competencies across both organisations (such as NHS Improvement's work on patient safety and trust procurement efficiencies, and NHS England's on cancer and mental health, on care integration and on pharmaceuticals).

- d. Build out capabilities where there has been a gap in national leadership (such as on NHS people management and leadership development).
- e. Mobilise national implementation resource for the forthcoming NHS 10 Year Plan.
- f. Reduce administrative costs for redeployment into frontline patient care, recognising the differing requirements of this on our separate organisations, and agreeing what this means for our collective resources as we work together more closely.

Transforming the way we work: key proposals

- 8. Our guiding principle in this work is setting ourselves up to provide effective system leadership to the NHS. This will require us to be agile and adaptive, developing a learning culture that allows us to be flexible to the changing needs of the health and care system. We are now proposing our next set of changes to support this, encompassing all aspects of our current operating models: governance, systems and processes; organisation structures and capabilities; and culture and behaviours.
- 9. In terms of **governance, systems and processes**:
 - a. While respecting the legal need for the NHS England and NHS Improvement Boards separately to oversee their distinctive responsibilities, the Boards will also want to consider over the next several months the extent to which some of NHS England's and NHS Improvement's non-executive led *board committees* might be reshaped and aligned, building on the recent experience of the joint finance advisory committee.
 - b. NHS England and NHS Improvement will establish a new *NHS Executive Group*. Co-chaired by the two CEOs, membership will comprise all national directors and regional directors from the two organisations.
 - c. A new *NHS Assembly* (provisional title) will be created, drawn from – amongst others – national clinical, patient and staff organisations; the voluntary, community and social enterprise (VCSE) sector; the NHS Arm's Length Bodies (ALBs); and frontline leaders from integrated care systems (ICSs), sustainability and transformation partnerships (STPs), trusts, CCGs and local authorities. It will become the forum where stakeholders discuss and oversee progress on the NHS Five Year Forward View and help co-design the proposed upcoming NHS 10 Year Plan, and will build on the recommendations of NHS England's Empowering People and Communities Task Force.
 - d. We will align all our core processes so that both our internal management and our interactions with the system are conducted once, with clear accountabilities at national, regional and system level. This will include establishing a single financial and operational planning process for the health system; a single performance management process and alignment of

regulatory interventions; a single internal talent management process; and a single process for establishing and reviewing national strategic programmes such as mental health. This builds on our already integrated management of IT across the system. And we will establish a single version of the truth in reporting and sharing information about the system.

10. In terms of **organisational structures and capabilities**:

- a. At a regional level, we will create integrated regional teams covering both NHS England and NHS Improvement functions, and led by regional directors with full responsibility for the performance of all NHS organisations in their region in relation to quality, finance and operational performance.

The Regional Directors will play a major leadership role in the geographies that they manage, making decisions about how best to support and assure performance within their region, as well as support the development and identity of local STPs and ICSs. This is a move to a different kind of local leadership of the NHS, where Regional Directors promote, encourage and support local systems to achieve more integrated and sustainable models of care. It also means that the locus of decision-making will be centred more on the Regional Directors and their teams, with national teams generally providing support and intervention where agreed with Regional Directors.

The Regional Directors will report to the two CEOs and be full members of the national NHS Executive Group, with responsibility for developing the overarching strategy and architecture for the NHS as well as translating that into operational plans. Through this, they will help agree where a more standardised model to policy and delivery makes sense to ensure a unified approach, alongside the areas where regional teams should have the authority and discretion to design their own approaches or to implement in a more locally specific way. Appendix Two has more detail.

- b. At a national level we will increasingly align functions across the two organisations, creating a set of new roles to support delivery:
- i. Three national director roles will be created which will report to both CEOs:
 1. A single *NHS Medical Director*.
 2. A single *NHS Nursing Director/Chief Nursing Officer for England*.
 3. A single *Chief Financial Officer* (responsibilities include leadership of the integrated financial and operational planning and performance oversight process).
 - ii. Individual national directors in NHS England and NHS Improvement will take on responsibility for a number of 'do-once' functions supporting both organisations, with shared governance and oversight. These functions include:

1. National service programmes such as cancer and mental health; implementation of the FYFV and NHS 10 Year Plan, the move to ICSs, digital/tech, and the health/social care interface, led by the *NHS England Deputy CEO* – who will also lead NHS England’s distinct responsibilities including commissioning specialised services (£17bn portfolio), primary care, oversight of CSUs, and emergency preparedness, resilience and response (EPRR) (*NHS England*).
 2. Strategic programmes such as life sciences, commissioning development, primary care policy, patient choice and personalisation of care, innovation and research, led by the *National Director for Strategy and Innovation (NHS England)*.
 3. A new strategic approach to configuration of the provider landscape led by the *Chief Provider Strategy Officer (NHS Improvement)*.
 4. NHS leadership and NHS people management, led by a new role of *Chief People Officer (NHS Improvement)*.
 5. System-wide improvements in quality, access and efficiency, led by a new role of *Chief Improvement Officer (NHS Improvement)*.
 6. A system-wide approach to improving estates, procurement and back-office services, led by a new role of *Chief Commercial Officer (NHS Improvement)*.
 7. A shared approach to urgent and emergency care and elective care, led by a *National Director for Emergency and Elective Care (NHS Improvement)*.
- iii. A single *National Director for Transformation and Corporate Development*, who reports to both CEOs, leading most corporate operations across both organisations, including organisational development – both internally and with respect to system transformation – and people functions.
 - iv. For other areas of our work, where the nature of the organisation’s statutory functions requires, the activity and structure will remain separate and distinct, for instance NHS Improvement’s regulatory functions in relation to pricing, competition and patient choice, and its hosting of the Healthcare Safety and Investigation Branch; and NHS England’s responsibility for tariff currency development, commissioning of specialised services and primary care, and EPRR.
 - v. For communications and engagement, each organisation will need its own dedicated resources to support its own distinctive functions, but we are planning further work to align our approach more closely.
 - vi. For analysis, we propose further work to agree where we need to establish a single team for core areas of analysis to provide 'one version of the truth'; how we develop a shared approach to professional

development across our shared analytical community; and how we develop greater agility and flexibility in deploying our collective analytical skills, knowledge and experience in ways that best support our shared business.

11. We recognise that the proposed governance and structures must operate within constraints of the existing legal framework, including the requirement that, subject to some exceptions, each body's functions must be exercised by its own committees or staff. Specific governance and decision-making arrangements will enable effective and legally compliant joint working, and provision to avoid or manage the actual or potential conflicts which may arise in relation to the exercise of different functions.
12. The net effect of these changes is that the two organisations will increasingly be working in a combined way on a shared set of system priorities, covering most key functions and capabilities:
 - a. System strategy: encompassing, amongst other topics, health inequalities reduction, patient choice/personalisation, developing the provider landscape, innovation and research.
 - b. Planning and performance: operational and financial planning, performance reporting and intervention.
 - c. The move to integrated care systems: a single approach to supporting STPs and ICSs.
 - d. Service transformation: single national service transformation programmes, for the Five Year Forward View clinical and service priorities such as mental health, cancer, learning disabilities, maternity and integrated care for older people.
 - e. Improvement: a single approach to developing specialist resources that regional teams use with local health systems to deliver continuous improvement in quality, access and efficiency.
 - f. NHS leadership and workforce: a single approach to developing senior leadership in the NHS and supporting the NHS in recruiting, retaining, deploying and developing today's NHS workforce.
 - g. NHS information and digital technology: a single approach to transforming how the NHS uses digital information and technology to improve quality of care, health outcomes and efficiency.
 - h. NHS estates, procurement and back office services: a single approach to helping the NHS manage its estates/facilities, equipment, consumables and corporate services more efficiently and effectively.

Transforming the way we work: Creating a shared culture and managing change well

13. At its heart, this programme of work is about reshaping the culture, mind-sets and ways of working of our two organisations, so that rather than defining ourselves around the traditional boundaries between commissioners and providers, primary and secondary care, or the identity of NHS England or NHS Improvement (including Monitor and TDA), we collectively see our role and purpose as providing system leadership to the NHS.
14. A joint approach to culture and behaviours will be developed with all staff, building on their input about what should be maintained and what needs to change in our current operating styles and our leadership behaviours. We will also work with colleagues across both organisations to redesign core processes, using a continuous improvement methodology, in parallel with the redesign, to ensure what we put in place is both effective and efficient.
15. As part of managing this change well, we will provide support to colleagues through various mechanisms, including:
 - a. Ensuring all 'people processes' are fair and transparent, and adhere to our existing organisational policies.
 - b. Providing support on how to 'manage through change' to all colleagues who want to participate, including support to develop resilience and manage stress.
 - c. Providing additional support to line leaders to ensure they can support and engage their teams effectively through this period of change and beyond.
16. In light of this, we will be launching a joint staff engagement programme, as part of the joint All Staff briefings on 25 May, under the umbrella of '*Project 70.*' This programme of work will enable us to learn from staff across our organisations and ensure that they are involved in the development and implementation of this work. Appendix Three sets out more detail.

Timeline and next steps

17. We will make the changes to the most senior roles (at a minimum, roles reporting to the two CEOs) by September and to the changed roles at the next level during the autumn. We will continue to move quickly so as to minimise the period of uncertainty for colleagues while minimising the risk to the system of a lack of continuity. We are aiming for all changes to be made by the end of this financial year.
18. We will be agile and responsive in our approach to implementation, identifying a clear set of measurable goals so we can measure success. We will also engage regularly with our staff, Trade Unions and system partners, both to involve them

in the detailed design, including the creation of a shared culture and leadership model, and to enable us to learn as we go and course correct where necessary.

Conclusion

19. The Boards are asked to endorse these proposals.

Refocusing NHS Improvement's Purpose and Operating Model

- 1.1 NHS Improvement has recently completed a major programme of work to identify how to improve organisational purpose and operating model to better drive continuous improvements in the quality and efficiency of the NHS provider sector.
- 1.2 The conclusions from this work represent a significant change in focus, operating model and senior structures that will need to form an integral part of how we develop and implement the proposed approach to joint working. It has significant implications for how we shape the proposed new functions that will be led by NHS Improvement or hosted by NHS Improvement on behalf of both organisations, particularly our Provider Strategy, People, Improvement and Commercial functions, and for the new integrated regional teams. This will entail significant changes both to the senior executive structure of NHS Improvement and to ways of working, including the style of our relationship with the provider sector.

Key conclusions

- 1.3 The key conclusions from this work are that NHS Improvement, both through its new partnership with NHS England – including integrated regional teams – and through the distinctive functions that it will in future host or lead, needs to orientate itself more fully towards supporting improvements in quality and efficiency of care, rather than acting primarily as (and being seen primarily as) a regulator.
- 1.4 By gathering evidence from our staff and from the providers and systems with whom we interact, this work has identified where the greatest sources of value lie in our work to support the provider sector and what this means in terms of our future operating model and senior executive structures. It has also provided valuable insight into the distinctive skills, capabilities and behaviours that will be needed to realise greater benefits for patients and taxpayers.
- 1.5 Our work identified seven sources of value where NHS Improvement and its national partners could have the greatest impact in supporting the provider sector to drive sustainable improvements in quality of care and efficient use of resources. All of these sources of value are reflected in the proposals set out in the main paper to align the work of NHS Improvement and NHS England. Four of these sources of value map to functions that NHS Improvement will lead or will host on behalf of both organisations:
 - **Configuration of the provider landscape.** There is a clear need to be more proactive in shaping the future provider landscape, including organisational models (eg 'group' or 'chain' models for hospitals, mental health services or other services) and service models. Working with NHS England, providers and with local health systems, we need to identify changes that will best support long-term improvements in clinical and

financial sustainability, agree collectively the strategic benefits to be gained from these changes, and better manage the realisation of those intended benefits, supported by a stronger focus on clinical leadership and clinical engagement. Integrated regional teams will in future lead this agenda, supported by national work – led by NHS Improvement’s proposed new Provider Strategy function – to distil evidence and best practice.

- **Quality and operational improvement.** We need to streamline and consolidate the way we support both providers and local health systems in driving continuous improvements in quality and efficiency of care. This will include developing the way we work with the most challenged providers to address persistent performance problems (taking into account the context of their wider local health system), more rigorous prioritisation of improvement priorities, and more hands-on support for providers and local health systems. The new integrated regional teams will lead work on improvement in local health systems, supported by a Chief Improvement Officer who will lead national work to develop tools, data, resources and specialist support, building on the existing work of NHS Improvement’s current directorates for operational productivity and improvement.
- **NHS workforce and leadership.** While Health Education England (HEE) has a clear national role in the education and training of the future NHS workforce, there are a number of organisations working – without sufficient coordination – to support NHS organisations to recruit, retain and develop today’s workforce. Our work identified a clear need to develop a more proactive and coherent approach to supporting leadership development, including talent management and succession planning, and helping the NHS to improve its people management processes. Under the proposals in the main body of the paper, NHS Improvement will host a new directorate, led by a Chief People Officer, working on behalf of both organisations to improve leadership and people management, working closely with Health Education England, NHS Employers and other national partners. This focus on leadership and people management will also be reflected in the design and resourcing of integrated regional teams.
- **NHS estates, equipment and consumables.** A further key source of value is the work we do to support the NHS in using all its physical assets more efficiently and effectively, improving quality of care and unlocking additional resources for patient care. This is already a key part of the NHS Improvement operational productivity. The proposed new Chief Commercial Officer will lead this work on behalf of both organisations, including continuing to increase our support for local health systems in managing their estates on a more system-wide basis to support new models of care and enhance value for money.

1.6 These four sources of value will be at the heart of the work undertaken by the new Provider Strategy, People, Improvement and Commercial directorates in NHS Improvement. The functions currently carried out by NHS Improvement’s Regulation Directorate will in future be carried out by Provider Strategy, People, and Improvement, working with integrated regional teams.

- 1.7 A further key source of value identified through the work is in relation to **NHS information and digital technology**. NHS England and NHS Improvement are already jointly responsible – with DHSC and NHS Digital – for a programme of work to transform the way the NHS uses digital information and technology to improve quality of care, health outcomes and efficiency. Our work identified the need to go further in embedding the importance of the digital agenda in all the work we do with the provider sector, so that it is an integral part of improving quality and efficiency. Under the proposed new joint working arrangements, NHS England will host the national digital programme (which will be led by the Deputy CEO of NHS England), with shared governance and oversight to help mainstream this work in all our engagement with the provider sector.
- 1.8 The two final sources of value identified from this work go to the heart of the proposals for joint working between the two organisations:
- **Planning and performance review.** The work identified a range of ways to support providers and local health systems in producing credible but realistic plans, allowing more productive and supportive discussions of key risks and the support needed to address them. The work identified significant opportunities to refresh the approach to monitoring and managing performance through a greater focus on understanding what improves performance, joint problem-solving (not simply upwards assurance) and using data and analysis to identify risks at an earlier stage. This work will now feed into a single programme of work between NHS England and NHS Improvement to design our future joint approach to planning and performance, including the interface between regional teams and local health systems (STPs and ICSs), trusts and CCGs.
 - **System incentives and financial architecture.** We have identified a number of practical ways of simplifying and rationalising financial flows and incentives, helping us to go further in improving efficiency and quality within provider organisations and at the same time improving value across patient pathways. This will feed into a joint programme of work, led by the new Chief Financial Officer, to design and implement a new approach to managing collective NHS resources and driving value.

Conclusion

- 1.9 In the absence of the proposed new approach to joint working, NHS Improvement would have wanted in other ways to reflect these key conclusions in its own operating model and organisational structure. The new approach to joint working across NHS England and NHS Improvement makes it easier in some ways to make the necessary changes to our operating model, particularly in relation to financial architecture and performance management. The implementation of these changes will nonetheless require considerable change management and organisational development in relation to the new Provider Strategy, People, Improvement and Commercial functions hosted by NHS Improvement and the transition from current ways of working within NHS Improvement. This will require, in particular, the development of a strong improvement-focused and engaging culture.

Regional Teams

- 2.1 In March, the Boards agreed a new integrated regional model, with seven integrated regional teams each led by a single Director, working for and reporting into both NHS England and NHS Improvement. Since March, we have been working closely with the current Regional Directors and teams across our two organisations to develop proposals for a new integrated regional operating model, including the core functions that regional teams will be responsible for and the underlying principles that will guide their ways of working.
- 2.2 The new integrated regional teams will have a major leadership role driving improvement and transformation for local health systems and providing joined-up oversight across the system. We see the new regional teams as playing a crucial role as ‘translators’ between the national level and local health and care systems, helping to ensure that all our work is responsive to local system needs.
- 2.3 As part of moving to joint working, we need to set up the single regions to better support local health systems. NHS England and NHS Improvement are working towards an oversight model that empowers systems to take a shared or leading role in functions that affect their populations. Under this model, STPs and ICSs will relate to a single Regional Director acting on behalf of both NHS England and NHS Improvement. As they develop and mature, we envisage ICSs holding more responsibility, including:
- Developing a system vision, strategy and plans to meet operational, financial and quality requirements.
 - Developing and maintaining relationships with local people, staff, local government, voluntary and independent sectors; making sure they feel engaged in their system.
 - Leading on provider transformation including integrated providers and primary care networks.
 - Providing first line support to organisations within their system, drawing down national and regional expertise where needed.
 - Some commissioning (including current direct commissioning) not performed at national level.
- 2.4 Regional teams will adopt a differentiated approach as they work with local health systems at different levels of maturity. They will be agile and adaptive in their delivery of the functions outlined below, working to strengthen the leadership, capacity and capability of local systems so that they are able to becoming increasingly self-governed and require less support and oversight from regional teams.

Core functions of regional teams

2.5 We have been working across our current national and regional teams to develop the proposed core functions for the new integrated regional teams, focusing on those areas that will deliver the most value in supporting local health and care systems.

2.6 We propose that the new integrated teams deliver the following core functions:

- **Performance, improvement and intervention** – tracking performance in relation to quality of care, access, efficiency and health outcomes, developing and maintaining capacity and capability for targeted improvement support, managing regulatory interventions and promoting peer support between providers, CCGs, STPs and ICSs.
- **Strategy and system transformation** – development and oversight of STP/ICS transformation strategies, shaping national programmes and leading the regional implementation of agreed national priorities, proactively shaping the provider and commissioner landscape, and prioritising and supporting improvements in service configuration where needed.
- **Commissioning** – commissioning of specialised services, primary care services, prison healthcare, s7a public health services, and oversight of CCGs with delegated responsibility for commissioning primary medical care. There will be a clear separation between the work of these commissioning teams and NHS Improvement’s regulatory oversight of those commissioning functions.
- **Operational management** – ensuring the safe and effective day-to-day running of the NHS and providing support in the face of any emerging issues (eg temporary A&E closures, cybersecurity attacks). Working with the Local Resilience Forums to support local emergency preparedness, resilience and response.
- **Finance** – oversight of local system financial planning and performance to a national framework, to manage system control totals that combine commissioning expenditure and the income and expenditure of NHS providers, oversee delivery of cost improvement programmes across local systems, support systems in the design of new payment and risk-sharing methods, and prioritise STP capital proposals.
- **Specific quality responsibilities** – professional leadership for quality improvement programmes, professional leadership for clinical staff, safeguarding, managing clinical senates and networks, the statutory duties discharged by the Medical Director (Controlled Drugs Accountable Officer, Caldicott Guardian, Performers list management), oversight and governance for patient safety and clinical support and review of reconfiguration decisions.

- **Workforce and leadership** – overseeing regional systems of leadership development, talent management and succession planning, identifying pipeline of future leaders for national leadership development, working with HEE to develop robust regional workforce strategies and improvement plans.
- **Information, digital and technology** – development and oversight of system strategies to deliver the national strategy, working with NHS Digital to ensure the robustness of local systems and local implementation programmes for care records and data sharing, and overseeing the development of services to exploit opportunities of new technology.
- **Estates and procurement** – ensuring that systems develop and implement strategies to improve the use of estates and facilities, and the efficiency of procurement and back-office services.
- **Analysis and insight** – processing and analysis of specific data to inform performance and transformation interventions, assurance of local data quality, to enhance the national core data sets.
- **Communications and engagement** – communication, engagement and partnership with regional stakeholders, including local government, MPs and patient groups, alongside relationship management with ALB and government departments where relevant.
- **Corporate functions (including HR)** – utilising and overseeing locally assigned corporate resource dedicated to the region from nationally managed functions.

Principles: interface between national and regional teams

2.7 We propose the following principles to guide the implementation of a new integrated regional operating model, relating in particular to the interaction between regional and national teams and the authority, freedoms and accountabilities of the new Regional Directors.

2.8 Regional teams will:

- Be led by Executive Directors who are part of the senior national leadership team of NHS England and NHS Improvement, together helping to design the right support and intervention for local health systems, ensuring we create maximum value and avoid unnecessary burden.
- Decide when and how to intervene in systems, providers or CCGs in their region, or – where the seriousness of the intervention requires a national decision – make the relevant recommendations to the decision-making group.
- Be responsible for managing all interventions with – or seeking information/assurances from – systems, providers or CCGs, except where

the regional team ask another team to act on their behalf or where the wider national leadership team collectively agree a different approach.

- Treat performance management and improvement as a continuum, not only holding systems, providers and CCGs to account but having the right capacity and capability to help solve them complex problems and access the right improvement support.
- Help develop standardised national approaches to improvement and performance, but have discretion to allow systems, providers or CCGs to depart from standardised approaches where they are performing well or where the regional team consider the system, provider or CCG has a cogent alternative approach to making performance improvements.
- Have access to all relevant data and analysis about their region, easily accessible at the right time to inform local decisions.
- Are trusted to manage their resources in a way that meets the needs of their region, subject to organisational designs and policies that are agreed collectively by the senior national leadership team.
- Be held to account for the responsibilities delegated to them.

Regional geographies

2.9 In March, based on learning from our existing regional model and the complexity of supporting systems across large geographies, the Boards agreed that we should have seven regional teams, by splitting the North and Midlands and East regions into two. Working with the Regional Directors in the North and Midlands and East, and using detailed analysis of regional populations, patient flows and performance, we developed proposals for the new regional geographies to test with staff, trade unions and local health and care systems:

Initial proposals

2.10 For the North, this was:

- **North West:** Lancashire and South Cumbria; Greater Manchester; and Cheshire and Merseyside.
- **North East and Yorkshire:** Cumbria and the North East; West Yorkshire; Humber, Coast and Vale; and South Yorkshire and Bassetlaw.

2.11 For Midlands and East region, this was:

- **Midlands:** Staffordshire; Shropshire and Telford and Wrekin; Derbyshire; Lincolnshire; Nottinghamshire; Leicester, Leicestershire and Rutland; Black Country and West Birmingham; Birmingham and Solihull; Coventry and Warwickshire; and Herefordshire and Worcestershire.

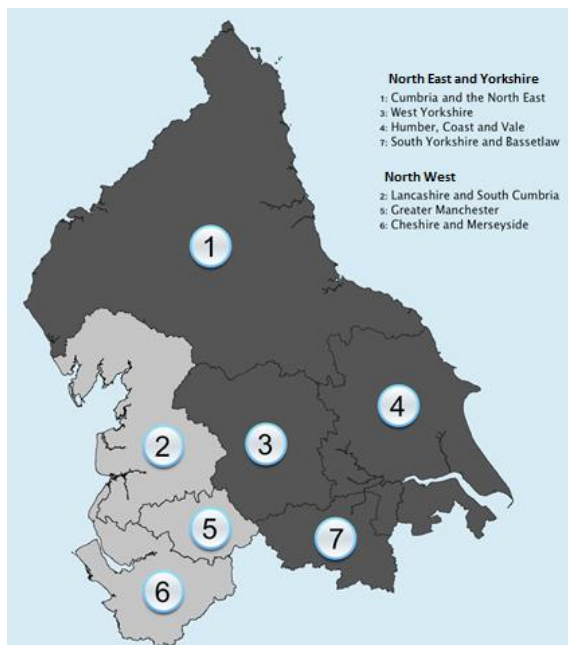
- **Central and East of England:** Northamptonshire; Cambridgeshire and Peterborough; Norfolk and Waveney; Suffolk and North East Essex; Bedfordshire, Luton and Milton Keynes; Hertfordshire and West Essex; and Mid and South Essex.

System engagement

- 2.12 To ensure the most appropriate decision could be made for local systems, we then engaged with our trade unions, NHS England and NHS Improvement staff, system leaders in both regions – including CCG Accountable Officers, STP leaders, Trust Chief Executives and Chairs and the Local Government Association.
- 2.13 We received 69 responses to our joint letters, 28% from individuals in the North region and 72% from those in the Midlands and East region. Of these, the large majority supported the split proposed for the North region, whilst concerns were raised about the Midlands and East proposal. It appears that this would significantly impact Northamptonshire’s patient flows with Leicester and Warwickshire, especially direct commissioning of primary care and public health.

Revised proposals

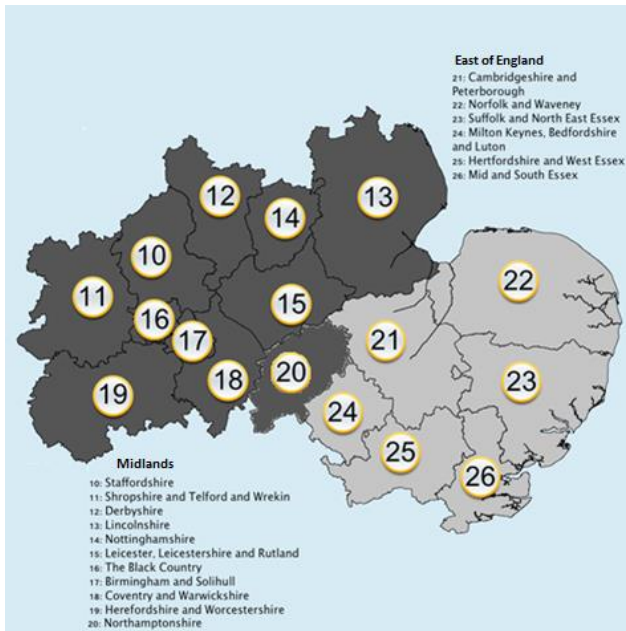
- 2.14 Based on the feedback, we now would like to propose to the Boards that the North be split as initially proposed – North West; and North East and Yorkshire.



- 2.15 Taking into account feedback from staff and system partners, for the Midlands and East, we propose that Northamptonshire should become part of the Midlands.

2.16 This would mean that the regions would split into:

- **Midlands:** Staffordshire, Shropshire and Telford and Wrekin; Derbyshire; Lincolnshire; Nottinghamshire; Leicester, Leicestershire and Rutland; Black Country and West Birmingham; Birmingham and Solihull; Coventry and Warwickshire; Herefordshire and Worcestershire, and Northamptonshire.
- **East of England:** Cambridgeshire and Peterborough; Norfolk and Waveney; Suffolk and North East Essex; Bedfordshire, Luton and Milton Keynes; Hertfordshire and West Essex; and Mid and South Essex.



2.17 These proposals are supported by system leaders in the two regions.

Creating a shared culture

- 3.1 Staff have generally welcomed the direction of travel to transform how we work together, to improve the coherence and impact of our collective system leadership role. We know that working with staff to shape the implementation of these changes and agree which ways of working we want to leave behind and which we want to take forwards will be crucial to success. We are also conscious that uncertainty can be unsettling for us all and we need to take care to engage and support our staff through this process. In light of this, both organisations are committed to managing this transition well in ways that best support our staff and realise the intended benefits.
- 3.2 Across our two organisations, there is a wealth of knowledge on how to manage change using lessons learned from previous change programmes. We have started a dialogue with staff to hear about their experiences and ideas of how to manage this joint change programme well. In addition, we have also held a very productive initial session with both Executive teams, Chairs and Deputy Chairs, focused on agreeing what our shared change approach might look like in light of lessons learned from previous examples of leading change, both within the NHS and other sectors.
- 3.3 We have identified the following characteristics as key to success, and will build these into our shared change approach:
- **Clear vision and goals** – having a clear purpose and narrative of what we are trying to achieve and why, alongside a focused plan of how to get there.
 - **Honesty and clarity** – communicating clearly with staff, through a frequent dialogue about what we want to achieve and how we can work together to get there. Being honest and authentic about uncertainty and sensitive to the personal impacts of change.
 - **Strong leadership and transparency** – ensuring leaders at all levels authentically model the importance of this change programme and the related mind-sets, culture and ways of working. Being proactive about training leaders within our organisations to lead this programme through a network of ambassadors, with authority to identify problems and find solutions.
 - **A well-managed and resourced process** – a well-resourced and well-led programme and process, with the necessary speed and agility to enable pace and the ability to course correct.
 - **Stamina and perseverance** – ensuring the necessary resilience and stamina across the two organisations to ensure that lasting changes are made to culture, mind-sets and behaviours to fully transform the ways we work.

‘Project 70’ – our engagement and organisational development approach

- 3.4 On 25 May, at our two all-staff briefings, we will launch the new operating model with colleagues. This approach, called ‘Project 70’ will facilitate a cross-organisation dialogue with staff, about how we should transform our ways of working to provide effective system leadership for the NHS as it heads into its next 70 years. We will also be asking staff their reflections on lessons learned from previous change programmes and their views on the key success factors to get this process right. To prepare for this, we have already started to pilot a series of structured conversations across our two organisations, and staff have welcomed the chance to share honest views and shape our future ways of working.
- 3.5 Colleagues from our joint working programme will bring both communications and engagement and organisational development expertise to deliver ‘Project 70’, and we will source additional resource if required to deliver this engagement approach at the necessary scale. We see this engagement approach as a crucial part of enabling a frequent and frank dialogue with our staff, whilst also helping us to identify the building blocks of that shared culture and way of working that we want to build.

Resourcing and managing change

- 3.6 We have mobilised a joint programme team to support the implementation of this change programme. The team, reporting jointly to Emily Lawson and Ben Dyson, is operating as a joint resource across both organisations to coordinate the overall operating model design work alongside key enablers such as HR processes and organisational development activities. A snapshot of key activities is provided below:
- **Supporting teams through change.** Alongside implementation of our change policies and HR processes, we will be providing a bespoke offer of career transition support to teams and individuals affected by change. There will also be a broader offer of support to equip all line-managers with the resources they need to support their teams and ensure their own personal resilience.
 - **Leadership and culture change.** We are developing a joint set of leadership capabilities, working with staff across both organisations to co-create a leadership model and culture fit for the future. This will be followed by development sessions for all staff, focused on:
 - equipping staff to live the new leadership model
 - equipping staff to take responsibility for improving their area of work
 - supporting staff to build resilience and adaptability so that they can deliver their best work even through periods of uncertainty and change.
 - **Developing effective team working capability.** We are developing a programme of work to support the development of new joint teams and inter-team working across both organisations and with our system partners.

- **Ensuring that the right enablers are in place.** We are working to ensure that the right enablers, including the use of IT and Estates, our internal finance and budgeting processes are in place to support this transition.
- **Engaging system partners and the public.** In addition to engaging with staff, we are working closely to jointly engage our Trade Union partners at key points within this process. We will be developing a broader external engagement strategy to engage more fully with the public, patients, local systems and ALB partners through the next phase of this work.