Monitor

Making the health sector work for patients

Strategy development toolkit

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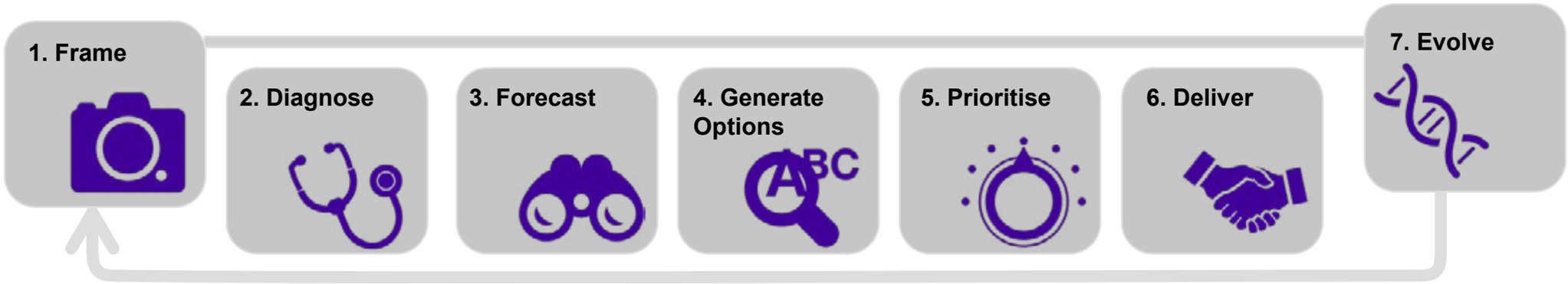
The seven-stage framework of strategy development for foundation trusts

The seven stages of strategy development are introduced in more detail below



Agree on the important strategic decisions to be made, and the criteria and constraints for making them	Establish detailed insight on the FT's[1] starting position and what determines performance	Create a clear view of the potential future(s) in which the FT might operate	Develop, explore and evaluate strategic ideas and options for change	Make choices about the set of strategic ideas for change and build them into one effective coherent strategy	Create and communicate the action plan and allocate resources to deliver the goals of the strategy	Monitor the impact of the strategy and recommit, refresh or recreate when needed
What questions do you need to answer?	**What determines your performance?**	**What futures do you need to plan for?**	**Where and how could the FT change?**	**What is the best strategy for your FT?**	**How can you support making your strategy a reality?**	**How can your FT learn and adapt when the world changes?**

1 Here and throughout the Executive Summary, foundation trusts are referred to as FTs

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What is strategy and why is it important?

The NHS belongs to the people.
It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.
The NHS Constitution

A clear and well thought out strategy will help achieve the vision, principles and values of the NHS by sustaining safe, effective patient care. A sound strategic plan will help protect the clinical, financial and operational sustainability of the services that foundation trusts, local health economies (LHEs) and the wider NHS provide for their populations.

Strategy is a set of choices and principles designed to help an organisation achieve long-term goals. It will influence how resources are allocated and how staff prioritise their time. If leaders communicate their strategy successfully, it will help employees understand the organisation's direction. Whether or not the organisation achieves its aims will depend on the strategy's quality.

Through strategic planning, board members can shape patient care into the future. Their role includes articulating ambitions, gauging possibilities and assessing risks. Developing strategy involves close consultation with clinical colleagues and staff across the organisation, as well as commissioners and other partners in the local health economy. It means seeking patients' views and listening to their aspirations for services.

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Strategic planning offers opportunities for innovation and challenging the status quo. It may mean testing or striking out in unfamiliar directions that could radically improve outcomes for patients by adopting new treatments and technologies. Board members must deploy their expertise in leading discussions and making decisions – it may fall to them to add the bold, imaginative steps to their trust's strategy. Creating and delivering a successful strategy goes beyond a checklist, a step-by-step process or something written down on paper.

A recent study identified the differences between successful and failing strategies across all business sectors. Successful strategies are built on common principles and broken down into stages.[1] This applies to successful strategy formulation in foundation trusts,[2] and we have developed a seven-stage strategy development framework that is the basis for this toolkit. These stages are:

Frame: establishes the scope of the strategy development process by identifying the important strategic choices and decisions to be made and the criteria for making them. In this stage FTs may ask, what are our greatest challenges in delivering quality care affordably? Will we face an uncertain financial future if we make no changes? What will success look like?

Diagnose: assesses the FT's current performance in detail and provides insights into what lies behind it. Performance is compared to national and local standards, peers, and 'best in class' providers in the NHS and beyond. All aspects of performance are included: quality, operational, financial and workforce. If poor performance is identified, the FT carries out detailed diagnostic work to understand the causes.

1 Independent report on the principles of best practice strategic planning
https://www.gov.uk/nhs-foundation-trusts-planning-and-reporting-requirements

2 The strategic development toolkit was written for NHS foundation trusts but is relevant to board members in both foundation and NHS trusts, whether they provide acute, community, mental health or ambulance services

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Forecast: creates a clear view of what the future might look like. Projecting what will happen if current trends continue – often known as the baseline forecast – is critical here. This involves forecasting demand for services based on future patient needs and expectations as well as commissioner and provider plans; forecasting the corresponding income; and forecasting costs based on predicted activity levels, inflation and any additional factors such as plans to improve quality or introduce new technology.

Generate Options: exploring alternative ideas about what services the FT could provide and how it could provide them to best meet patients' needs. Important questions can include: what services might we begin to provide or stop providing? How could we radically improve care quality or productivity? What technology innovations and new practices could we adopt? How can we collaborate with other providers and our commissioners to redesign services to better meet patients' needs?

Prioritise: choosing which strategic initiatives to pursue and building them into a coherent strategy. These initiatives should create a strategy that combines quality care for patients with financial viability, resulting in sustainable clinical services.

Deliver: creating and publicising the implementation plan, as well as allocating resources to achieve the strategy. This involves setting out the activities, milestones, measurements and key performance indicators, being clear about who will deliver what by when. Now is the time to identify gaps in resources or systems – and to take action to fill them.

Evolve: monitoring delivery to ensure the strategy is effective. This involves re-evaluating the strategy regularly, or when unexpected changes occur, to recommit to the existing direction, refresh or recreate if necessary.

In developing its strategy, a board will encounter debate, challenge and dissenting views while exploring new possibilities. Dealing with uncertainty is at the heart of strategy development, but clear and explicit decisions are needed to address the challenges facing the NHS.

The toolkit has been developed with five NHS foundation trust ‘test sites’: James Paget NHS Foundation Trust, Moorfields Eye Hospital NHS Foundation Trust, University College London Hospitals NHS Foundation Trust, Lincolnshire Partnership NHS Foundation Trust, Salford Royal NHS Foundation Trust. We would like to thank everyone involved who helped in the development of this resource.

We have developed this toolkit to support all FTs – acute, community, mental health and ambulance trusts – in developing sound strategies. We expect FT strategies to set out how they intend to meet the challenges of delivering quality care for their patients and adopting new clinically effective treatments and technologies while remaining financially sustainable.

We hope you find this toolkit helpful and we welcome your feedback.

How to use this toolkit

The toolkit contains guidance on each stage of developing a strategy as well as many illustrations of possible analyses and case studies of strategic changes that some NHS providers have already implemented.

It is intended to help you develop a strong strategy for your FT. It is not prescriptive guidance. It is not exhaustive in its illustrations. Its examples of analyses, frameworks and sources of ideas are all intended to provide useful direction and inspiration rather than a set of rules.

The toolkit also includes three separate documents:

- demand forecast summary model and explanation for use
- strategic workforce planning guidance
- lists of measurements

You can use this toolkit in many ways

- If you are about to embark on developing a strategy, the toolkit will give you ideas for each stage: what to do and on how to do it.
- If you are midway through developing a strategy, the toolkit may prompt additional lines of enquiry, as well as suggesting what to do next and how to do it.
- If you already have a strategy but want to judge how strong it is, you can use this toolkit to check whether your strategy development process involved the stages described here; you can also use the Testing the Strategy section for questions to ask.

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The seven-stage framework of strategy development for foundation trusts

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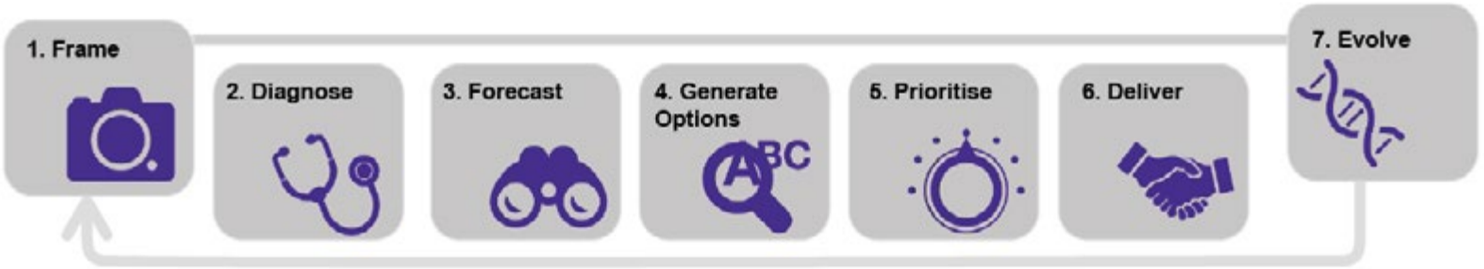

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The complete contents of the strategy development toolkit

This toolkit describes a seven-stage process to develop a strong strategy. It contains guidance and examples for completing each stage. Supporting sections describe how to manage the strategy development process and how to test your strategy. In addition, three separate documents provide further details on specific areas.

Chapters of the Strategy Development Toolkit

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- **1. Frame**
- **2. Diagnose**
- **3. Forecast**
- **4. Generate Options**
- **Testing the Strategy**
- **How to Get This Done**
- **5. Prioritise**
- **6. Deliver**
- **7. Evolve**

(all included in this PDF)

Additional tools

- **Demand Forecast Summary tool**
- **Strategic Workforce Planning tool**

(available for download separately)

Measurement pick list

- **Longlist of potential measurements for use within trust**

(available for download separately)

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Setting up a strategy development programme
Involving the whole organisation in strategy development (detailed guidance)

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Methods for identifying strategic questions
Criteria for assessing and prioritising strategic initiatives
Developing an engagement plan

2. Diagnose
Understanding patients' and commissioners' needs, challenges and priorities
Assessing and understanding clinical and financial performance
Understanding local providers and their strategies
Appendix: Further examples

3. Forecast
Base case forecasting – summary of key steps
Forecasting your FT's demand and activity
Forecasting your FT's income
Forecasting your FT's costs
Forecasting you FT's financial performance
Scenarios, sensitivities and risks

4. Generate Options
Choosing or confirming your strategic themes
Identifying options for change
Creating a longlist of strategic initiatives
Filtering initiatives for further consideration
Appendix: Further information, sources and examples

5. Prioritise
Modelling the impact of initiatives
Making choices
Example of a service strategic review
Developing a coherent strategy
Summarising the strategy

6. Deliver
Supporting the delivery of your strategy
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Introduction

This section helps you decide which stages of the strategy development process your FT needs to undertake and how to set up the work.

It will help you to think through:

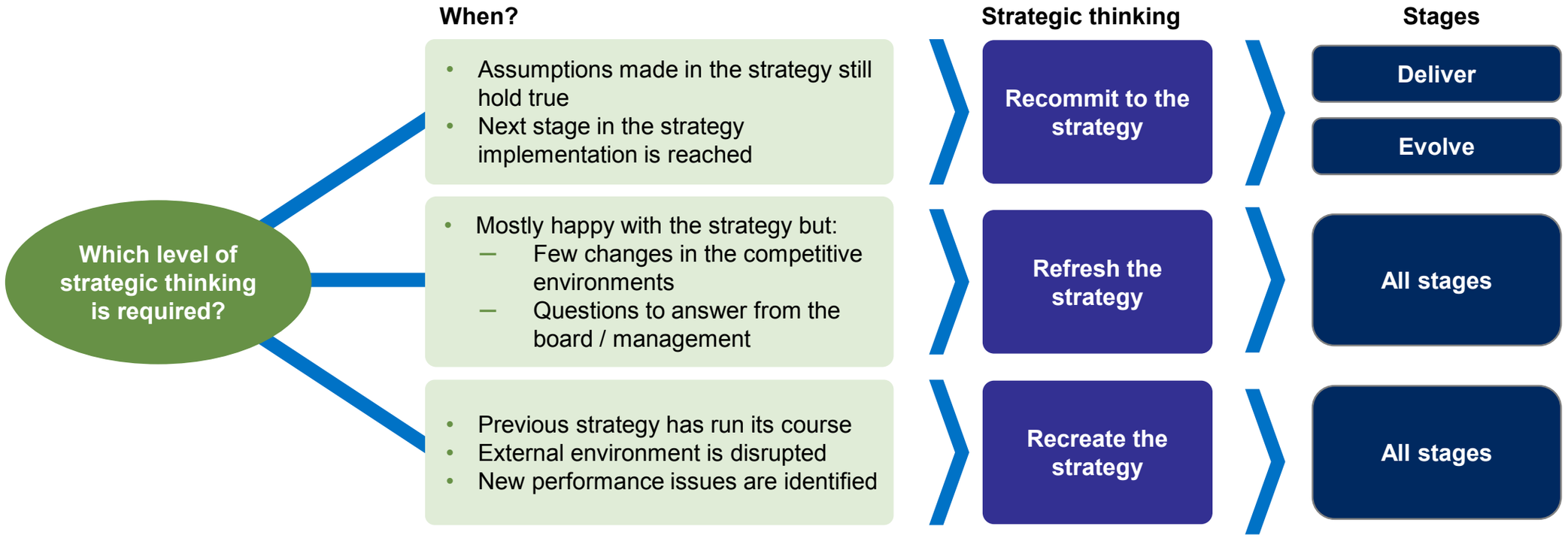
- which of the seven stages you need to focus on
- the time required to complete the work
- the skills and capabilities needed to create an effective strategy
- the internal and external stakeholders you will involve, how and when
- ways to ensure governance structures for strategy development are in place

The additional detailed guidance on involving the whole organisation offers ideas on how to benefit from the experience, wisdom and innovative thinking of your staff, patients and partner organisations.

Selecting stages that are important for you

Three situations may prompt you to undertake strategy development work and use this guide.

- **Recommit.** If your strategy's underpinning assumptions are still accurate and implementation is on track, you will want to recommit to the strategy. This means briefly revisiting the Deliver and Evolve stages.
- **Refresh.** If you are happy with your strategy but the external environment has changed, you may want to refresh the strategy. This will involve working through all the stages in the guide and checking whether you need to change any assumptions or outputs, asking questions outlined on the next page.
- **Create or recreate.** If you do not have a strategy to meet your goals – perhaps because the local health economy has changed or your FT has identified new performance issues – you will want to recreate your strategy. This will involve going through each stage in detail.



Overview of questions to ask within each stage, to recommit to, refresh or recreate your strategy

	Frame	Diagnose	Forecast	Generate options	Prioritise	Deliver	Evolve
Recommit						How do we recommit?	Are our measures of success still the best ones to use?
Refresh	What issues should be addressed?	Has anything changed in the LHE or internally?	Has our view of the future changed?	What new options are available?	How do we adjust the choices we made?	How do we implement adjusted strategy?	Are our measures of success still the best ones to use?
Recreate	What is the right set of questions?	Who are we caring for and who funds their treatment?	What futures do we need to plan for?	What are the potential ideas for change?	What is our integrated strategy?	How do we implement new changes?	How should we set up our strategy to constantly evolve?

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Setting up a strategy development programme

After deciding which stages to undertake and to what depth, you need to devise a programme for carrying out the work. For this you need to understand how long each stage will take, the resources and skills required and which stakeholders to engage. You will also want to decide what governance structures to put in place to manage the process.

Time required and fitting it into the planning cycle

Creating a strategy or refreshing one will probably take two to six months. The time required will depend on:

- the scope of the work and the strategic questions you need to answer
- the scope and variety of your FT's services
- the number of people assigned to full-time strategy development and those who will work on it in addition to 'day jobs'
- the extent of planned participation from the wider organisation
- how easily data can be accessed
- any previous work done on the stage
- the level of existing commitment from staff, patients, commissioners and other external stakeholders

To create a full plan, you need to judge the time needed to complete each stage. To reduce total time, some stages can run in parallel. The **Forecast** and **Generate Options** stages, for example, could be started together, though you will need to complete the forecasts before you finish generating options.

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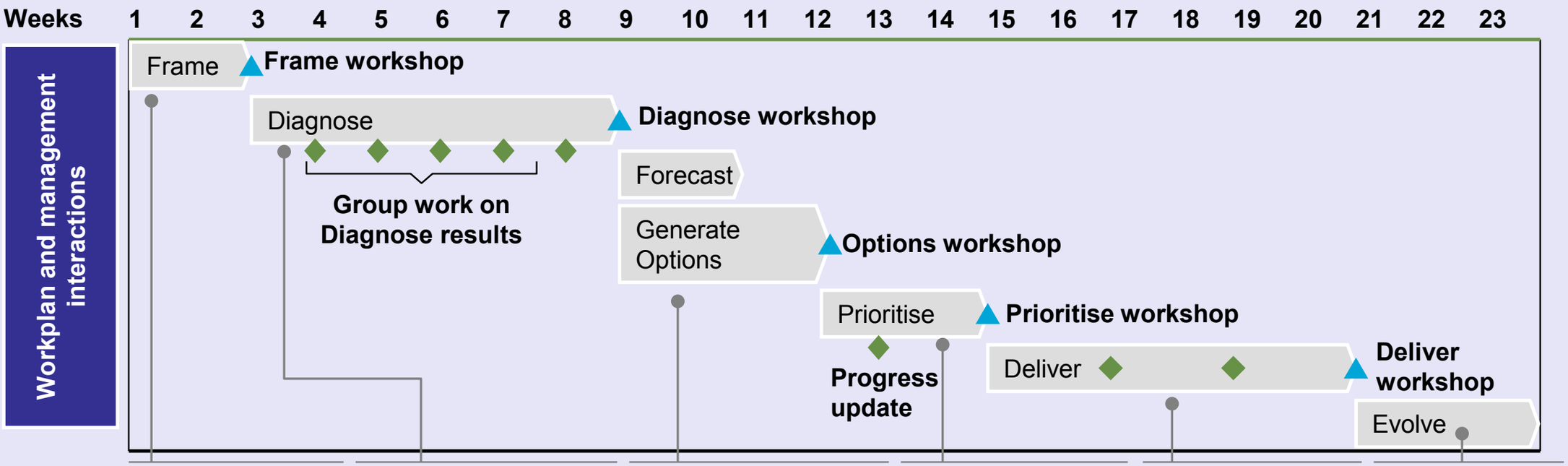
EXAMPLE

Programme of work, including the staff involvement plan, developed in the Frame stage

This is a high-level example of how a large and complex FT recreated a strategy. A dedicated team led the work with involvement from others in the FT and externally where needed. The workshop timings and the number shown are indicative; more details can be found in the guidance on developing strategy with your organisation.



Activities

Frame
- Agree scope
- Outline key strategic choices and what you need to know to make them
- Design staff involvement and board interaction process

Diagnose
- Assess how the FT has been performing against a balanced set of measurements and why
  - quality diagnosis
  - perform revenue and cost driver tree analysis
  - detailed review of specific issues/trends

Forecast and Generate Options
- Conduct forecast analysis to support strategic options assessment
- Agree strategic themes or choices to focus on
- Create lists of initiatives for each theme then filter to make a shortlist

Prioritise
- Assess implications of the shortlisted strategic options
- Put together and agree the integrated strategy and the portfolio of initiatives planned to deliver it

Deliver
- Develop and agree overall roadmap with
  - proximate goals
  - resourcing plan
  - initiative sequencing
- Update measures and targets

Evolve
- Monthly 'pulse checks' to monitor progress of strategy
- Triggers to reassess strategy if internal or external environment changes

Source: Based on an NHS provider example

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Skills and capabilities needed to create an effective strategy

The resources you require will depend on whether you are refreshing or recreating the strategy, how easily you can access data, the FT's size and complexity and the time you have to do the work.

Creating a detailed project plan will help, with each development stage divided into activities and the resources needed. You can use this to identify key pieces of work at each stage.

You may set up a full-time team or assign activities for staff to do alongside their day-to-day work. You will need support from clinical directorates and corporate functions such as IT, HR and finance. Choose a dedicated contact point in each, with agreed time devoted to assisting the project. Depending on the spread of the work across the organisation, you may consider setting up a project management office to help co-ordinate strategy development and delivery, once it is agreed. Alternatively, the strategy director and team may adopt this role.

Match the people you assign to strategy development with the skills demanded for each activity at every stage: for example, during the **Diagnose** and **Forecast** stages this will include financial modelling and the ability to interpret quality measurements.

To develop an effective strategy you will need at least the following:

- board sponsorship and board discussion time
- a trust executive team able to work with clinical and central directorates to engage others in the organisation
- clinicians with dedicated time to help interpret results from the **Diagnose** and **Forecast** stages, as well as generate and assess ideas before selecting the best ones
- colleagues with skills in engaging external stakeholders
- colleagues with project management skills to ensure the work is completed on time and to a high standard
- colleagues with strong analytical and data interpretation skills – in clinical and central directorates, as well as the strategy team – to gather and interpret facts and forecasts, and estimate the impact of ideas for change.

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Engaging with stakeholders

Various stakeholders need to be involved in strategy development, within your FT and externally.

Your internal stakeholders will include the board, FT governors, executive team, strategy team, leading clinicians, managers and staff across functions. These should be involved from the beginning – the **Frame** stage. You will need regular opportunities for conversations with them. It is important that people who would not normally communicate with the strategy team, such as clinicians without management responsibility, or non-clinical staff, have a chance to contribute to strategy development.

More detailed ideas on involving staff from across the FT is included in the chapter on **Involving the whole organisation in strategy development**.

Your external stakeholders, identified during the **Diagnose** stage, will include patients, health and wellbeing boards, commissioning organisations, the local authority and educational and research-funding bodies. You may wish to involve them throughout to understand their priorities, validate your diagnosis and forecasts, and test the feasibility and likely impact of strategic initiatives. External stakeholders can help assess the coherence of your proposed strategy.

More detailed ideas on involving external stakeholders are included in the next two pages.

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Ideas for external stakeholder involvement in strategic development and planning in an FT (1/2)

	Frame	Diagnose	Forecast	Generate options	Prioritise	Deliver	Evolve
Health and wellbeing boards	Discuss areas of delegated commissioning	Share impacts of strategic needs assessment – Patient views via HealthWatch		Share knowledge and aims on integration Targeted input to assess ideas on criteria	Appropriate consultation on any major proposed changes in services		
Patient bodies, FT members, national and local groups		Use expertise to understand local position on services	Use expertise on data and trends to forecast services	Involve in generating high-impact initiatives on themes	Involve in setting criteria for selection	Patient bodies can advise on implementation or may be delivery partners	
Commissioners (NHS England, CCGs and Specialist, LA for public health)	Share perspectives on key questions and challenges Resolve any differences in expectations of scope	Reach common position on baseline activity, demand, setting quality standards Agree priority performance areas of concern	Joint forecasting of LHE demand Common understanding of respective forecast financial positions	Joint work on possible solutions – giving rise to strategic initiatives Take account of commissioner requested services (CRS)	Discuss impact of proposed initiatives Agree new delivery models, future service portfolios Assess impact on commissioner priorities	Joint work on implementation on system-wide changes eg integration	Periodic review of main assumptions about all commissioners funding and provision
Local authority	Share perspectives on key questions and challenges for population health	Share data for important analyses/avoid duplication (public health)	Share data for important analyses/avoid duplication (public health)	Joint work on initiatives linked to greater commissioning role eg Better Care Fund	Significant change, consultation at overview and scrutiny		Periodic review of main assumptions about LA funding and provision

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Ideas for external stakeholder involvement in strategic development and planning in an FT (2/2)

	Frame	Diagnose	Forecast	Generate options	Prioritise	Deliver	Evolve
Other healthcare and social care providers in LHE (acute, community, mental health and primary care)	Share perspectives on key questions and challenges	Understand scope of provider strategies – look for competition or collaboration	Anticipate provider strategies Formal joint forecasting where working together	Explore collaborations with other providers eg with primary care, other acute trusts		Joint work on implementation where there are joint solutions Integration across pathways eg social care on frail elderly	
Educational bodies/ commissioners	Discuss proposed scope and process Joint work to identify strategic questions	Consult on issues to address, current status of educational provision	Understand future teaching requirements, opportunities Discuss and agree future FT workforce requirements	Joint work to identify opportunities to tackle issues and innovate		Joint work for implementation	Discussion and reporting for any periodic strategy reviews
Universities and research bodies	Discuss proposed scope and process Joint work to identify strategic questions	Validate data and agree interpretation	Understand future priorities for clinical research	Share knowledge with others; generate ideas Targeted input to assess ideas on the criteria for shortlisting		Joint work for implementation	Discussion and reporting for any periodic strategy reviews

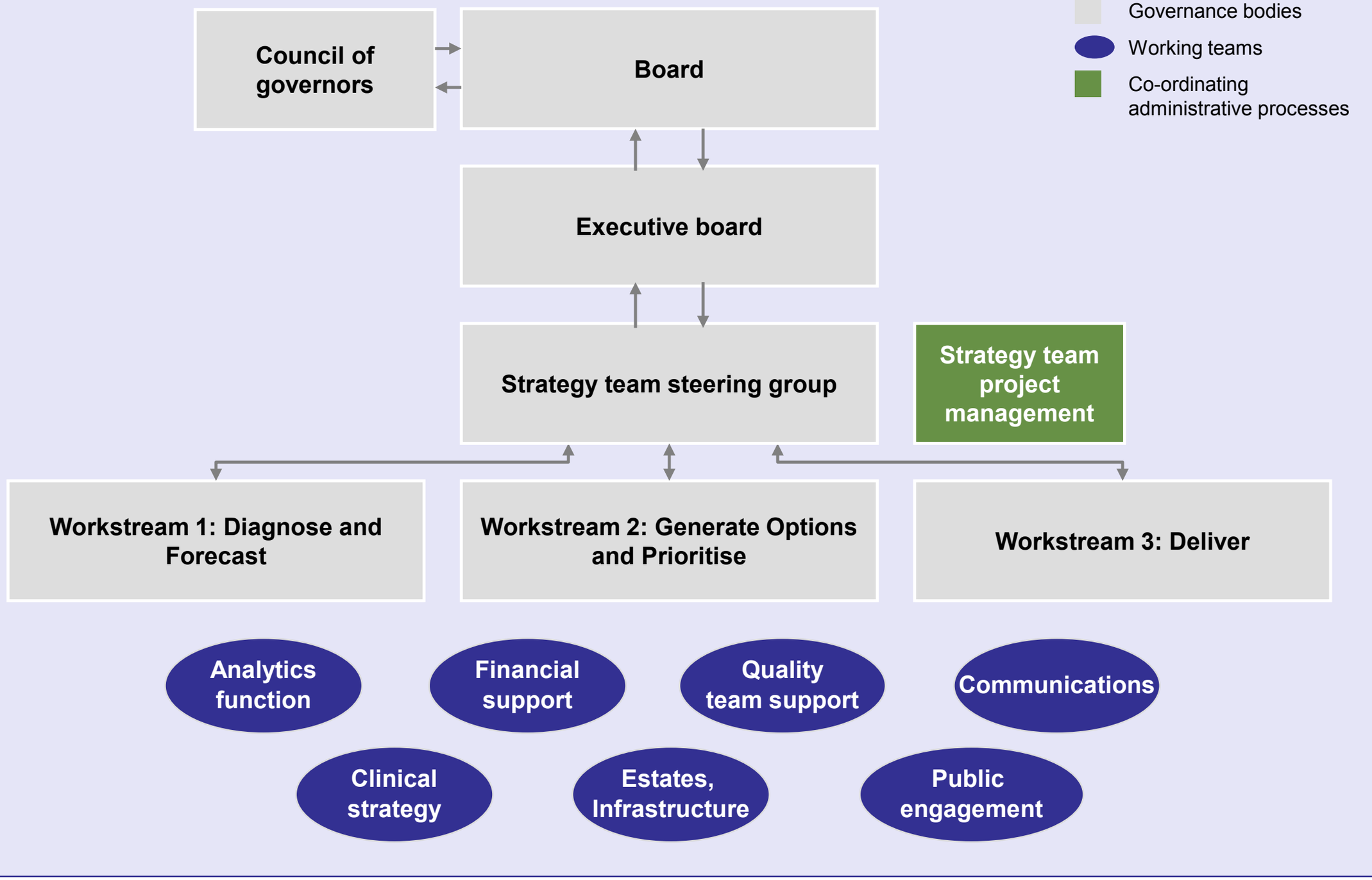
Setting up the right governance structures

You will need appropriate governance structures to manage creation of the strategy and ensure the right stakeholders are involved. Your governance structure will reflect the scope of the task, whether you are refreshing or recreating the strategy.

An example of one FT's governance structure for developing a strategy is included on the next page. Though you may choose different elements, this significant undertaking may call for additional governance systems to keep it effective and on track.

EXAMPLE

FT governance plan for managing a strategic review (1/2)



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EXAMPLE

Detailed FT governance plan for managing a strategic review (2/2): meetings

	Purpose	Frequency and length	Membership
Workstream: Diagnose and Forecast	• Trust-wide alignment • Strategic oversight • Challenge • Prioritises decisions and ratifies strategy • Manages risk Chair – Chief executive	• Every two months • Also for key decisions • 2-3 hours	• Board non-execs • Governors' representatives • Executive directors • Director of strategy
Executive board	• Challenge and direction to review • Sets objectives • Ensures quality of process • Holds to account on timescale and deliverables • Secures necessary resources • Ensures collaborative working Chair – Medical director	• Monthly • 2 hours	• Executive directors • Director of strategy • Associate directors • Divisional clinical directors
Strategy team steering group	• Supports executive board • Manages detail of work programme Chair – Director of strategy	• Monthly • Weekly during stocktake • 2 hours	• Strategy team • Leads for workstreams • Leads for supporting working groups • All clinical directors

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Involving the whole organisation in strategy development

Introduction

Why should you involve the whole organisation?

Strategy developed by an FT as a whole will contain more insight from across the organisation and will have been challenged more thoroughly by those closest to the situation on the ground. Implementation will be more effective, and staff involved in creating the strategy are more likely to support it.

What is included in the detailed guidance?

The detailed guidance contains suggestions about who should contribute at each stage, and how to secure their involvement. The extent and nature of this will vary between stages. For example, in stages such as **Diagnose**, where the strategy team will do most work, involvement takes the form of sharing their analysis and asking for help to interpret it. In others, such as **Generate Options**, the organisation should suggest and debate ideas for change. Crafting the overall programme of work with colleagues across the FT is critical to ensuring you gain the best possible help in developing the strategy. That should ensure you have the trust's support for implementing it.

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What's the goal?

The quotes below come from a conversation with FT general managers (GMs) and clinical directors (CDs).

Common pitfalls in the words of GMs and CDs

"CDs and GMs gave input briefly at the end of the planning process, after the board had a strategy awayday – they just plopped this document down in front of us and there was a good 10 seconds of stunned silence"

"Details of the strategy are left until implementation: six months later they come along and say, "Oh, you're not making a surplus from this," and we could have told them that we'll never make a surplus from it!"

"We have to have a strategy to survive"
"But no-one cares about outputs if they're not involved in inputs"
"Our healthcare assistants couldn't tell you the strategy"

Ideas to achieve a better future state

"CDs and GMs should participate in strategy workshop sessions to determine the scope of strategy"
"CDs and GMs can help generate options, rather than just getting involved in picking from someone else's list"

"We should consider implementation plans and business cases before strategy is chosen"
"We need resources to be allocated to support people who are asked to take on extra work to make the change happen"

"We could use the weekly meetings with the GM to be a place to spread it [knowledge of strategy]"
"We could use more visibility from the CEO and executives on strategy face-to-face with us"

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Ideas for staff and patient involvement

Summary of ideas for staff and patient involvement in strategy development in an FT

		Frame	Diagnose	Forecast	Generate options	Prioritise	Deliver	Evolve
Exec directors, NEDs		Agree on scope and process	Review findings	Review findings	Suggest ideas; agree shortlist criteria	Select strategy from shortlisted initiatives	Agree long-term goals	Assess overall progress and take action
Strategy team (and HR, finance)		Create proposed scope and process	Do analyses; interpret findings; involve colleagues	Do analyses; interpret findings; involve colleague	Gather inspiration and synthesise analysis	Detailed analyses of shortlisted ideas	Suggest key performance indicators	Provide updates and watch out for triggers for reviewing
Clinical directorates	**Divisional directors and GMs**	Agree on relevant areas of the scope and process	Validate data and agree interpretation	Agree forecast assumptions; validate forecasts	Share knowledge with others; generate ideas	Targeted input into detailed assessment of ideas	Hold responsibility for strategy delivery within own areas	Flag triggers to indicate need to rethink strategy; suggest changes
	Wider staff groups	Understand why strategy is being developed	Review findings	Review findings	Suggest ideas for change	Understand why specific choices have been made	Cascaded responsibility for delivery	Understand process for changes to strategy if needed
Patients		Articulate their hopes and wishes for the new strategy	Provide input to Diagnose work; review findings	Review findings	Suggest ideas for change	Help shape selection criteria and understand why specific choices have been made	Support strategy delivery	Flag triggers to indicate need to rethink strategy; suggest change
Governors		Feed in views of members to the board				Feedback trust plans to members and public	Hold NEDs to account for performance of the board	

Note: involvement of commissioners is addressed in the external stakeholders section and not here

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Involvement in the Frame stage

Frame

Workstream	Who to involve	Joint goal	Input from strategy team	Output from joint work
Scope of strategy: what can and cannot be considered in the strategy review	Board members, governors and strategy leadership	Extensive discussion and agreement, eg through a half-day workshop	The FT's last strategy; list of suggested goals/themes for the strategy	An agreed list of goals/themes for the strategy to present to the senior trust leadership
	Senior trust leadership (both managerial and clinical)	Discussion and agreement, eg through a one hour presentation and one hour of facilitated discussion	Suggestion of scope for the strategy from the meeting of board members and strategy leadership	Agreed scope for the strategy, with clear direction on what can and cannot be considered
Governance structure	Senior trust leadership (both managerial and clinical), executive, board, strategy leadership	Final sign-off	Proposed plan for governance structure, to include boards with membership and terms of reference and required steering committee meetings	Agreed governance structures and steering committee meetings
Internal stakeholder engagement plan	Senior trust leadership (both managerial and clinical), executive, board, strategy leadership	Final sign-off	Proposed plan for internal stakeholder involvement in developing the strategy with suggestions of likely time-commitments for senior leadership	Agreed plan for engaging internal stakeholders and commitment to carve out senior leadership time for this
External stakeholder engagement plan	Senior trust leadership (both managerial and clinical), executive, board, strategy leadership	Final sign-off	Proposed plan for external stakeholder involvement in developing the strategy	Agreed plan for engaging external stakeholders
Understanding context of strategy development	Wider staff groups	Understanding context	Summary of context	Understanding of context
Goals for strategy	Patients	Articulate patients' priorities and hopes for the new strategy	Hypotheses on scope, goals, themes	Input on scope, suggested goals/themes

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Involvement in the Diagnose and Forecast stages

	Workstream	Who to involve	Joint goal	Input from strategy team	Output from joint work
Diagnose	Validate and interpret quantitative measures of current performance	General managers, clinical leaders, corporate functions (ie finance, HR) as relevant	Validating data and agreeing an interpretation for clarification, or through meetings for final sign-off	Assessment of trust performance	Agreed assessment of FT performance
	Gain feedback from patients and commissioners	Patients, commissioners, education and research-funding bodies, FT governors	Feedback through interviews (face-to-face, over the phone) and surveys	Surveys, structured interviews	Feedback from all current customers on FT performance
	Review findings	Wider staff groups, patients	Review findings and accept/ challenge	Summary of findings as relevant (eg for specific lines/whole organisation)	Agreed assessment of FT performance
Forecast	Understand commissioners' intentions	Commissioners	Discussion of implications of commissioner intentions	Summary of implications of commissioners' intentions on FT's plans	Agreed statement of commissioner priorities Agreed timeline to commissioner priorities
	Assumptions of likely changes to demand, income and cost	General managers, clinical equivalents, corporate functions (ie finance, HR) as relevant	Inputting knowledge of correct assumptions to make, eg through meetings Agreement of final analysis, eg over email and phone, or through meetings if necessary	Initial assumptions on forecast of demand, income changes and cost changes at specialty level and HRG level where the HRG: • makes up a significant portion of the businesses revenue • has unique drivers that would cause their demand to change • is very costly	Agreed forecast of demand, income changes and cost changes at specialty and HRG level where appropriate
	Review findings	Wider staff groups, patients	Review findings and accept/ challenge	Summary of findings as relevant (eg for specific lines/whole organisation)	Agreed assessment of likely future developments for FT

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Involvement in the Generate Options and Prioritise stages

	Workstream	Who to involve	Joint goal	Input from strategy team	Output from joint work
Generate Options	Generate ideas for change	Senior trust leadership (both managerial and clinical), board, executive	Provide ideas for options that may not have been suggested by the strategy team	Agreed strategic themes under which to suggest ideas Synthesis of Frame, Forecast, and Diagnose Inspiration from a wide range of sources: national guidance, NHS, international, and other industries	Longlists of ideas for change on each theme
		Wider staff groups and patients	Use materials from strategy team and individual knowledge to generate ideas for change	Synthesis of Frame, Forecast, and Diagnose, along with inspiration from other industries/geographies/providers	Longlist of ideas for change
	Shortlist ideas	Senior trust leadership	Discussion of criteria to use in shortlisting	Initial hypotheses on which criteria to use, and frameworks/inspiration for criteria	Criteria for shortlisting
		Targeted wider trust groups and colleagues	Assessment of ideas on long-list according to criteria chosen	Criteria and a template for assessment	Longlist of ideas, assessed against the criteria
Prioritise	Selecting ideas	Board	Selecting ideas, eg half-day workshop	Synthesis of longlist of suggested ideas for change, and relevant information for assessing	Selected list of ideas for change
	Assessing feasi-bility of shortlisted ideas in depth	Senior clinicians and managers	Assessing impact and feasibility of shortlisted ideas in detail	Analytical support for assessing ideas	Detailed assessment of shortlisted ideas for change
	Review strategy	Wider staff groups, patients	Review prioritised initiatives and accept/challenge	Summary of strategic priorities	Agreed FT strategy

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Involvement in the Deliver and Evolve stages

	Workstream	Who to involve	Joint goal	Input from strategy team	Output from joint work
Deliver	Long- and short-term goals	Senior trust leadership (both managerial and clinical)	Suggesting and agreeing short- and long-term goals for implementing the strategy and the indicators for measuring progress against each	Suggested short- and long-term goals and associated indicators	Suggested list of short- and long-term goals with associated indicators to be presented to the board and executive.
		Board and executive	Agree on targets for long-term goals	Suggested list of long-term goals agreed with the senior trust leadership, and assessment of how they meet the strategy's goals as set out in Frame	Agreed list of long-term goals
	Cascade responsibility for strategy to whole organisation	Whole organisation	Understand the need for change and the vision of the strategy, what it means for them and their responsibilities	Detailed communication of the strategy with a compelling need for change, vision for the strategy and detailed responsibilities for staff	Organisation aligns itself with the strategy and understands responsibilities and goals
	Strategy deliver	Patients	Support strategy delivery	Summary of strategy	Support for strategy from patient groups
Evolve	Regular divisional progress reviews	Senior trust leadership (both managerial and clinical)	Discussion	Reported progress on indicators	List of next steps
	Overall progress reviews	Board and executive	Discuss and assess progress on the strategy	Reported progress on indicators to date Detail of any change to the external environment that significantly differs from forecast created and sensitivities applied in Forecast and Prioritise	Decision on whether to recommit to the strategy, refresh elements of it, or completely recreate it
	Process for change	Wider staff groups	Review process for flagging necessary changes	Summary of process for assessing strategy & changing where necessary	Agreed and understood process
		Patients	Understand process for change	Summary of process for assessing strategy & changing where necessary	Understand process for suggesting changes

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Resources for involving the whole organisation in strategy development

The following pages contain examples of other resources that could be helpful in the involvement of people across your organisation in strategy development. These include:

- Methods for involving staff, patients, and external stakeholders
- A range of techniques for gathering feedback
- Guidance on running a scenario workshop
- Idea generation (to be used in Generate Options stage)
  - an introduction
  - example timings
  - best practices for workshops
  - example workshop exercise

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Methods for involving staff, patients and external stakeholders

Engagement format	What do participants get from it?	How is it executed?	When does it have most impact?
Intensive knowledge development	**Deep understanding** of a specific knowledge topic	1-2 hours led by knowledge expert (eg clinician) – teaches content to participants	• Team members have an insufficient level of understanding of specific content to draw insights from analysis and make decisions
Think tank	**Agreement on insights** and implications drawn from analysis	1-2 hours working meeting led by working-team facilitator – working-team and senior stakeholders discuss set of analysis to jointly draw insights	• Team members and senior stakeholders have deeply entrenched views that need to be validated or disproven with facts, and like to understand and own data to align with insights
Workshop	**Agreement on insights** and implications drawn from open discussion	4-6 hours led by working-team facilitator – broad working group discusses and aligns on relevant issues	• Large team wanting, or required, to contribute to solving the problem • Time for alignment across multiple stakeholders on one or more topics
Steering committee	**Decisions and agreement on recommendations** and subsequent next steps	1-2 hours led by working-team facilitator – presentation of recommendations to senior stakeholders (timing varies, depending on number of decisions)	• Need for decisions from senior stakeholders on specific recommendations in order to progress • Guiding or directional inputs are required from senior stakeholders
Knowledge tour	**Insights, knowledge and inspiration** about the way parts of the hospital / other hospitals work	2-3 days – visit to parts of the hospital or other healthcare providers for senior stakeholders or working team	• Team is struggling with development of inspirational ideas • Team has limited exposure or experience outside their hospital / directorate
Informal discussions	**Perspectives on selected issues**	1-3 hour informal session (over lunch or dinner) – for working team, senior stakeholders or broader stakeholder group to discuss perspectives on a relevant topic	• Working team has had limited interactions outside the immediate working group • Large number of stakeholders have interest in the specific work

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An introduction to a scenario workshop

This is a 1-2 day workshop with strategy and operational teams.

It helps to define fundamental uncertainties in the environment, and to construct plausible scenarios, so that teams:

- align on major trends and how they affect our work
- identify and prioritise key uncertainties and discuss how to reduce them
- create a view of the most credible futures and agree on 3-5 most likely scenarios for further investigation

It provides a basis for discussing signposts for each scenario, and decision points.

It helps to account for uncertainty and build flexibility into strategy.

> We know which trends and un-certainties really matter and how they may affect us.
>
> We have a good view of credible, but truly different scenarios for our organisation.
>
> The future is starting to feel more clear and actionable.

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An introduction to idea generation

An idea-generation workshop is a structured creative session

The right questions

- Structured list of questions (15-20 for a 20-people workshop)
  - take an unfamiliar perspective
  - limit the conceptual space
- Example: What's the biggest inconvenience or concern that our patients experience?

The right process

- Conduct multiple, discrete, highly productive idea-generation sessions
- Max 3-5 people per session
- For each session run for 30 minutes, expect 2-3 ideas

The right ending

- Ask each sub-group to prioritise their ideas
- Share all prioritised ideas in the bigger group but do not choose any
- Follow up quickly

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Idea generation: example rules for participation

Encourage creative thinking.
Any idea is worth considering

Do not disregard ideas. In this workshop, quantity and breadth of ideas are a priority. Everyone should share ideas openly as well as building upon others' ideas

There are no 'sacred cows'
nor ownership of the ideas

Do not criticise others' ideas. Can-do attitude is required to bring new and innovative solutions and overcome obstacles/ challenges

No hierarchy. Everyone's ideas, opinions, and points of view are equally relevant

No **history stories**, ie sharing **past experiences,** which only delays the process and limits creativity

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Idea generation: best practice for running workshops

- **Create an open environment** with broad participation. Encourage big ideas and ideas that haven't worked before, as well as new ideas. Encourage specificity
- Make sure everyone is **familiar with the fact base**. It's better to invest more time **aligning the level of knowledge** at the beginning, than having people failing to participate
- Include some **provocative ideas** to inspire the participants (some examples are included in Generate Options section of this toolkit)
- The more **diverse the background of participants** is, the richer the workshop will be. Be sure to **invite colleagues from as many areas as possible** (for example, clinicians, general managers, bed managers, finance, catering, porters, HR analysts)
- If your total participant group is greater than ~10, consider **breaking into smaller groups for the review and prioritisation** of ideas; this discussion can be lengthy!
- Encourage **rigorous thinking when prioritising ideas**; urge the participants to be as **fact-based** and objective as possible.
  - for example, when assessing up-front investment, use actual figures instead of 'low', 'medium' and 'high'
  - tailor definitions of feasibility and impact to match situation and nature of product/service
- Keep a **record of all the ideas** that came out in the workshop and share broadly with participants and other key people. When refining ideas, sometimes **merging them with previously discarded ideas** results in valuable insights

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EXAMPLE

An idea generation workshop exercise

Use a series of thought-provoking questions to direct the thinking process and promote exhaustive idea-generation

Question 1
Give participants an easy place to start

How can we reduce the waste that currently exists in our processes or services?

Question 2
Push participants to think at the limits of expected change

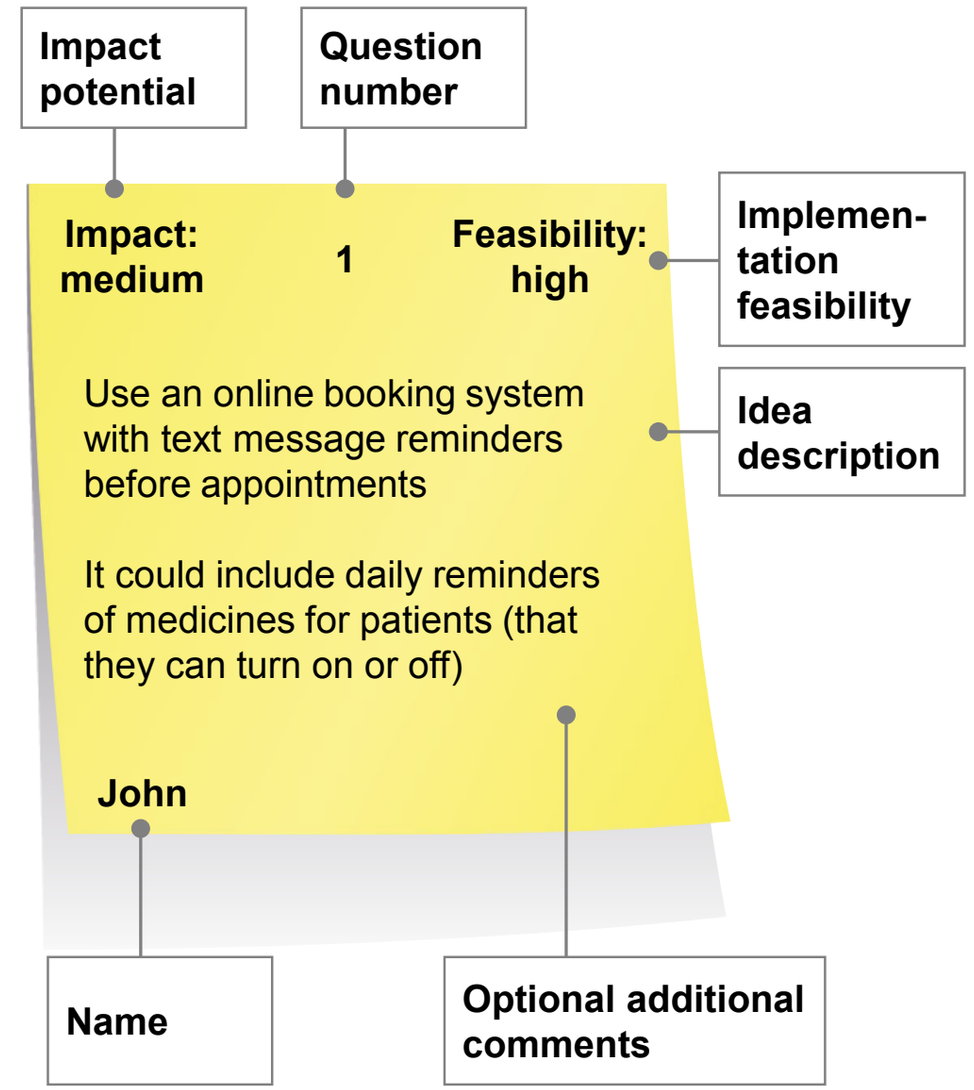
If you had to care for twice as many patients tomorrow, what radical changes would you have to make?

Question 3
Let participants feel this is an opportunity for their opinions to be heard

If you had a magic wand and a blank cheque, what changes would you make to our services or processes, without changing running costs?

Questions may be tailored as appropriate to the specific topic

For each question, invite participants record a target number of ideas (~5) using post-it notes



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Generating ideas: advanced techniques

Technique	Description
Survey	Design and conduct the best possible survey, given your resource constraints, picking the right respondents and developing the most insightful questions
Problem redefinition	Go beyond the question at hand, get past deductive reasoning, and stimulate new insights and innovative ideas by redefining the problem
Reframing	Walk in the shoes of others – take another perspective to trigger innovative ideas and see previously-unnoticed aspects of the problem
Point-of-view analysis	Explore new perspectives easily, alone, and quickly (in less than an hour); trigger new insights not available from your usual point of view
Reverse thinking	Force yourself into a different frame of mind for a moment and open up your thinking – particularly helpful if you are stuck with the same ideas
Constraint release	Explicitly identify and challenge the implicit assumptions and constraints that limit the solution-space unnecessarily

Technique	Description
Induction thinking	Generate new ideas with 'pre-inventive forms', a tool for inductive thinking that will focus your attention on unusual and interesting attributes of the problem
Analogies	Generate breakthrough solutions by considering other problems with similar key features from completely different areas
Tangible ideas	Make your ideas tangible by collecting meaningful feedback and developing ideas toward fully-implementable solutions
Rapid piloting	Harness the creative power of an evolutionary process by generating many ideas and testing them in a real-world setting, then quickly redesigning and testing again
Large-group intervention	Tap into dispersed knowledge by involving many people in problem-solving at the same time; generate ownership and energy through co-creation

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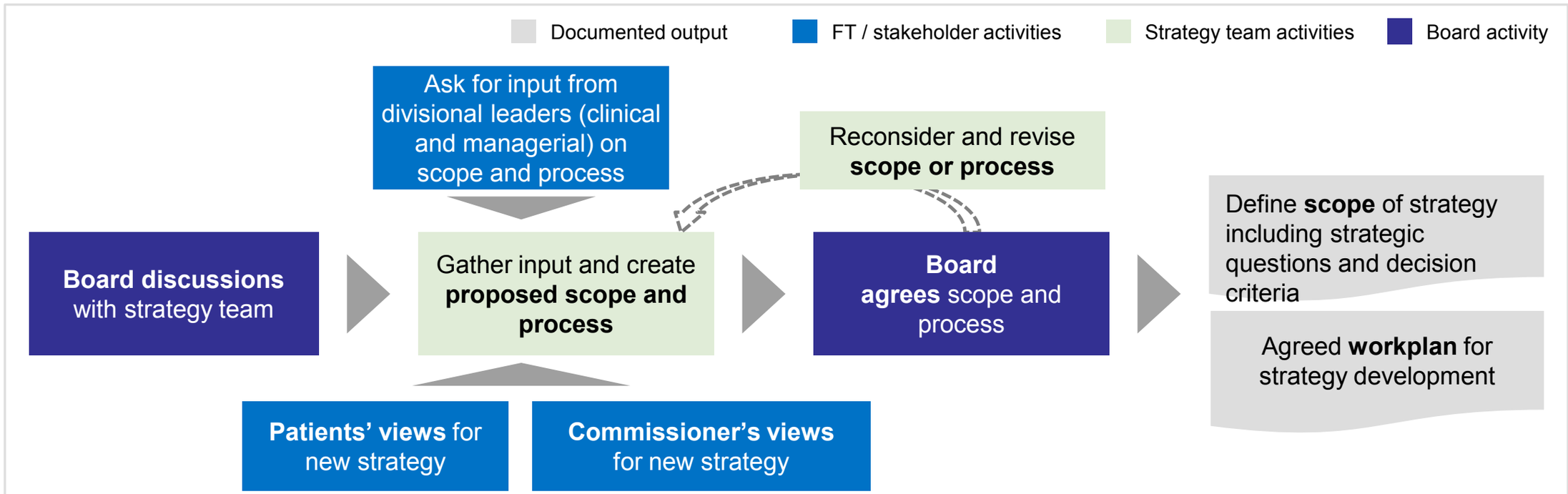
Introduction

Frame is the first stage in any major strategy review process. It involves determining the important decisions that the strategy development process will enable you to make. There should be a reason why the FT is embarking on strategy development; developing a case for change is an important starting point for identifying the critical decisions. The Frame stage ensures that the organisation is clear about:

- what strategic decisions need to be made
- how the strategic decisions will be made
- who will make the strategic decisions
- the programme and timetable of the strategic review process

This stage establishes a clear process and timetable that is transparent to the whole organisation and creates a work plan for developing the strategy with input from your internal and external stakeholders. It is important, at this early stage, to identify what the strategic questions are and to develop the criteria you will later use to prioritise your strategic initiatives. Failing to agree these issues explicitly and clearly at the start of your strategy-development process can cause confusion and disagreement later on. A process map for the Frame stage is shown here.



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Methods for identifying strategic questions

There are various ways to identify the most important strategic questions facing a trust. Although this may mainly involve the executive and full board, it is also important to involve service leaders, managers and functional specialists and others. It is worth involving external stakeholders in generating the questions your strategy should address.

There are four methods to develop your strategic questions. It may not be necessary to use each of them, but cross-referencing results from at least two will add validity and a greater sense of engagement.

1. **Identifying initial high-level objectives for the strategic review, using a 'case for change' approach that identifies the most important factors affecting the trust**
2. **Outlining the trust's key strategic levers and choices to identify the most relevant**
3. **Developing high-level hypotheses about strategic moves the trust could make**
4. **Using 'horizon scanning' on existing information on external and internal challenges and opportunities**

When using any of these methods, you should review the strategic plans of your commissioners (and possibly other local providers) to assess and include the strategic questions that arise from these submissions.

When you identify your strategic questions it is vital to engage people across the organisation. They have a vast amount of information about the context and the external environment. Organisational leaders may already have some preconceived ideas about the future direction of the trust should be, all of which provides important input into the process. The section on 'How to Get This Done' contains more detailed guidance about ways to engage your organisation during the various stages of the strategy planning process. This can be found **here**.

Other useful sources are national guidance, reports and consultations on areas that may impact on the trust; examples include reports on emerging models of care such as Monitor's 'Facing the Future: smaller acute providers', Nuffield Trust's 'NHS Mutual', Payment by Results (PbR) guidance, the Keogh Emergency and Urgent Care Review, NICE guidance and models of integrated care.

No trust will undertake this Frame stage with a completely fresh start. Each method outlined needs to acknowledge previous strategies and their successes and failures, whilst keeping an open mind about the future opportunities and threats.

At this stage it is important to maintain the focus on identifying the strategic questions rather than generating answers to them. There should also be a clear expectation that the scope of the exercise may be challenged later on, as a new insights emerge. The following page shows an example output for a Frame stage.

EXAMPLE

Frame output from an academic medical centre in the US shows specific questions to guide strategy development

Strategy	1	Which therapy areas do we make 'yes choices' for? How do we make those choices?
	2	In ten years' time, should we be an academic centre or an academic health system? How far do we integrate across the care continuum into primary, secondary and other forms of care?
Informa-tion	3	Should we create a shared information platform with other players: for example, a shared patient information set across the pathway in chronic diseases reaching into primary care? An inter-operable platform with other academic medical centres (AMCs)? What can we learn from the world's most successful integrators?
	4	How do we begin to build longitudinal data on clinical activities, genotypes and phenotypes per patient?
Perfor-mance and health	5	How can we deliver our clinical work for 30% lower cost, at higher quality than today, in 3-5 years' time? How do we work with our health system for appropriate funding for specialist care, education and research and the productivity penalty academic systems incur? What can we learn from the funding structures others have built in new areas such as philanthropy?
	6	How healthy is our organisation and we are creating the capabilities and culture we need to win in tomorrow's world?
Gover-nance	7	Are we a productive partner for those organisations we aspire to collaborate with? How productive are our external partnerships for us? What would be the three moves we could make to raise our aspirations or get otherwise more value from our partnerships?
	8	Are we a single- or double-headed board across university and hospital, and how do we make decisions where benefits and costs arise on different sides?
Talent	9	How can we better align our incentives to our strategy? Should we consider more radical models (eg grant-based compensation without base salary)?
	10	How are we rated by the world's best clinical and research teams in the areas we want to be good at? What evidence do we have from the past?

Source: Interviews and events with an AMC leadership team

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Method 1: Identifying initial objectives from a ‘case for change’

This method involves using initial information and understanding of the FTs position to consider the reasons for undertaking a strategic review process. Monitors existing strategic planning guidance sets out that long term trust strategies should address ways to ensure high quality, cost-effective services on a sustainable basis. You can develop a set of questions for the review by assessing the service and performance issues that need to be addressed and/or that could be enhanced. The Frame process might also help you to articulate an early aspiration on the vision for your trust.

A useful start to creating this initial vision and objectives is to be clear about the ‘case for change’ that has initiated the need for strategy development. There may be a single issue, or several. For example, a trust experiencing deteriorating clinical standards of service would identify a primary case for change in the turnaround of quality and safety of care for their patients. Or another FT might be providing excellent quality of care but has a financial deficit which requires a strategic response.

These assessments of an FT’s current position and future prospects will be developed in greater detail at later stages of the strategy-development process. However, a board should already have sufficient information to understand the main factors in any case for change. In the examples shown in subsequent pages, the FTs have used high-level, yet compelling, information about the issues and developments that stimulate a case for change. Being explicit in this way enables effective communication of the case for change to engage staff in your organisation.

EXAMPLE

The case for change for this NHS provider was based on capacity and financial constraints

The givens

- A numbers of givens frame the development of the strategy:
  - The development of partnership endeavours
  - Continue to deliver trauma and stroke
  - Patient care and service quality
  - Meeting local health needs

Operations

- Trust is performing above average on most measurements (eg clostridium difficile infection rate, readmission rate)
- How do we bridge the 25% gap with the top-quartile benchmarks in average length of stay, which represents a ~200 beds opportunity?

Context for trust

Academic developments

- FT is performing well at XX location, with new facilities under development (eg palliative care institute)
- However, how do we close the gaps between our performance and national and international excellence, which will require clinical/academic investment?

Capacity and financial constraints

- How do we overcome the capacity-constraint with an expected gap of ~200 beds unless major operational improvements are undertaken?
- Despite strong current position, how will Cost Improvement Programmes of ~£80m be delivered by 2014/15 to manage financial pressures and low tariff growth?

Source: Anonymised NHS provider example

EXAMPLE

The types of issues that may form a case for change

	Example issues
 **Quality**	• Highly variable clinical outcomes from clinician to clinician • Long time taken to implement best-practice ways of delivering care • High and variable length of stay • Poor patient satisfaction
 **Access to care**	• Long waiting times for elective procedures • Poor access to primary care out of hours, with resulting over-reliance on trust services • Apparently endless increases in demand for urgent and emergency care
 **Value for money**	• Ever-increasing unit cost in context of tightening economic environment • Low workforce productivity • Poor physical asset utilisation

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EXAMPLE

Case for change: this trust faced quality, capacity and financial challenges similar to those of other trusts in England

	Challenge	Description
A	**Increasing quality standards**	• Quality standards rising with more effective regulation • Recommendations on patient care standards and safe staffing levels are changing
B	**Changing healthcare needs**	• Ageing population requiring additional capacity in social care • Growth in chronic conditions, eg HIV, renal, diabetes, cancer • Increasing need for access to out of hospital services • Increased use of A&E when other services are not available
C	**Financial pressures**	• Rising costs: treating the changing health profile, cost of new technologies, increasing unit input costs • Expected efficiencies of 4.0-4.5% year on year • Increased staffing and clinical coverage ratios to meet standards

Source: Anonymised NHS provider example

Method 2: Create hypotheses about strategies the trust could pursue

Another approach to the Frame stage is to create hypotheses about strategies. This means the Diagnose and Forecast stages then focus on confirming or contradicting the hypotheses created. It is important to ensure that the strategic levers chosen are in line with the trust's starting point. Trusts that start out with a stronger financial and quality position are likely to focus on strategic initiatives that are different from those chosen by trusts that are in a less sustainable position.

The method has four steps:

Step 1: Set out the assumptions that must be met in any hypothesis. For example, all strategic moves must be considered within the context of NHS efficiency requirements. Other areas to consider are regulatory requirements, mandatory provision of certain services, and meeting quality baselines that cannot be varied.

Step 2: Seek views in one-to-one discussions and/or facilitated group work about assumptions on what the future holds for the FT and hypotheses on strategic solutions with the board, the lead governors, other service leaders and those in pivotal roles. These should be relatively free-form conversations to encourage creativity. These conversations could cover themes such as:

- Core services – improvement in clinical quality and financial viability
- Changes to service portfolio – grow or cease to provide
- Significant integration – vertical or horizontal
- Longer-term strategic investments
- Changes to organisational form
- Investment in the 'enablers' to deliver your strategy such as estates, IT, workforce change

Step 3: Undertake a ‘mirror’ workshop at board level, feeding back findings from the one-to-one discussions and looking for consensus. This is a workshop in which the views from individual interviews are fed back to the whole group for discussion. The output of this work would be your agreed hypotheses about strategies the trust could usefully pursue, including strategic themes and anticipated high-level initiatives.

Step 4: Turn these hypotheses into questions that the subsequent Diagnose and Forecast stages must address. This helps to create a compelling framing narrative.

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EXAMPLE

A trust that was considering a merger asked four questions to frame its analysis

What are the patient benefits?	• Good access to both local and specialist care • Higher quality and safety of core local services • Receive services that comply with all latest clinical guidance
What are the financial benefits?	• Savings from merging duplicate teams and support • Transfer of savings into maximising frontline care
What else might change and why?	• Possible service changes in the short term • Possible longer-term options for services
How best to capture benefits?	• Benefits (and risks) from collaborating • Benefits (and risks) from merging

Method 3: Identify the strategic levers and choices for your trust

There are a number of approaches the trust could take to ensure future success. These can be regarded as strategic levers. The following list includes both those that can be used independently and others that will be used collaboratively with commissioners. If using any of these levers is a realistic option for your FT, then this may form the basis of identifying some of your strategic questions.

1. Focus on transformation of clinical quality, outcomes and safety, independently and in collaboration with commissioners and partners
2. Strategic investments in clinical technology, digitisation, mobile technologies to change models of care delivery
3. Service-line mix:
    - select and focus on specific clinical services that are core to the trust
    - stop providing services that are no longer sustainable either on quality or economic grounds
    - change the model of service delivery and clinical practice
4. Horizontal integration to benefit from economies of scale, ranging across partnerships and joint ventures to merger and acquisition
5. Operational efficiency and productivity programmes, eg efficiency in pathways of care, asset utilisation
6. Vertical integration with acute, social care, community care or primary care, depending on current service
7. Creating joint ventures to provide services, eg to bring in specialist expertise, access to capital
8. Major capital expenditure (eg IT systems, equipment, estates)
9. Buildings and land rationalisation and/or development, eg reducing numbers of locations, increasing geographical reach
10. Maximising alternative revenue streams (eg clinical research)
11. Strategic decisions about education (eg change extent of teaching, subjects)
12. Strategic decisions about research (eg recruit additional talent, grow income)

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Method 4: Horizon scan from known information

No one can begin to develop a new strategy without some knowledge of the FT's history and environment in which it operates. Using this existing knowledge to horizon scan is another way that strategic challenges and opportunities, and hence strategic questions, can be identified.

One illustration of this is given in the next two pages, using an example from a mental health FT. This scan was produced without deep or complex analysis using existing information.

Usually this can be gathered during the Frame stage from facilitated discussions with the board, among clinical service leadership teams and by individual discussions with people in pivotal roles. The output gives a high level scan of important challenges facing the FT or opportunities. Using this, the board and leadership teams can set out strategic questions that can be answered during the strategy-development process.

EXAMPLE

Method 4 – Horizon scan from known information at a mental health trust (1/2)

Horizon Scan : External environment

Policy/think tanks

- Launch of NHS Five Year Forward View
- Barker Report
- 2015 Challenge Manifesto
- Chief medical officer's annual report – make mental health a priority
- Integrated personal commissioning
- Urgent and emergency care review update
- DH response to Health Select Committee's report on long term conditions

Quality

- Increase in number of patients self-harming and attempt suicide in units
- One in five GPs report patient harm as mental health services struggle to cope
- Dementia UK: 2nd edition
- New dementia toolkit for GP5
- WHO report on suicide

Finance

- NAO review of healthcare funding allocations
- DH confirms 2014 LA allocations for social care grant and Care Bill implementation grant
- NHS patient, visitor and staff car parking principles
- Guidance on personal health budgets

Technology & Innovation

- New app to report adverse drug reactions
- Healthcare Efficiency Through Technology(HETT) conference — 24/09/14

Regulation

- Visible CQC ratings
- New mandatory food standards for hospitals
- NHS terms & conditions for procuring goods and services

Reputation

- Positive coverage on local services
- Website and social media statistic
- Negative coverage
  - Rise in self-harm reported by patient bodies

Source: Lincolnshire Partnership NHS Foundation Trust

EXAMPLE

Method 4 – Horizon scan from known information at a mental health trust (2/2)

Horizon Scan: Market mapping

General health market

- NJIS mental health providers experience 2.3% real-term funding cut
- In a move that will open the GP market to the private sector, NHS England will only use alternative provider medical services contracts for all new practice procurements
- The NHS Partners Network has launched a review looking into how the independent sector can help NHS cost pressures

Commissioning

- NHSE is currently reviewing the area team footprint. Consolidating into bigger area teams may lead to bigger CCG5
- Government taskforce to address children's mental health SEND: guide for health professionals
- Transfer of 0-5 children's public health commissioning to local authorities
- New tool re. NHS and social care spend
- Commissioning personalised care within a capitated budget model

Competition

- The XX group has acquired YY a clinic for men suffering from personality disorders
- AAA is in talks to buy fellow mental health provider
- ZZZ Healthcare has announced plans to develop a second service in DDD
- EEE plans to pull out of clinical service provision in the UK

Service user needs & expectations

- No assumptions: a narrative for personalised, co-ordinated care and support in mental health
- New project launched to explore how well health and social care services are co-ordinated
- Understanding the rise in the number of complaints
- Updated engagement cycle guidance

LHAC

- Board position statement

Delivery partners/networks

- New 'hospice in the hospital' at Grantham opened in September

Source: Lincolnshire Partnership NHS Foundation Trust

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Criteria for assessing and prioritising strategic initiatives

It is important at the start of the strategy review process to agree the criteria by which you will later make strategic choices. These may include the following.

1. Impact on quality of care:
   - maximise clinical outcomes, patient experience or safety of service provision
   - improve access to care
   - enable adherence to mandatory quality standards
2. Impact on efficiency and financial performance:
   - improves positive net present value (NPV), return on capital and other financial requirements
   - improves income/cost balance of individual service lines
   - improves headline productivity ratios (eg activity to WTE, average length of stay)
3. Impact on sustainability and development objectives:
   - improve long-term sustainability, either directly through a specific initiative or as a result of improved scale
   - increase diversification, in terms of funding sources or kinds of care provision (eg with aim of increasing resilience to uncertainty)
4. Feasibility:
   - regulatory and other legal considerations
   - alignment with commissioner priorities and commissioning intentions
   - organisational ability to make changes happen, eg leadership skills, programme management
   - breadth of organisational commitment
   - time required to have effect

At this stage it is sufficient to describe the criteria. When the criteria are applied in making choices (in the Prioritise stage) it will be necessary to agree clear methods of measurement.

Developing an engagement plan

At the outset of the strategy development process it is important to create a plan for involving all levels of the organisation in the development of the strategy and its implementation. Both executive staff and clinical staff should be clear about levels of commitment, meeting dates and the extent of preparatory work.

This is important because:

- Strategy development is more effective and more inclusive when everyone knows when they need to contribute, and can plan accordingly.
- There is transparency about who is doing what, so that everyone has the chance to engage in the process, ask for updates and talk to the identified decision-makers.
- Leaders throughout the organisation can hold to account the individuals and teams who will conduct the strategy review and development process, ensuring that the outputs are delivered on time.

This need not be a complex project-planning exercise.

In the first example in the next page, the organisation has identified the important process components and their timings, keeping the engagement schedule simple. In the second example that follows the plan also specified other staff groups and external stakeholders who would be involved at the various stages of the process.

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EXAMPLE

A high-level plan to develop trust strategy

July	August	September	October	November	December	January
• **Continue integration** work across merged organisations • **Begin trust strategy development** process (eg approve 'Vision and Mission') • **Interview clinical and managerial leaders** on strategic issues	• **Continue to appoint and develop Confidential Advisory Group** (CAG) medical, nursing and manager leaders • **Appoint service leads**	• **Complete case for change** – Clinical – Financial – Commissioning • **Understand facts on the baseline position** for trust • **Agree strategic issues** to be addressed • **Complete creation of Service Line Reviews** for CAGs	• **October 1: CAG Go Live** • **Continue CAG Strategy and leadership development**	• **Agree high-level strategic priorities** • **Surface range of big strategic decisions** and implications of main choices • **Cascade** trust's strategic priorities to inform CAG strategies • **Approve and start process for managing** performance on strategic priorities	• **Finalise discussion and agree judgements** on all trust strategy components, to enable choices to be made in January • **Finalise CAG strategies** • **Define key actions and timelines to put in place all required enablers**	• **Make choices across all components of trust strategy, to create an integrated tri-partite strategy, supported by required enablers**
Suggested future board conversations	• **Sept board seminar:** Agree key components of strategy work and focus areas	• **Oct awayday and Oct board**: Case for change facts; financial sustainability and clinical components	• **Nov:** Review Oct follow-up and other components (eg integrated care, teaching and training enablers)	• **Dec:** Review integrated draft trust strategy • Review CAG strategic plans and any issues to solve	• **Jan**: Process to approve trust strategy • **By March**: Agree Service Line Activities and budget plans	

Source: Anonymised NHS provider example

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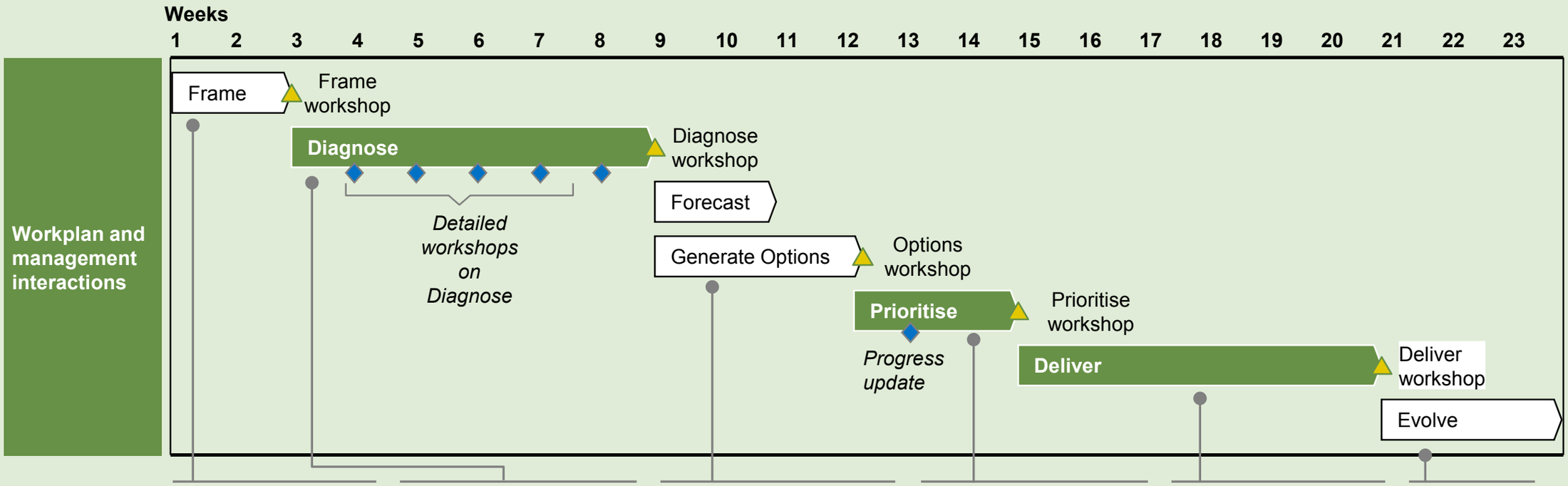
EXAMPLE

Another example of a high-level plan reflecting the stages in this guide, developed in a non-healthcare environment



Activities

Frame
- Agree on scope
- Design interaction process
- Send out initial data requests

Diagnose
- Assess how the business has been capturing value and why
  - Perform Return on invested Capital (RoiC) driver tree analysis
  - Analyse specific issues/trends
- Outline key strategic choices and what you need to know to answer them

Forecast and Generate Options
- Agree on the strategic choices to focus on
- Create set of strategic options
- Agree on existing forecast analysis to support strategic options

Prioritise
- Assess implication of the strategic options
- Pull together and agree on the integrated strategy and portfolio of initiatives planned to deliver it

Deliver
- Develop and agree on overall roadmap with
  - proximate goals
  - resourcing plan
  - initiative sequencing
- Update measures and targets

Evolve
- Monthly 'pulse checks' to monitor progress of strategy

Source: Anonymised NHS provider example

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Supporting resources

Stage	Monitor resources	Other resources
Frame	• Meeting the needs of patients: Improving strategic planning in NHS FTs • Supporting NHS providers considering transactions and mergers • NHS healthcare providers: working with choice and competition • Applying for NHS FT status: A Guide for Applicants (2013 version) • Quality Reports and Accounts Guidance (February 2014) • Enforcement Guidance	• Everyone Counts: Planning for Patients 2014/15 to 2018/19 • Better Care Fund Guidance

Monitor
Making the health sector work for patients

Diagnose

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Introduction

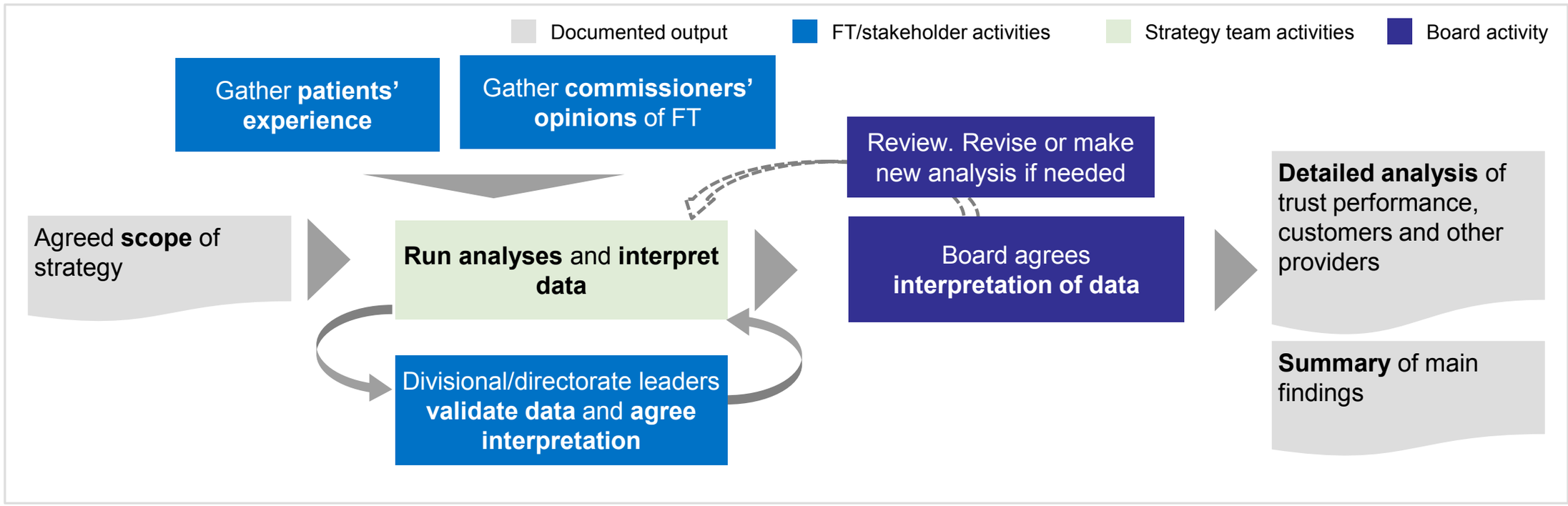
At the Diagnose stage you will make a comprehensive analysis of your FT's current position. You will build an understanding of your FT's performance, both on its own and in the context of the wider health economy, and this will bring up strengths and weaknesses for strategic consideration.

This analysis requires you to assess and understand three categories of information:

- the needs, challenges and priorities of the people you serve: this requires identifying exactly who your patients but also NHS commissioners and primary care clinicians who refer patients to your FT
- your clinical and financial performance, both the current position and how it has changed over time: it may be helpful to draw comparisons with other healthcare provider organisations in the NHS and internationally, and with other industries
- the identity, performance and strategies of the other healthcare providers that operate in your healthcare economies

You can find this information in your own local data sources, public NHS data sources, data from partners such as the local authority and educational institutions, along with expert reports and publications. See Appendix at the end of this stage for suggestions of data sources.

The process map below shows the Diagnose activities in sequence.



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Your patients and commissioners are important direct sources of data about your services. You can get this information from NHS commissioners and feedback from GPs and other primary care professionals who work with you and refer patients to you. If you provide private patient services, then health insurers are another source of information.

You will need to involve relevant staff from across your FT in validating and interpreting the data you collect and analyse. They may themselves also hold important sources of information. This approach to involving staff is covered in detail in Involving the whole organisation in strategy development which is in the ‘How to Get This Done’ section of the toolkit.

Understanding patients' and commissioners' needs, challenges and priorities

Identifying the full range of people your FT serves and their needs

You need to understand, both at trust level and for individual services, where your patients come from and therefore who commissions their care, plus characteristics such as age, deprivation levels and incidence of disease.

You can find this information at a service-line level through Hospital Episode Statistics (HES), Secondary Uses Service (SUS) and Service Level Agreement Monitoring (SLAM) data.

You can define your main commissioners in two ways. The first is to choose a percentage of NHS clinical revenue, and analyse the minimum number of clinical commissioning groups (CCGs) needed to cover it. Most acute trusts receive most of their clinical revenue from one to three CCGs, while the specialist trusts and some of the larger teaching trusts receive revenue from a distinct set of five or more CCGs with regional or national coverage. We recommend that, at a minimum, you should analyse the CCGs that account for at least 75% of your clinical revenue.

The second is to identify those CCGs that spend a large proportion of their budget at your FT. This is because each commissioner will make operational and strategic decisions about their main trusts. Even if a commissioner accounts for a smaller fraction of your revenue, they may still be making commissioning choices that will have implications for you.

Different types of analysis (by specialty) that could help you understand where your patients come from and who commissions their care include:

1. boroughs, wards or postcode areas that your patients come from
2. how much activity is driven by which commissioners
3. how much of a CCG's activity comes to your sites
4. what your share of health economy referrals is, both within and outside your direct catchment area (this is particularly applicable for specialist trusts)
5. which GP practices are referring to you, and how far they are from your trust

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To understand your patients' needs, you will need to analyse all the patients within your whole catchment area (ie not only those who use your services). This will help you understand how their needs are changing relative to the rest of the region or country, which will be useful for forecasting future demand.

You will also need to understand their age profile, deprivation levels and disease prevalence and burden. This information will be invaluable in creating assumptions about future demand in the Forecast stage of the strategy development.

Analysis of the main characteristics of your patients could include:

1. demographic indicators
2. deprivation indicators
3. disease burden indicators

Understanding your commissioners' needs, challenges and priorities

To understand your commissioners, you may want to analyse national guidance for CCGs and specialised commissioners, as well as local priorities. You need to review all priorities, including quality, safety, outcomes, patient experience and alternative models of care, and the current outcomes against those measures. It may also be useful to look at your FT's historic performance against your commissioners' intentions.

In addition, you will want to understand national guidance on and the local priorities of educational and research institutions that you have identified as important to you, as well as private health insurers where relevant.

You will also want to understand the financial situation of your commissioners including CCGs and NHS England Direct Commissioning. There are three potential problems with commissioner finances: carry-forward of historic deficits, high in-year spend and low recurrent allocations. You will need to work closely with commissioners to gather, analyse and interpret this data.

Analysis of your commissioners' needs, challenges and priorities could include:

- assessment of CCG intentions
- assessment of CCG performance against measures of public health outcomes
- assessment of historic CCG deficit through analysis of 2013/14 carry-forward and the 2014/15 year-end forecasts of areas of overspend
- comparison of commissioner spend per weighted population with allocation per weighted population
- commissioners' analysis of the overall balance of spend against an 'ideal' profile, highlighting potential root causes of local issues

The **Appendix** contains example analyses to understand patients' and commissioners' needs challenges and priorities.

Assessing and understanding clinical and financial performance

A detailed understanding of your FT's strengths and weaknesses is a key part of the strategy-development process. You will need to consider how it is performing on four broad dimensions and in aggregate, as explored in more detail in the following sections:

1. Understanding current and past performance across quality dimensions including patients' needs
2. Understanding current and past performance across operational dimensions
3. Understanding current and past performance across workforce dimensions
4. Understanding current and past financial performance
5. Understanding your performance as a whole

Your strategy will eventually contain coherent sub-strategies at service-line level so your diagnostic work must also look at performance by service line (and, where needed, at a more detailed level, such as by pathway or staff team).

You will want to understand for each dimension how your performance is changing over time and how you are performing against your own goals, and national and potentially international benchmarks and targets set by commissioners. The Useful resources list sources of national and international data and benchmarks.

Selecting the right measurements to answer your questions is an important process. In some cases, it will be a measurement widely used across the NHS: in others, you will agree your own measurements. For quality measurements in particular, clinical staff need to be involved, perhaps using an existing clinical audit as a basis for discussion.

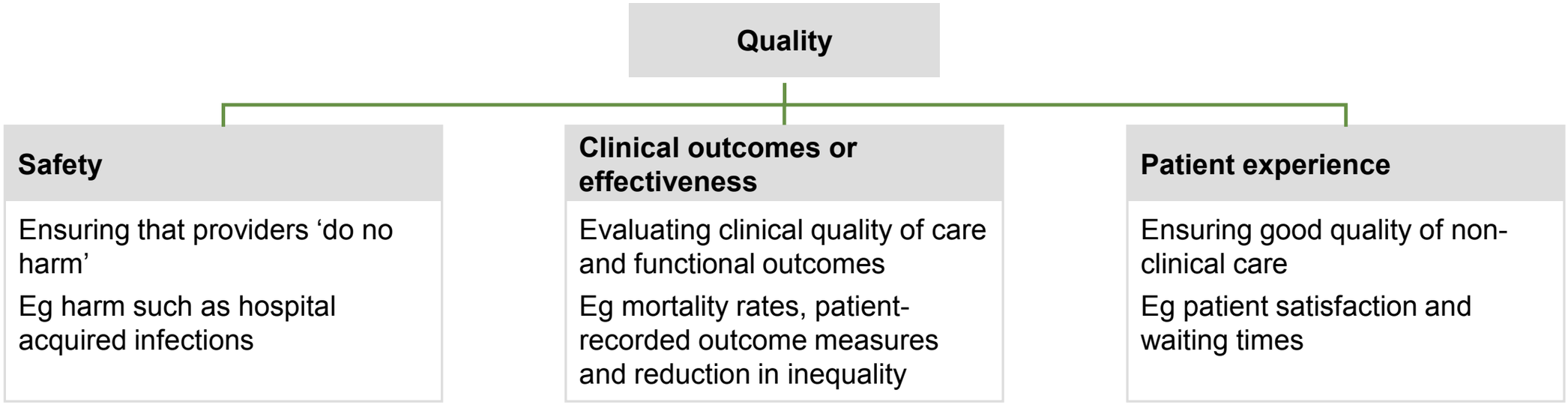
To support you with this Monitor has compiled a **Measurement pick list**. This list is not exhaustive and is there to provide possible insights and options for you when thinking about measurements to use.

You will also want to understand what drives performance. Once you have completed the initial analysis, you will need to select areas for further work, to understand the likely causes of good or poor performance, either over time or compared to others.

This next level of analysis may require you to collect less routine data and also to rely on comparisons of performance between different areas of your FT, since it may be hard to find comparable benchmarks for very detailed analysis. However, many trusts will want to delve into the same issues, and you can often make informal arrangements to share data to support improvement across the NHS.

Understanding current and past performance across quality dimensions

In order to understand your operational performance, you will need to understand your quality performance across the three dimensions of safety, clinical outcomes and effectiveness, and patient experience.



Many measurements can be used to assess your quality outcomes but assessing patient experience will require more qualitative approaches such as patient experience questionnaires and interviews. You will want to carry out this analysis at an FT-wide level, as well as within individual directorates and service lines.

You will also need to work closely with your clinicians to agree the measurements that would best enable you to gauge whether your quality meets your goals, along with the different measurements (if necessary) to support quality improvement.

Understanding your current and past performance across operational dimensions

Understanding operational performance involves assessing the main clinical operational areas, with a focus on staff productivity, patient flow through specialties, and utilisation of theatres, outpatient space and diagnostic equipment.

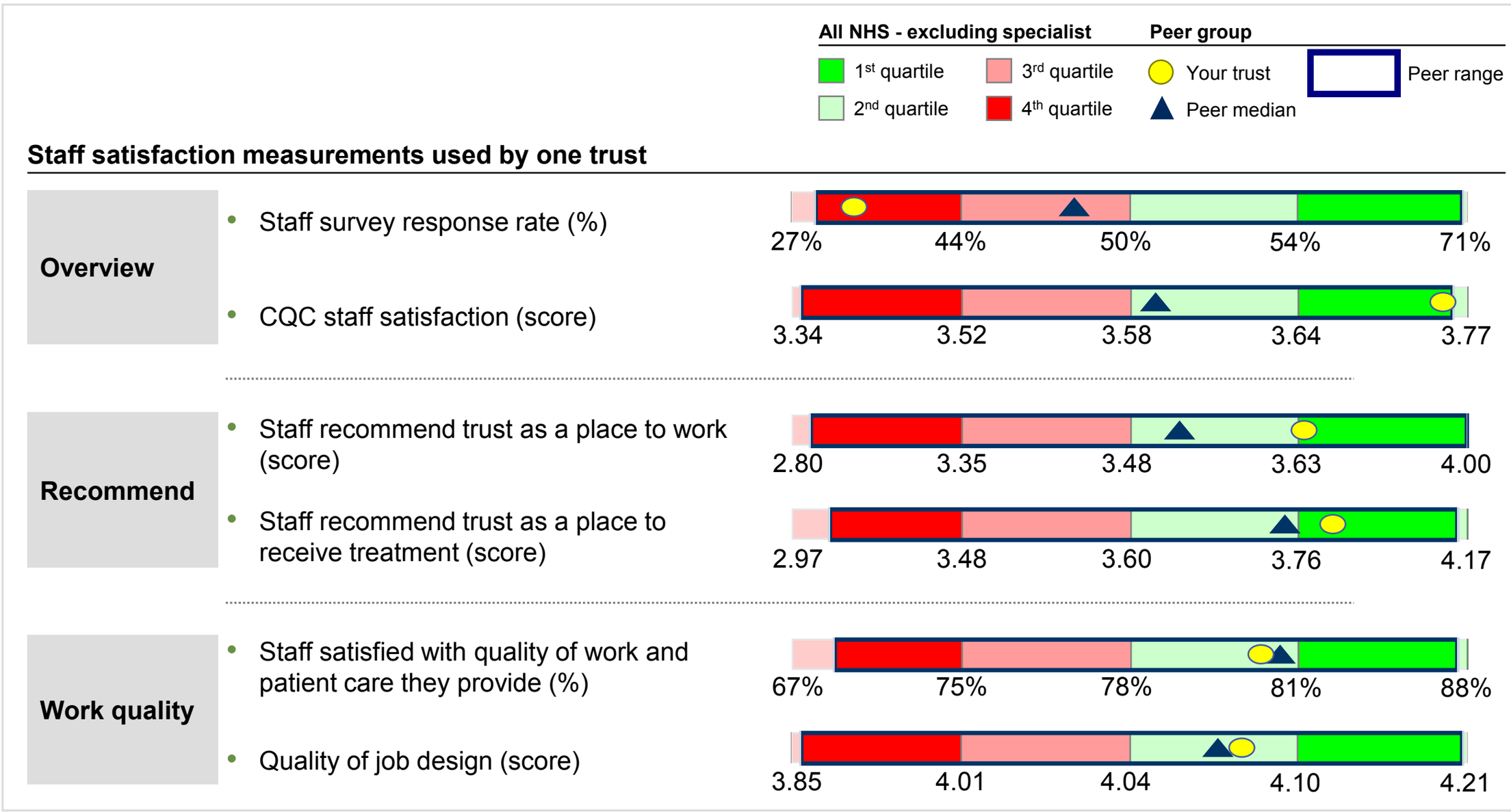
You can think about different measurements for the elective pathway, the non-elective pathway, staff and operational resources. For example:

- **elective pathway:** consider outpatient measurements such as cancellations and follow-up to new appointment ratios are often used; surgical measurements such as day-case rates, day-of-procedure admissions and cancelled operations, and length-of-stay measures
- **non-elective pathway:** consider A&E waiting times, length of stay and readmission rates
- **staff operational measurements:** can include consultant productivity, along with ratios of nurse staff to qualified nurses, and non-clinical staff to clinical staff
- **operational resources measurements**: can include bed and theatre utilisation, as well as estate measurements such as occupied space per bed

After an initial assessment of all areas at a high level, you will need to decide which measurement are relevant to you. You will also want to conduct detailed analysis through observations or additional data collection where you identify a particular strength or weakness.

Understanding your current and past performance across workforce dimensions

You will also want to understand performance on workforce dimensions. This can include staff satisfaction data from staff surveys and HR measurements such as turnover and sickness/absence rates.



Source: Anonymised NHS provider example

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Understanding your current and past financial performance

To assess financial performance, you will want to understand the main components of your costs and your income, and the ratio of the two (financial ratios).

1. **Income analysis** can include tariff income per spell, case-mix complexity, income per clinical employee.
2. **Cost analysis** can include creating a full 'cost-driver tree' that lays out the types of cost that make up the total cost-base and allows you to benchmark separate categories. For example, you can look at how your medical workforce costs compare with others, or how your estate fixed costs and maintenance costs compare. Within each cost-category you can do detailed analyses, such as comparing midwife productivity between two sites or over time, or comparing spend on specific consumables across departments.
3. **Financial ratio analysis** can include measurements such as ratio of capital expenditure to operating expenditure when relevant to specific decisions, but the most important ratio is likely to be the sustainability of your services, in total and by service line. You can look at service-line profitability before overhead costs are assigned, or assign these. In both cases, you will need to develop a detailed understanding of the operating costs of each service. Monitor's 'Service Line Reporting and Service Line Management' guidance documents give more detail on this.

Example analyses

The **Appendix** contains multiple examples of how to assess and understand various aspects of your clinical and financial performance.

Example detailed analysis

Another approach to understanding your current financial performance on costs is through detailed 'ideal cost' analysis comparing current costs with 'ideal' costs for delivering a particular service.

For this approach, consider the following:

- Develop an 'ideal' delivery model by point of delivery (POD), disease pathways or healthcare resource groups (HRGs).
- For each segment of care, identify all resources that will be used. These may include:
  - time with staff, non-clinical and clinical
  - supplies and drugs
  - lab tests
  - capital equipment time (eg, time spent on each x-ray)
  - non-clinical supplies
  - facility space.
- Create a full-cost model for each of the consumed resources:
  - for workforce modelling, assume a certain percentage of clinical staff time is spent interacting with patients to arrive at the number of whole time equivalents (WTEs) required
  - the model will continue to be sensitive to number of weeks worked by clinical staff; time per appointment; time per diagnostic test and patient volumes.
- Compare results with existing 'real' costs by service line and create a per-episode 'ideal' profile of costs by service line that you have determined as necessary for the ideal pathway.

You will want to discuss with clinical staff and additional resources to support you are:

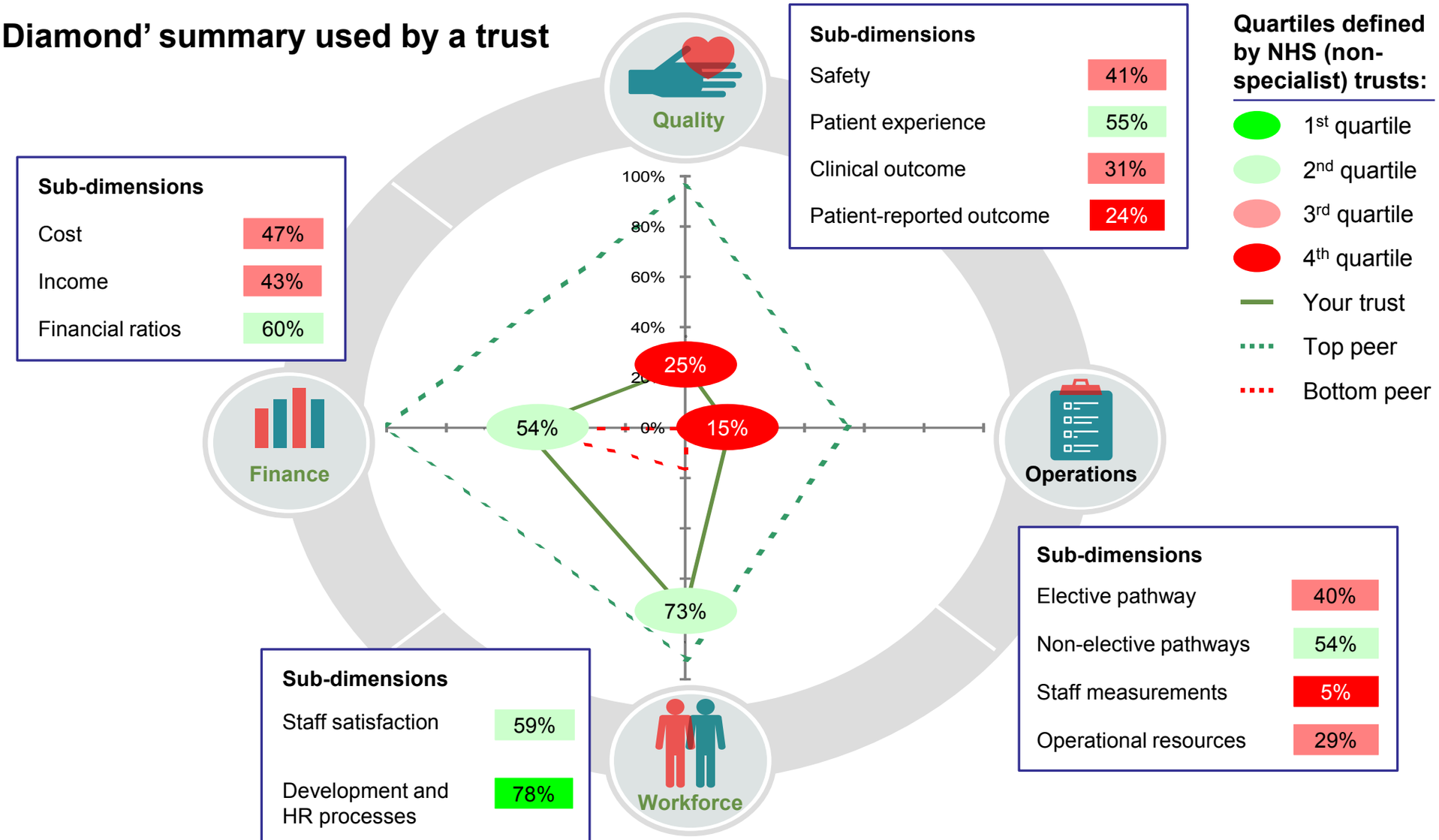
- CQC recommendations
- Specialty specific best practices

Understanding your performance as a whole

Once you have assessed the four dimensions – finance, quality, workforce and operations – both within your FT and in comparison with other healthcare providers, you can bring these elements together to understand your performance overall and communicate it to your stakeholders.

See below an example of performance summaries. There are two more examples in the **Appendix**.

'Diamond' summary used by a trust



Understanding other local providers and their strategies

To complete the analysis in Diagnose you will need to find out about the other providers of healthcare services to your patients, how they are performing, and their strategies. This will help you to understand likely future challenges and opportunities for specific services, as well as whether your ideas for change are consistent with what other providers are planning.

For each of your major service lines, you will want to know **who are the other providers offering services to your patients and commissioners**. For each service you provide, identify which other providers your commissioners and patients consider to be viable alternatives, including (where relevant) NHS, private and third-sector providers.

Your commissioners and patients may consider some of these providers to be better alternatives than others. Drawing on a range of information, including service performance, location of existing services and other aspects such as reputation, identify which providers they are likely to consider better alternatives and which worse. This will help you identify your stronger competitors.

Also compare their performance to national and international comparator organisations as you did with your own performance.

To know whether the performance of other providers is having an impact on your FT, you will want to understand **changes to referral flows or unscheduled care attendances**.

You need to ensure that you identify all the providers that are relevant to the service line that you are looking at. This can include primary, acute, mental health and community care; local authority social and personal care services, such as nursing homes; and independent sector providers of hospital, home, mental health and social care.

If you **understand other providers' future strategies**, you can use them in the Forecast, Generate Options and Prioritise stages, to compare your ideas for change with theirs, and whether they support or contradict each other.

The **Appendix** includes some example analyses.

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- National HES data
- CCG referral and activity data
- Shared data from local authority partners
- Public Health Observatories
- Office for National Statistics data
- Public Health England data and knowledge gateway
- Research/reports on patient experience/expectations
- HSCIC Indicator Portal
- Laing and Buisson healthcare research
- Dr Foster
- CHKS
- University research rankings
- GMC training survey
- CQC inspection reports and Intelligent Monitoring
- National Quality and Outcomes Framework

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Block	Existing Monitor resources	Non-Monitor resources
Diagnose	• Service Line Management resources • Guidance for the Annual Planning Review 2014-15 • Risk Assessment Framework • Approved costing guidance • Monitor's Approved Costing Guidance	• Care Quality Commission – Fundamental Standards • Methods Analytics Acute Quality Dashboards • How is the NHS Performing [Quarterly], King's Fund • Better Care Better Value • Productive community ward material

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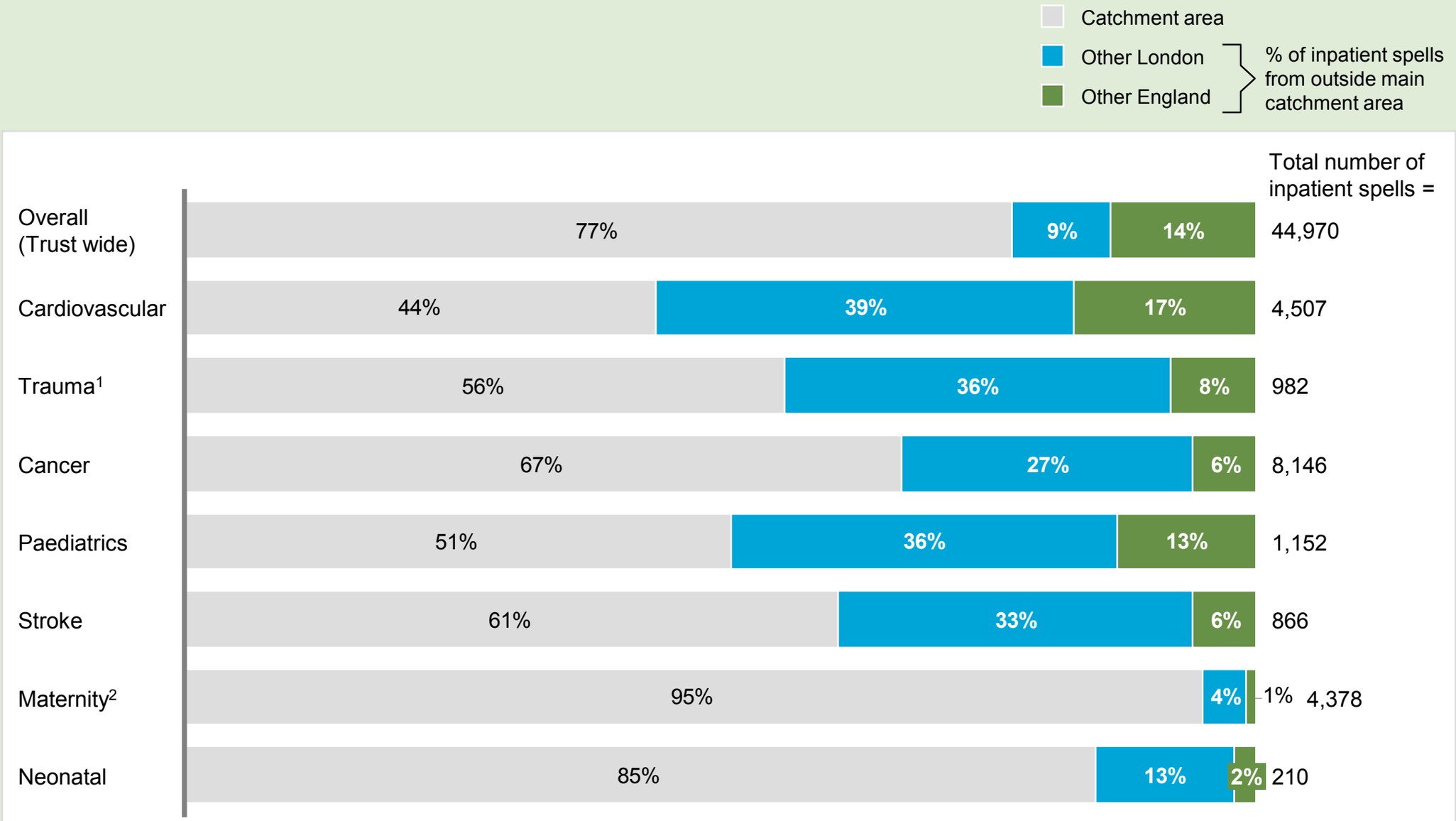
EXAMPLE

An acute provider's inpatient spells broken down by where patients come from



1 Contains only non-elective
2 Includes elective inpatients, non-elective inpatients and day cases

Source: Hospital Episode Statistics 2011-12

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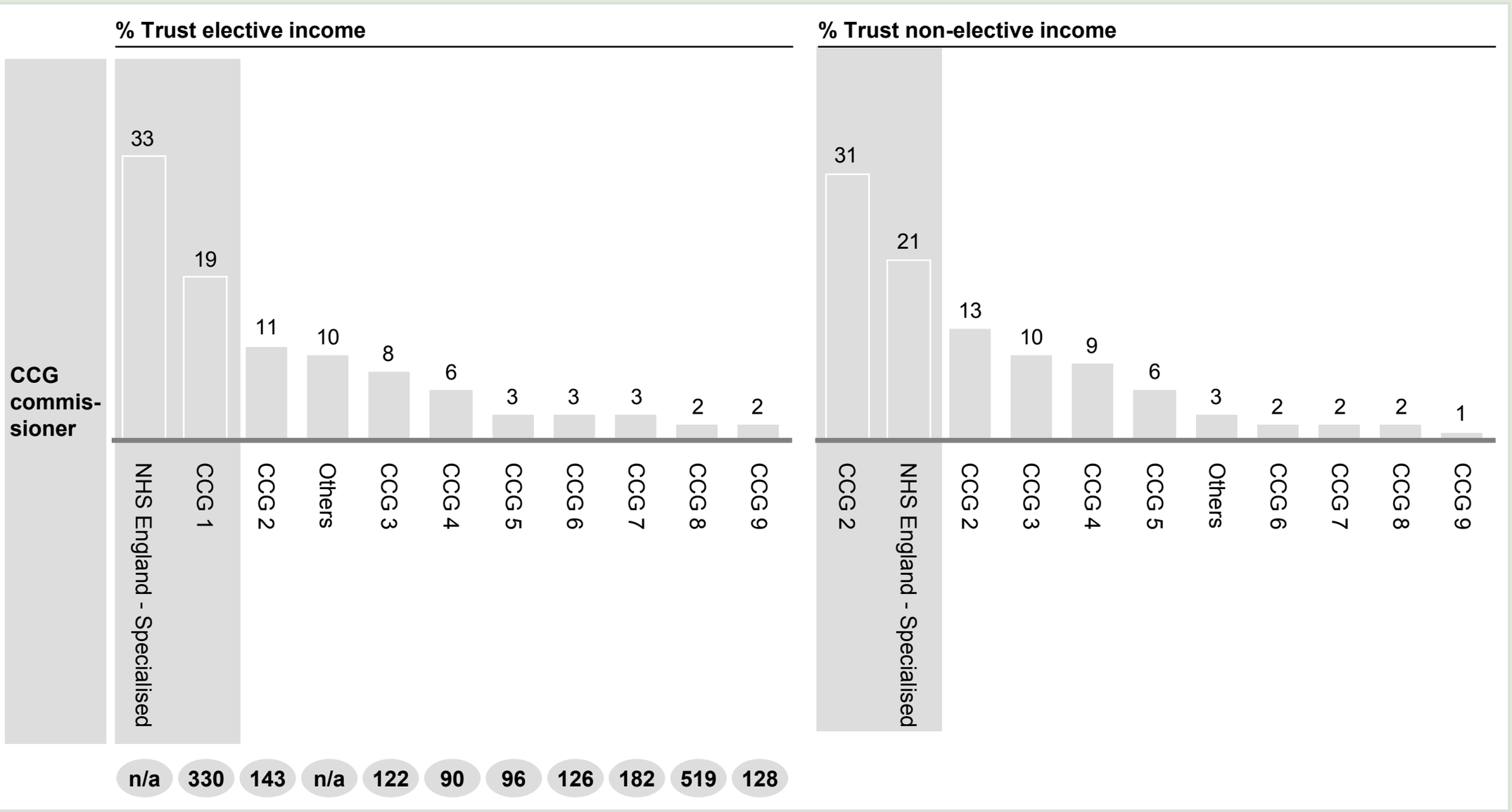
EXAMPLE

Analysis of income by commissioner for a trust

X **Population 2013 (1)**
Thousands



Source: Anonymised NHS provider example

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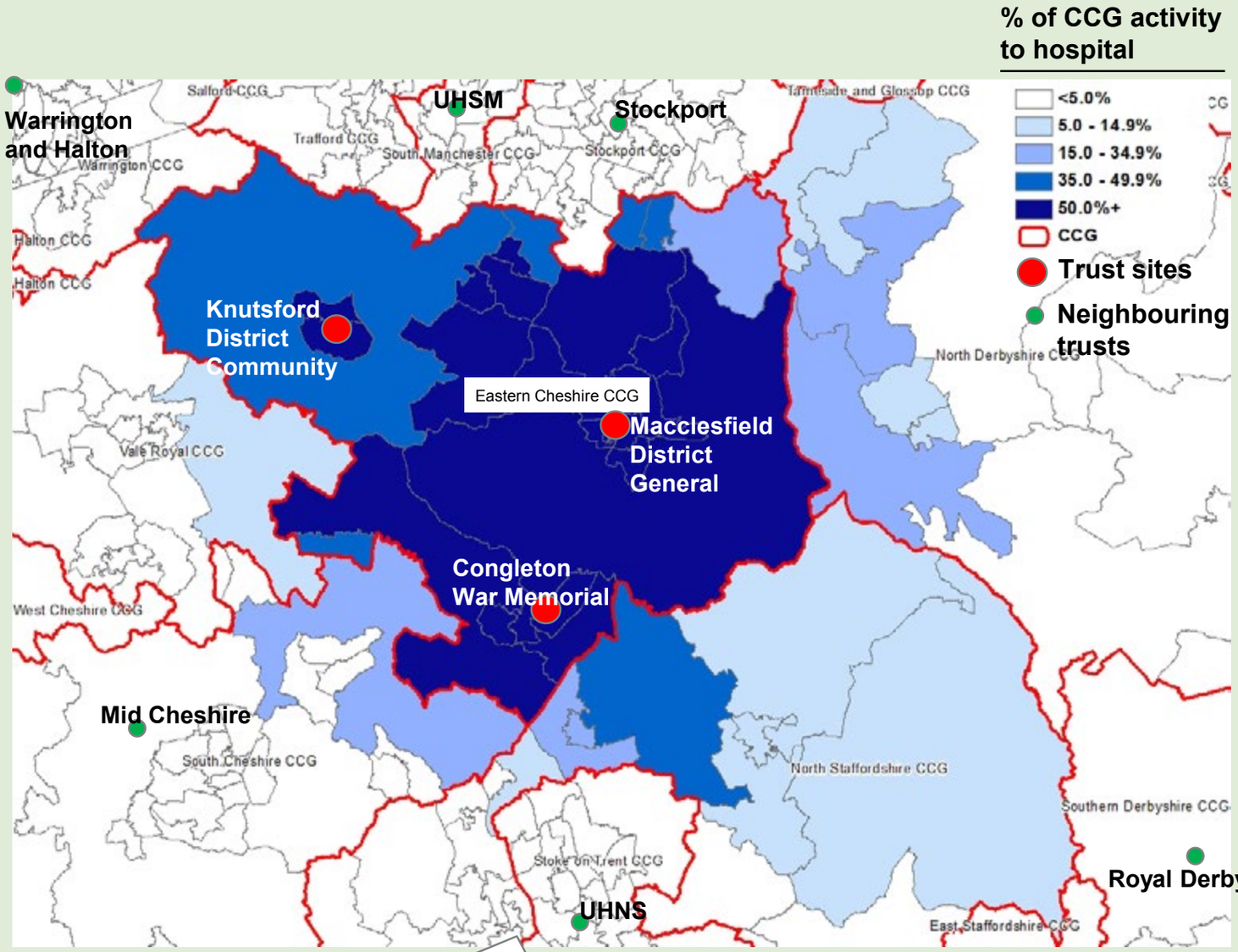
EXAMPLE

Mapping the catchment populations for a district general hospital

This demonstrates what the analysis of catchment populations might look like in practice.

- The trust in question (East Cheshire NHS Trust) has three main sites located in one CCG (Eastern Cheshire CCG).
- The trust provides most of the activity for the CCG and (not shown on map) receives the majority of its income from the CCG – therefore, in the current configuration the CCG and trust form a relatively self-contained local health economy (LHE).
- However, the map also shows a surrounding ring of hospitals that would be relevant if there were any service or configuration changes at the trust, suggesting the need to widen the scope in the case of sustainability issues.



Source: Hospital Episode Statistics 2012/13

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EXAMPLE

Analysis of GP referrals for outpatient activity for a trust

Source: Anonymised NHS provider example

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EXAMPLE

An analysis of deprivation levels and ethnicity

The level of deprivation among trust patients scores well above the national average…

Key

- Significantly worse than the England average
- Not significantly worse than the England average
- Significantly better than the England average

Indicators	CCG 1	CCG 2	CCG 3	England average
Deprivation	86.1	78.5	43.9	19.9
Children in poverty	42.6	57	34.3	20.9
Statutory homelessness	1.02	7.84	3.11	1.86
Violent crime	30.8	27.3	26.4	15.8
Long-term unemployment	11.8	13.6	8.7	6.2

… and the trust's patient base is ethnically diverse

	White	Black	Asian	Chinese and other Asian	Other
2011, %					
CCG 1	53.3	6.3	32.4	5.1	2.9
CCG 2	57.5	20	13.7	5	3.7
CCG 3	29.8	25.6	32.9	6.4	5.3
Greater London	65.7	13.9	11.5	4.8	4.1

Source: Anonymised NHS provider example

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EXAMPLE

Summary analysis of deprivation, age, disease incidence and primary care use across a local health economy

Deprivation

Index of Multiple Deprivation

Young, but ageing

People 65+ in the LHE

Lifestyle and ill health

- Compared to England average, and to similar areas elsewhere in England:
  - fewer people eat healthily, are physically active, or breastfeed
  - more people smoke, including while pregnant
  - more people suffer heart failure, chronic obstructive pulmonary disease, epilepsy and higher levels of obesity
  - more people die from cardiovascular, lung and liver disease, cancer, and causes considered preventable

Getting less primary care

- Compared to similar areas elsewhere in England:
  - fewer GPs, less primary care spend
  - fewer outpatient first attendances

Health outcomes are worse, and life expectancy is lower, than England average

Source: Anonymised NHS provider example

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EXAMPLE

LHE analysis examining disease burden, not just demographics

1. **Significantly lower life expectancy for both males and females than the national average**
2. **Smoking, heart disease, stroke and cancer rates are all above the national average**
3. **Diabetes is consistently higher in all boroughs than national average**
4. **New cases of tuberculosis are significantly more prevalent in LHE than the national average**
5. **Mortality rates amenable to healthcare are higher in LHE for both males and females than the London or England averages**

Selected measures of health for trust population

Indicators	CCG 1	CCG 2	CCG 3	England average
Life expectancy (males)	76.2	76	77.1	78.3
Life expectancy (females)	80.5	80.9	81.6	82.3
Infant deaths	5.3	4.4	4.7	4.71
Death from smoking	251	306.5	229.6	216
Early deaths – heart disease and stroke	116.9	113.6	90.3	70.5
Early deaths – cancer	118.1	141.4	113.2	112.1
People diagnosed with diabetes	7	6.1	5.9	5.4
New cases of tuberculosis	120	63	47	15

Mortality rates amenable to healthcare, 2007-09	Male	Female
City of London	63.39	24.18
Hackney	160.2	102.63
Newham	179.78	110.61
Tower Hamlets	196.25	93.52
London	120.96	78.56
England	115.38	78.59

Source: Anonymised NHS provider example

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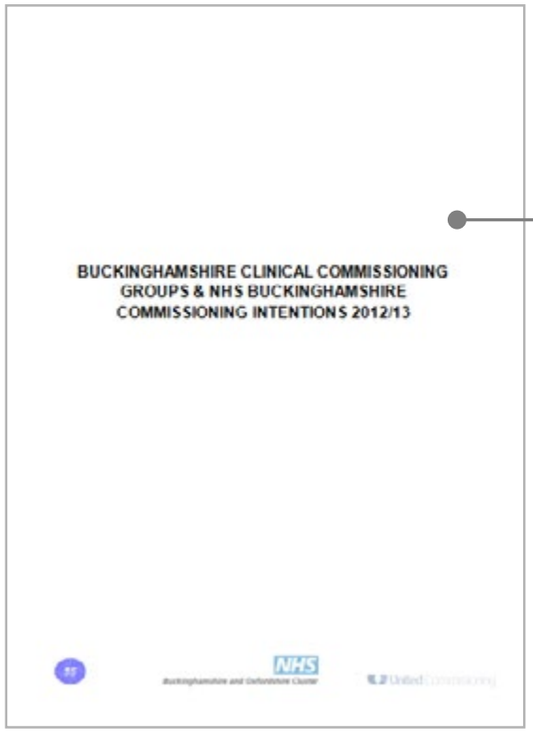
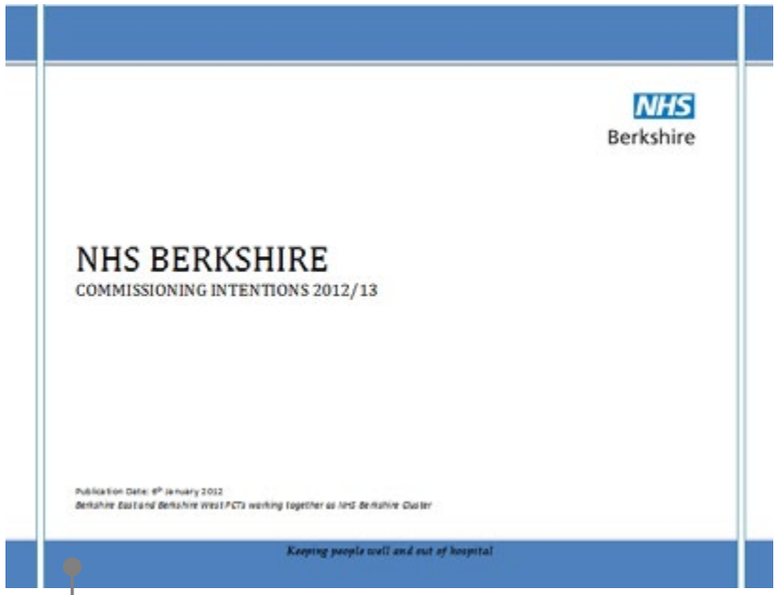
EXAMPLE

Summarising commissioner intentions to understand their main priorities

Commissioners' high level plans



- Objectives are to enhance the quality and safety of patient services
- Improve the quality of care by implementing innovations which, in turn will increase productivity and prevent ill health
- A&E attendances and emergency admissions should continue to reduce overall
- Early identification of dementia is a key priority
- Work with providers to develop Commissioning for Quality and Innovation schemes
- Expect to reduce rate of caesarean sections to 22%
- Funding of appropriate endoscopy capacity to facilitate the expected increase in demand



- Intention is to commission accessible, high quality, efficient patient care
- Key theme is the transfer of care, where appropriate, from hospitals to community and primary care settings
- Focus will be on promoting integrated care and driving improvement in clinical practice
- All legacy debt must be cleared in 2012/13
- An orthopaedic reduction scheme will be developed by the CCG
- New contracts will be introduced in dermatology

Source: Buckinghamshire and Berkshire commissioning plans 2012/13

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EXAMPLE

A mental health trust assessment of how its performance compares against the national service framework

Assessment against the national service framework (NSF) reveals gaps in the following areas

- **Focusing on mental health of community** and not reactive services for mental ill health
- **Seamless service and breakdown of traditional barriers** between primary/secondary care and between statutory and third sector providers
- **Reduction in stigma** and ensuring social inclusion is embedded in commissioning
- **Befriending schemes**
- **Crisis House/residential alternatives** to hospital admission
- **Culturally sensitive support** for people from African and Caribbean communities
- **Supported living** as alternative to residential care placements
- **BME access to psychological therapies**
- **Age discrimination** in terms of older people's access to services
- More **culturally appropriate services in community** and inpatient for BME communities

In particular, the BME[1] population (currently ~40%) is under served by existing mental health services

- **African and Caribbean communities are over-represented in compulsory detentions** under the 1983 Mental Health Act, inpatient admissions, assertive outreach, early intervention in psychosis; under-represented in mental health day services
- **Asian communities are over-represented in mental health day services**, carers services and early intervention in psychosis and under-represented generally in secondary mental health services
- **All BME communities are under-represented in counselling/psychological therapies**
- **All BME communities are over-represented in diagnoses of schizophrenia, psychosis** (data only available for inpatient, Mental Health Act assessments)
- **Older people with organic mental health problems are not able to access all services**
- **Lack of appropriate services in community and inpatient for BME communities**

1 Black and minority ethnic (BME)

Source: Anonymised NHS provider example

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EXAMPLE

Analysis of CCG performance against public health outcomes

This table shows public health outcomes for three CCGs, benchmarked to national quartile performance to identify public health issues in the LHE. This gives an indication of performance against the priority areas for Public Health England, as well as target areas for the particular CCGs. Outcomes are also compared against area averages to take account of potential demographic differences.

No data | National quartiles: 4 3 2 1

Public Health Outcomes Framework by domain		CCG 1	CCG 2	CCG 3	Area average	National median	Average of top quartile CCG
1 Improving wider health determinants	**Children in poverty**, %				26.1	17.1	10.5
2 Health improvement	**Low birth weight of term babies**, %				3.2	2.7	2.1
	Breastfeeding – Initiation (first 48h), %				81.2	75.5	84.1
	Breastfeeding – Prevalence at 6-8 weeks after birth, %				61.1	44.5	66.5
	Smoking status at time of delivery, %				9.7	14.1	7.8
	Percentage of physically active adults, %				52.9	57.1	62.3
3 Health protection	**Population vaccination coverage – Dtap / IPV / Hib[1] (2 years old)**, %				93.2	96.7	98.2
	Population vaccination coverage – PPV , %				62.5	68.8	73.2
	Population vaccination coverage – Flu (aged 65+), %				73.3	73.8	77.3
	Population vaccination coverage – Flu (at risk individuals), %				54.1	51.9	56.3
4 Healthcare public health and preventing premature mortality	**Infant mortality**, Deaths per 1,000 live births				4.3	3.8	2.5
	Mortality rate from causes con-sidered preventable (provisional), Rate per 100,000 population				141.3	153.8	118.8

1 Diphtheria, tetanus, whooping cough, Hib and polio

Source: Public Health Outcomes Framework Data Tool, Public Health England, Public Health Observatories – Public Health profiles, 2013; The Older People's Health and Wellbeing Atlas

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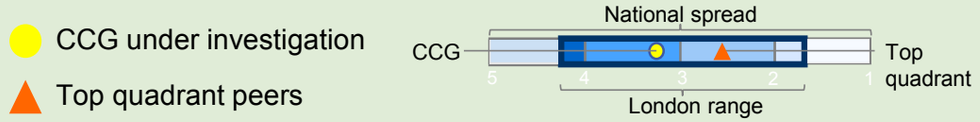
EXAMPLE

Analysis of detailed drivers of CCG spend

This assessment of CCG financial performance allows the trust to see how much the CCG is spending on specific services compared to others and identify areas that may be targeted for savings or additional investment. It uses commissioner finance returns combined with estimated CCG weighted populations



Spend per weighted population £	Your CCG spend/WP £	CCG spend £ m	Change to top quadrant CCG £ m	Change to CCG %	CCG saving opportunity £ m
Primary care 369 267 253 241 209	239	78	-6	10%	-1
Prescribing 192 160 150 139 86	149	49	0	90%	0
Acute – general and emergency 1,113 946 882 838 681	990	390	47	75%	35
Acute – maternity 89 57 48 41 16	68	27	8	100%	8
Mental health and learning disability 325 217 186 165 110	169	56	1	75%	1
Community care 448 224 181 143 77	213	70	10	90%	9
Total spend on healthcare 2,062 1,770 1,712 1,668 1,586	1,829	670	60		52

High spend ← → Low spend

Source: Commissioner finance returns (month 6, 2013/14); estimated CCG weighted populations

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EXAMPLE

Summary of CCG performance

In this example, the trust's main commissioner (CCG 1) has good finances, but poor health outcomes (indicated by potential years of life lost). Primary care access and patient experience are particular areas of concern, and may be contributing to the low A&E performance; access to cancer treatments are also an issue. CCG 3 is a particular concern, with significant challenges in finances, health outcomes and primary care; this may mean it needs to urgently redistribute funding away from hospitals and towards an improved model of primary care, representing a revenue risk for the trust.

Analysis such as this flags the main areas for you to investigate.

	CCG Finance		Clinical			Operations			
	Net surplus	Carry-forward surplus/ deficit	PYLL per weighted population	Patient experience – Acute	Patient experience – GP	GP access	A & E access (4 hrs)	Cancer wait times	Elective 18 weeks
Acute									
CCG 1	0.5%	1.0%	1,950	88%	75%	60%	85%	81%	95%
CCG 2	0.1%	1.0%	1,790	90%	81%	71%	99%	90%	99%
CCG 3	-2.1%	-4.0%	2,140	79%	55%	45%	90%	93%	94%

PYLL ('Potential Years of Life Lost') is a measure of premature mortality, and so it is a high-level indicator of health outcomes

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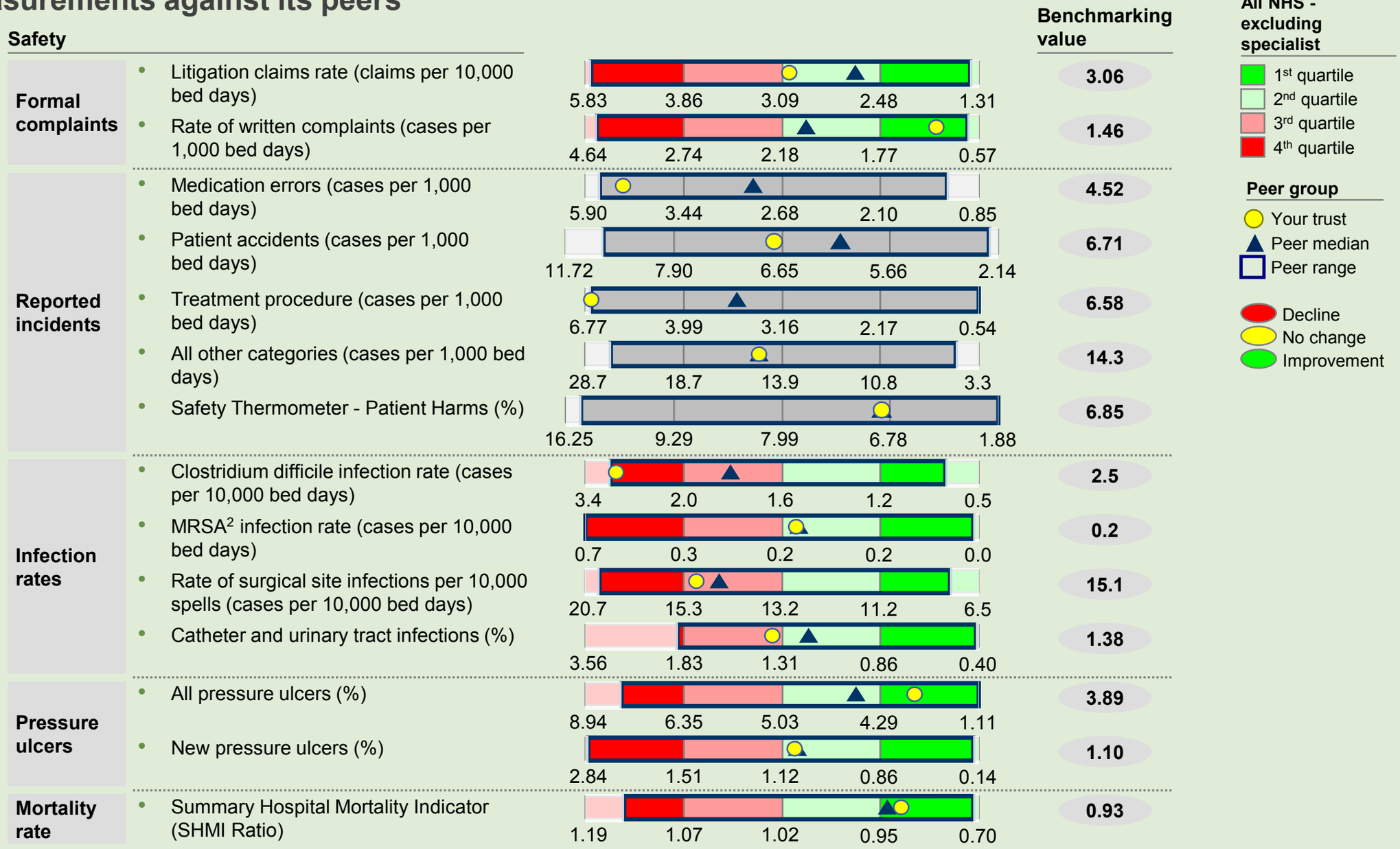
EXAMPLE

Benchmarking used by one trust to compare its performance on safety measurements against its peers



Source: Anonymised NHS provider example

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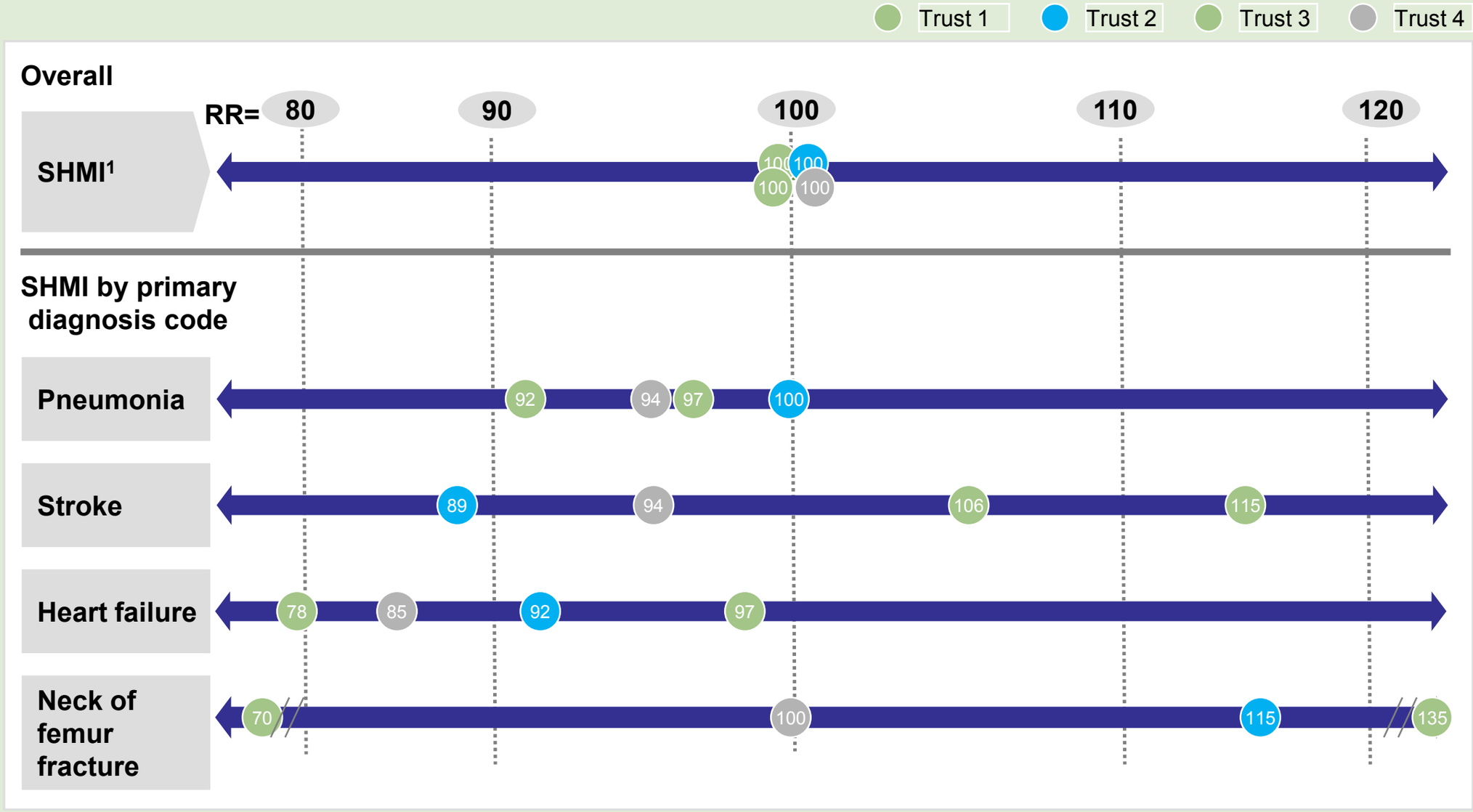
EXAMPLE

This shows the importance of analysing quality at a service or diagnostic group level as quality issues may be obscured in a trust level assessment



1 Summary Hospital Mortality Indicator (SHMI) measures the degree to which actual deaths compare to expected mortality rates given hospital admission profile. RR= 100 means that actual level of mortality is equal to expectations

Source: Anonymised NHS provider examples

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EXAMPLE

US hospital demonstrating that within orthopaedics, spine and sports medicine are the most financially sustainable, illustrating the value of analysis at sub-specialty level

	Revenues per case, 2004 $ thousand	EBITDA[1] per case, 2004 $ thousand	EBITDA margin	% of total orthopaedics EBITDA	% of total inpatient volume
Spine	13	3.0	22	91	32
Joint replacement	12	0.1	1	3	30
Fracture care	8	-0.1	-3	-5	22
Sports medicine[2]	6	0.4	7	2	4
Other[3]	9	0.9	9	9	12
				100%	100%

1 Earnings before interest, taxes, depreciation and amortisation
2 Sports medicine is largely outpatient, and thus not adequately measured with inpatient data alone
3 Other includes multiple low-volume, high-margin procedures including musculoskeletal biopsies, pathological fractures, and limb reattachment surgery

Source: Anonymised US hospital provider

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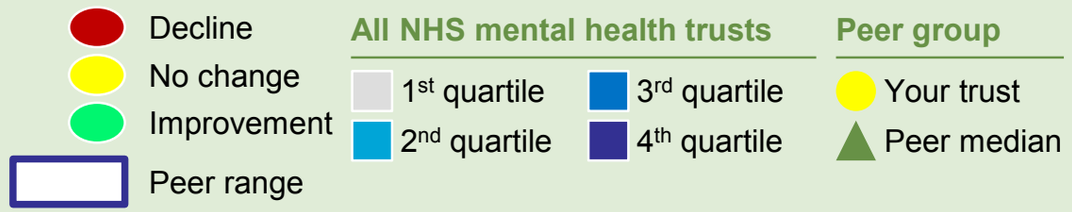
EXAMPLE

Clinical outcomes assessment in a mental health trust



Quality – trust vs peers

Outcomes		Benchmarking value	Trend[1]
• Patients discharged to usual place of residence (%)	10% 63% 72% 76% 89%	74%	
• Readmission to any mental health trust in 28 days (ratio)	0.0 0.1 0.1 0.1 0.6	0.1	
• Readmission to any mental health trust in 3 months (ratio)	0.0 0.1 0.2 0.2 0.6	0.2	
• Readmission to any mental health trust in 6 months (ratio)	0.0 0.2 0.2 0.2 0.6	0.2	
• Adults on Care Programme Approach (CPA) receiving secondary mental health service in settled accommodation /1000 population (Ratio)	0.3 2.2 3.2 4.6 12.0	5.4	
• Adults on CPA receiving secondary mental service in employment /1000 population (ratio)	0.1 0.2 0.4 0.7 2.6	0.4	
Patient experience			
• Overall patient experience (score)	6.1 6.5 6.7 7.0 7.5	6.5	

1 If CAGR is +/- 0.2% then trend is No Change
2 Reason for delay: completion of assessment, public funding, waiting further NHS non-acute care, awaiting: residential home placement or availability. Nursing home placement or availability. Care package in own home, community equipment and adaptions, patient or family choice, disputes, housing – patients not covered by NHS and community care act

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EXAMPLE

Divisional level dashboards of performance against chosen clinical outcome measurements

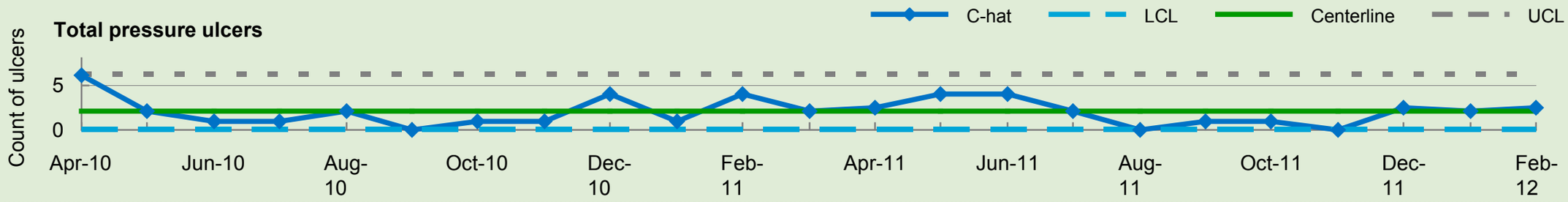
6. VTE (venous thromboembolism) assessment

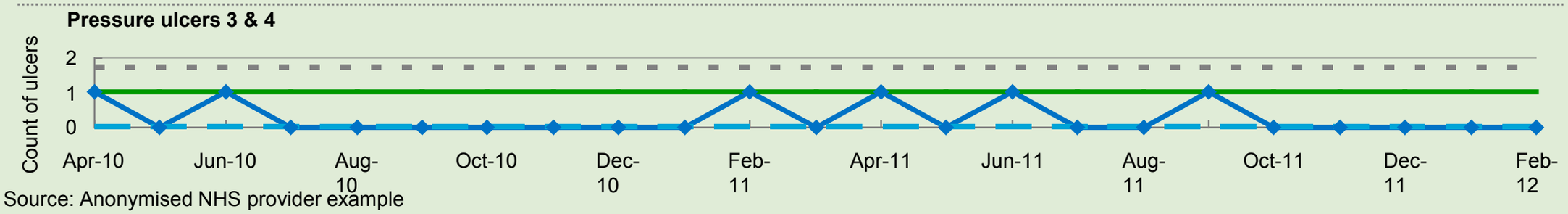
% of patients assessed

	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
	VTE %	VTE %	VTE %	VTE%	VTE%	VTE%	VTE%	VTE%	VTE%	VTE%	VTE%
Bariatric surgery	83.3	93.3	95.8	100	90	100	100	94.1	100	100	96.2
Breast surgery	91.7	95	88.9	88.5	83.3	100	91.3	96.7	94.7	96.8	100
Colorectal surgery	98.2	92.9	93.7	97.1	96.1	94.7	97.3	96	99.4	95.7	98.5
General surgery	86.2	88.1	93	91.4	91.2	89.7	93.4	91.5	90.7	93.6	91.0
Gynaecology	88.8	91	86.3	87.4	89.3	90.3	94.6	94	98.2	94.1	95.9
Gynaecology Oncology	100	92	94.7	100	100	94.7	94.4	94.7	90.9	95.5	100
Intestinal failure	100	93.3	100	100	93.3	100	105	100	100	100	93.8
Oral surgery	32.8	44.8	50.8	51.6	45.9	61.3	66.3	52.8	52.6	60.6	93.8
Trauma & orthopaedic	77.1	82.5	79.8	80.5	84.7	92	88.1	88.4	90	85.9	87.7
Upper gastrointestinal surgery	92.5	90	96.9	98.4	98.1	94.4	100	96.5	100	93.8	98.6
Urology	93	93.2	91.6	89	93.1	88.4	89.9	93.9	94.1	94.8	93.5
	84.8%	86.5%	87.4%	86.1%	88.0%	89.9%	90.5%	90.3%	92.6%	90.9%	92.6%

3. Pressure ulcers

There is no significant trend in either Total Pressure Ulcers or Grade 3 & 4 Ulcers. There have not been any Grade 3 or 4 Ulcers reported: last 5 months





Source: Anonymised NHS provider example

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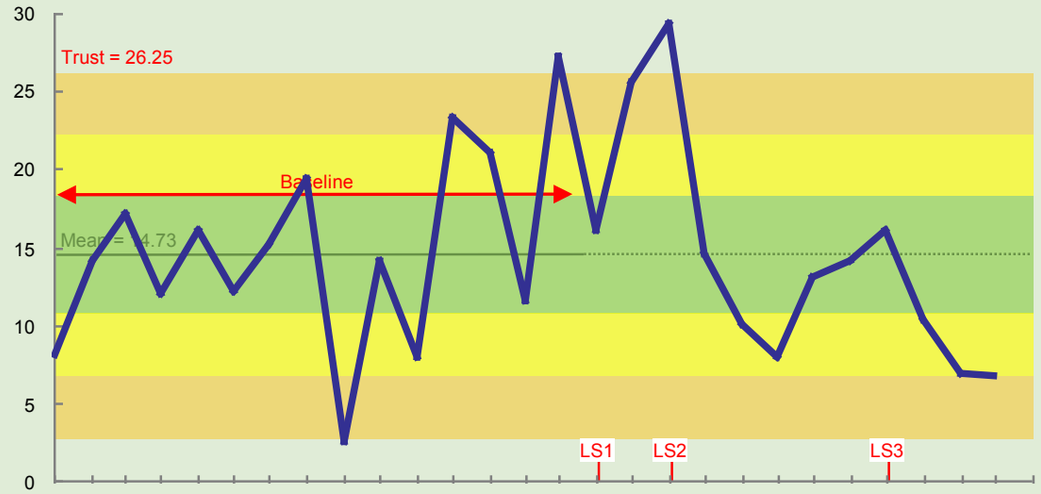
EXAMPLE

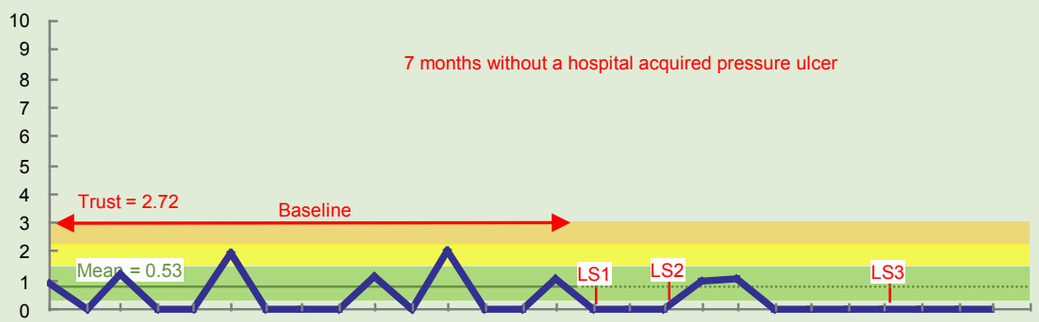
Clinical outcomes – tracking quality measurements over time

A project level dashboard showing performance against quality measurements can give you an insight into a particular service.

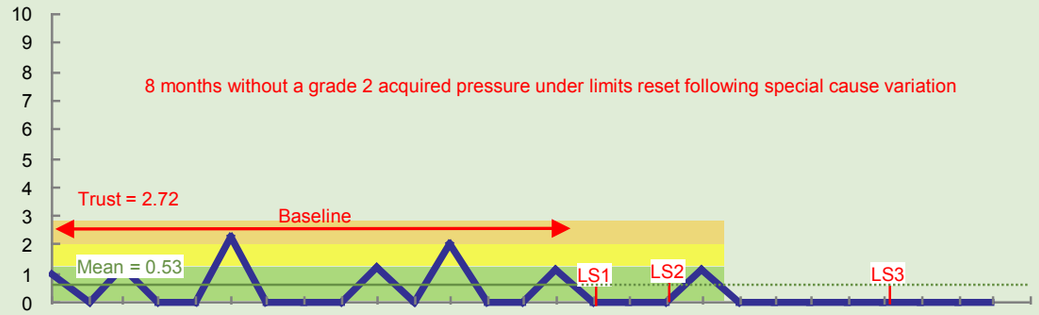
Hospital acquired pressure ulcers (Grade 2,3 and 4)
Control chart – Baseline: Trust = 26.25, mean = 14.73



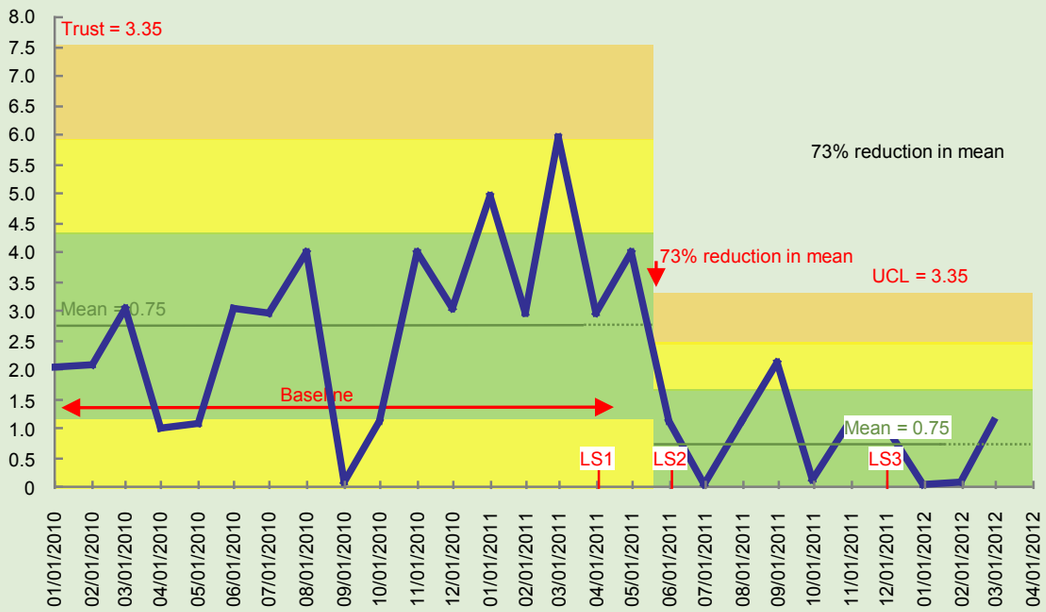
Hospital acquired pressure ulcers (Grade 2,3 and 4) – L5 (old L4)
Control chart – Baseline: Trust = 2.72 mean = 0.53



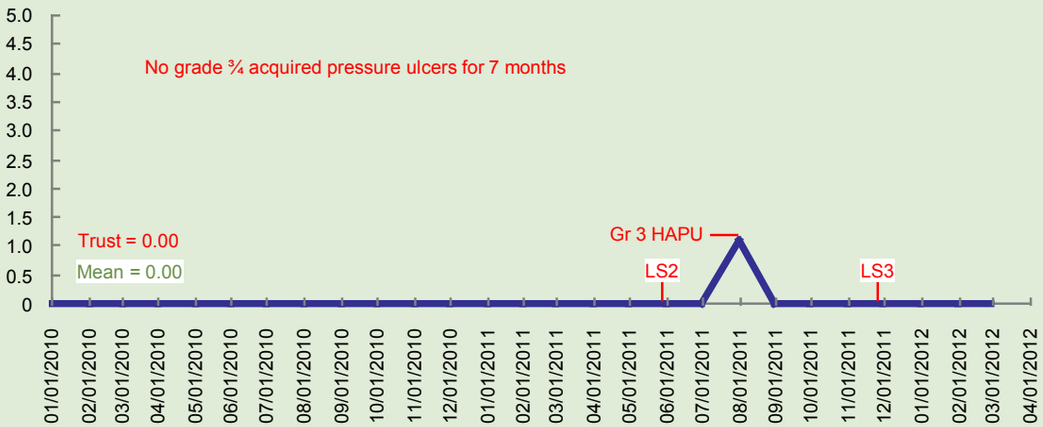
Hospital acquired pressure ulcers (Grade 2 only) – L5 (old L4)
Control chart – Reset1: Trust = 0.00 mean = 0.00



Hospital acquired pressure ulcers (Grade 3 and 4 only)
Control chart – Reset 1: Trust = 3.35 mean = 0.75



Hospital acquired pressure ulcers (Grade 3 and 4 only) – L5 (old L4)
Control chart – Reset1: Trust = 0.00 mean = 0.00



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EXAMPLE

Ongoing quality assessment across measurements chosen by the trust

	UOM	Standard / Threshold	2013-14YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Emergency readmissions within 30 days of discharge from hospital - %	%	11.80%	13.3	12.1	12.9	13.7	13.6	14.2	13.5	13.6	L	L	L
Stroke: % of Patients who spend > 90% of time on stroke unit	%	80%	85.1	77.4	84.4	85.4	83.6	87.2	81.8	82.0	93.8	88.2	87.8
Stroke: % admitted directly to stroke unit	%	90%	76.5	64.5	85.9	80.5	70.5	83.0	76.4	68.0	90.6	76.5	65.9
Stroke: % scanned in less than 1 hrs of hospital arrival	%	50%	68.3	78.3	70.2	57.1	65.0	62.8	66.7	57.4	75.0	72.3	71.4
Stroke: % of Patients scanned within 24 hours	%	100%	99.0	100.0	96.5	97.1	100.0	97.7	98.1	100.0	100.0	100.0	100.0
Stroke: % of high risk transient ischaemic attack cases treated in 24 hours	%	60%	66.4	82.0	50	65.0	58.0	61.0	77.0	65.0	92.0	33.0	79.0
Stroke: % of low risk risk transient ischaemic attack patients seen in 7 days	100	100%	94.6	92.3	96.7	89.7	92.5	96.9	93.5	90.0	100.0	100.0	94.7
Delayed Transfers of Care (DToC)	%	3.50%	3.1	4.04	3.0	3.0	2.6	3.17	3.04	3.2	3.0	2.9	3.6
Medically Fit For Discharge (MFFD) - number of occupied bed days	n	tbc	11489	1004	1057	1135	910	1152	1000	1257	1214	1270	1490
Nos of cases of MRSA bloodstream infections	n	0	6	3	0	0	0	0	0	2	1	0	0
Nos of Clostridium Difficile infections	n	34	43	3	2	2	7	4	4	2	4	9	6
Nos of cases of E.Coli	n	tbc	9	1	3	1	0	3	1	0	0	0	0
Nos of cases of MSSA	n	tbc	19	1	3	0	6	0	3	2	2	1	1
Number of medication error causing serious harm[1]	n	0	1	0	0	0	0	0	0	0	0	0	1
Incidence of newly-acquired category 3 or 4 pressure ulcers[1]	n	tbc	16	5	1	1	1	1	1	2	2	1	1
Nos of falls resulting in severe injury or death[1]	n	0	0	0	0	0	0	0	0	0	0	0	0
Open Serious Incidents Requiring Investigation (SIRI)[1]	n	tbc	17	6	16	11	7	6	11	10	15	17	17
Number of Serious Incidents reported each month.	n	TBC	17	0	1	0	1	4	2	2	3	2	2
"Never Events" reported in month	n	0	1	0	0	0	0	0	0	0	0	0	1
Caesarean section rates - percentage of all deliveries[1]	%	23%	28	27	28	29	27	25	29	31	26	31	L
Maternal deaths[1]	n	0	0	0	0	0	0	0	0	0	0	0	L
Summary Hospital Mortality Indicator (SHMI)	n	100	91.0	101.0	84.9	94.6	89.0	84.6	97.6	84.9	L	L	L
Hospital Standardised Mortality Ratio (HSMR) - all week	n	100	97.6	100.0	87.2	103.4	102.4	96.0	106.7	83.1	102.0	L	L
Hospital Standardised Mortality Ratio (HSMR) - weekdays	n	100	95.8	102.6	85.3	95.4	96.2	100.3	107.5	75.2	103.7	L	L
Hospital Standardised Mortality Ratio (HSMR) - weekends	n	100	104.5	92.4	93.2	130.4	124.7	83.4	103.9	110.6	97.1	L	L
Number of Deaths in low risk conditions / procedures	n	TBC	15	2	3	2	5	3	L	L	L	L	L
Percentage of completed VT (Venous Thromboembolism) Risk Assessments	%	95%	96.4	95.7	96.5	97.4	98.0	95.9	96.0	95.9	97.3	96.3	95.6

1 Published definition awaited

Source: Anonymised NHS provider example

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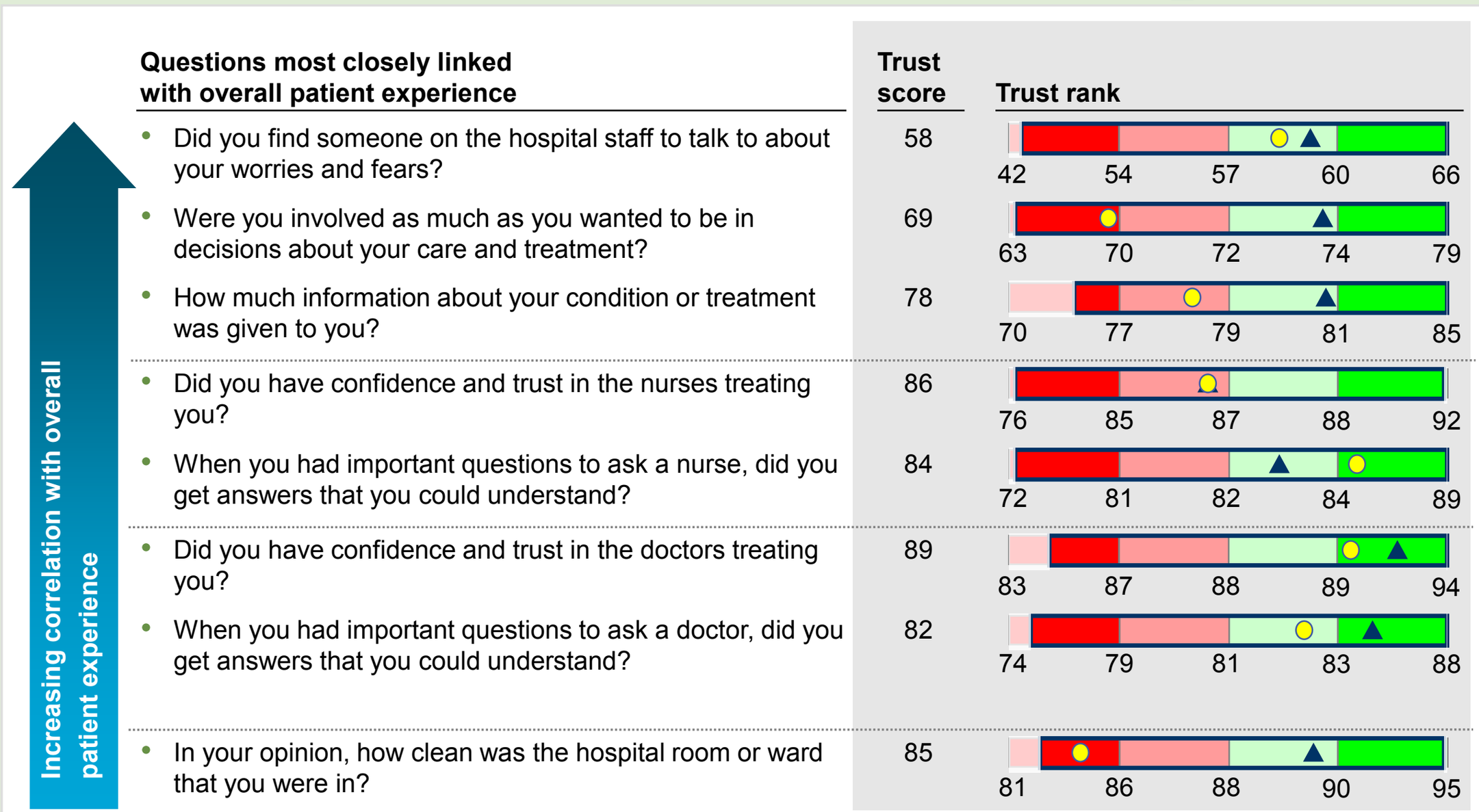
EXAMPLE

Patient experience – benchmarking responses to questions from NHS surveys



Source: Anonymised NHS provider example

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EXAMPLE

How qualitative measures can be used to understand patients' perceptions of quality

Issues expressed in online conversations (From negative messages)[1]	**Example quote**
N = 37 messages with negative sentiment toward trust's patient care[2]	
Discussed frequently	
Challenges scheduling an appointment/lack of efficiency (23%)	"Two days before my appointment … it was cancelled….I rang the trust to rearrange another one only to get an answer machine I was trying for four hours to be able to speak to someone in the end I had to ring PALS" 17-02-14
Lack of communication (17%)	"I have been waiting 9 months for serious ear surgery. The Ear, Nose and Throat Department cannot tell me when it will take place and when I said I was not happy they thrust a PALS leaflet in my hand, agreed it wasn't good enough and said there was nothing they could do!!" 05-08-14 "6hrs of asking for some pain relief!!! What the hell is going on in this place" 02-09-13
Unhappy with the strategy and/or knowledge for healing a condition (14%)	"My son was advised by GPs to attend A&E. He was discharged approx. 4am and told nothing wrong. Had a heart rate of 160 when walking and 126 lying down. Subsequently GPs discovered he has an autoimmune disease and said trust did no tests related to his symptoms. We then were referred to a consultant in a different city as trust was inadequate in diagnosis and treatment" 16-08-13
Dissatisfaction with treatment by staff (13%)	"Experienced totally desensitised, insensitive, distant and unhelpful Child and Adolescent Mental Health staff at trust yesterday – very sad to see" 25-10-13
Dissatisfaction with amenities/overall atmosphere (8%)	"Trust lacks many amenities, such as no pay per view televisions and telephones at your bedside as it's a very old run down hospital … The curtains do little to block out the noise from the person adjacent to your bed. Shower/washing facilities were lacking. No hairdryer provided. The ward was either too hot or too cold and it was a nuisance … The food was of a very low standard and hardly nutritious and the menu uninspiring and limited choices" 26-11-13
Discussed infrequently	

1 Messages generated on boards, blogs, comments, forums, and Twitter in study period

2 Topics not mutually exclusive

Source: Anonymised NHS provider example

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EXAMPLE

Analysis of operational measurements against agreed trust targets

		Target	Performance	Direction of change
Access	Emergency access within four hours	≥95%	90.80	▲
	12 hour trolley waits	0	0.00	=
	Ambulance handover >30 minutes	0	26.00	▲
	Ambulance handover >60 minutes	0	0.00	=
	% referrals successfully made via choose and book	≥96%	84.00	▼
	18 weeks referral to treatment time – admitted	≥90%	92.10	=
	18 weeks referral to treatment time – non-admitted	≥95%	97.80	=
	Specialities exceeding 18 weeks referral to treatment time	0	2.00	=
	18 weeks referral to treatment time – incomplete pathways	≥92%	96.60	=
	Number of cases exceeding 52 weeks referral to treatment	0	0.00	=
	% spending >90% of their stay on a stroke unit	≥80%	82.00	▼
	Diagnostic waiters, 6 weeks and over-DM01	<1%	0.04	▲
	Diagnostic waiters, 6 weeks and over-QDIAG	<1%	0.00	=
	Same sex accommodation standards breaches	0	0.00	▲
Cancelled Ops	Total non-clinical cancelled ops (elective)	<3.2%	2.10	▼
	Last minute non-clinical cancelled ops (elective)	<0.8%	0.60	▼
	Breaches of the 28 day readmission guarantee	<5%	2.00	▲
	Urgent operations cancelled more than once	0	0.00	=
Cancelled targets	2-week GP referral to first outpatient appointment	≥93%	95.10	▲
	31 day diagnosis to treatment	≥96%	97.60	▲
	31 day second or subsequent treatment (drug)	≥98%	98.40	▼
	31 day second or subsequent treatment (surgery)	≥94%	98.90	▲
	31 day second or subsequent treatment (radiotherapy)	≥94%	99.00	▼
	62 day referral to treatment	≥85%	81.00	▼
	62 day referral to treatment from screening	≥90%	93.30	▼
	62 day consultant upgrade referral to treatment	≥85%	90.00	▼
	14 days referral for breast symptoms to assessment	≥93%	96.80	▲

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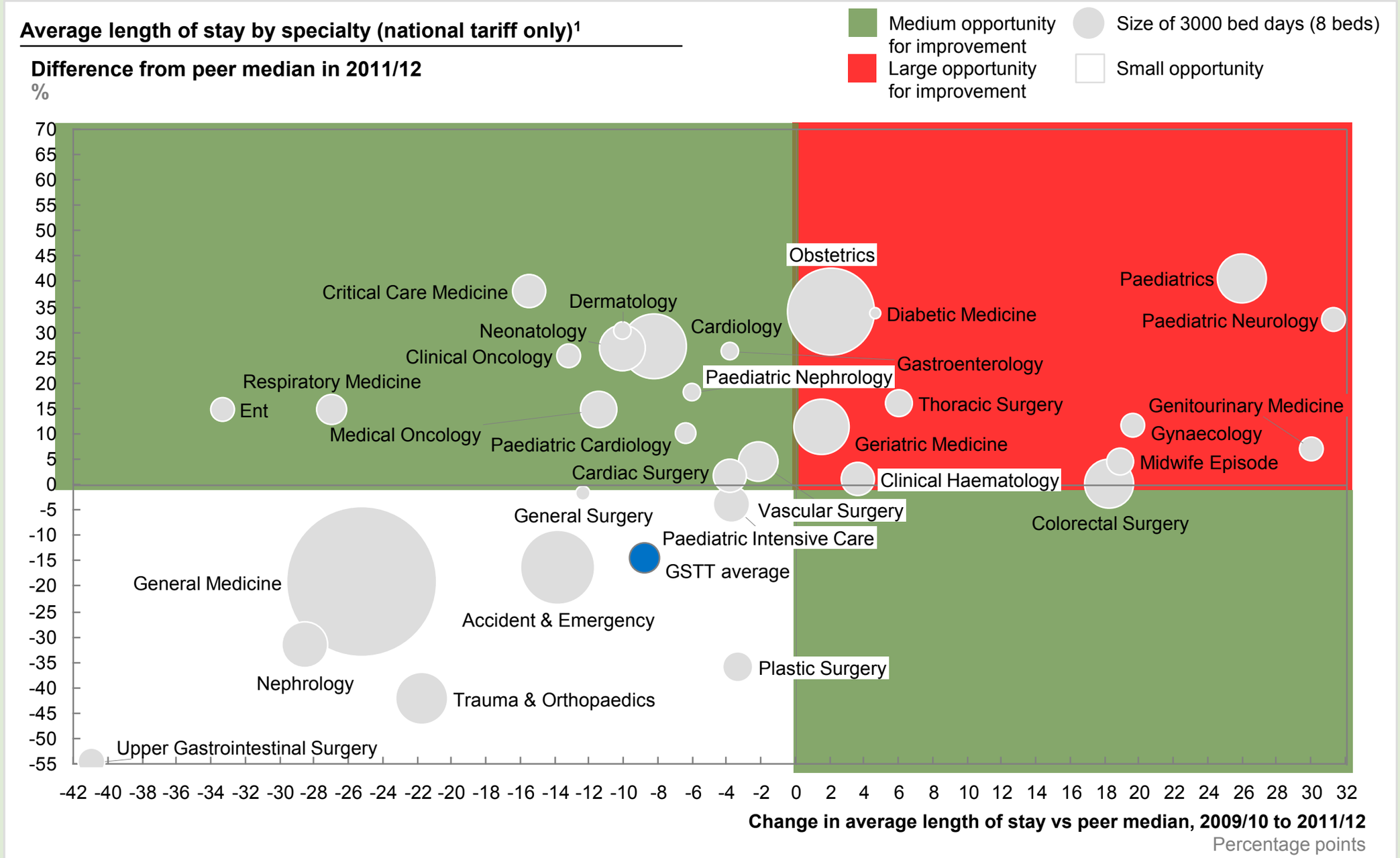
EXAMPLE

Elective/Non-elective pathways – analysis of length of stay



Source: Anonymised NHS provider example

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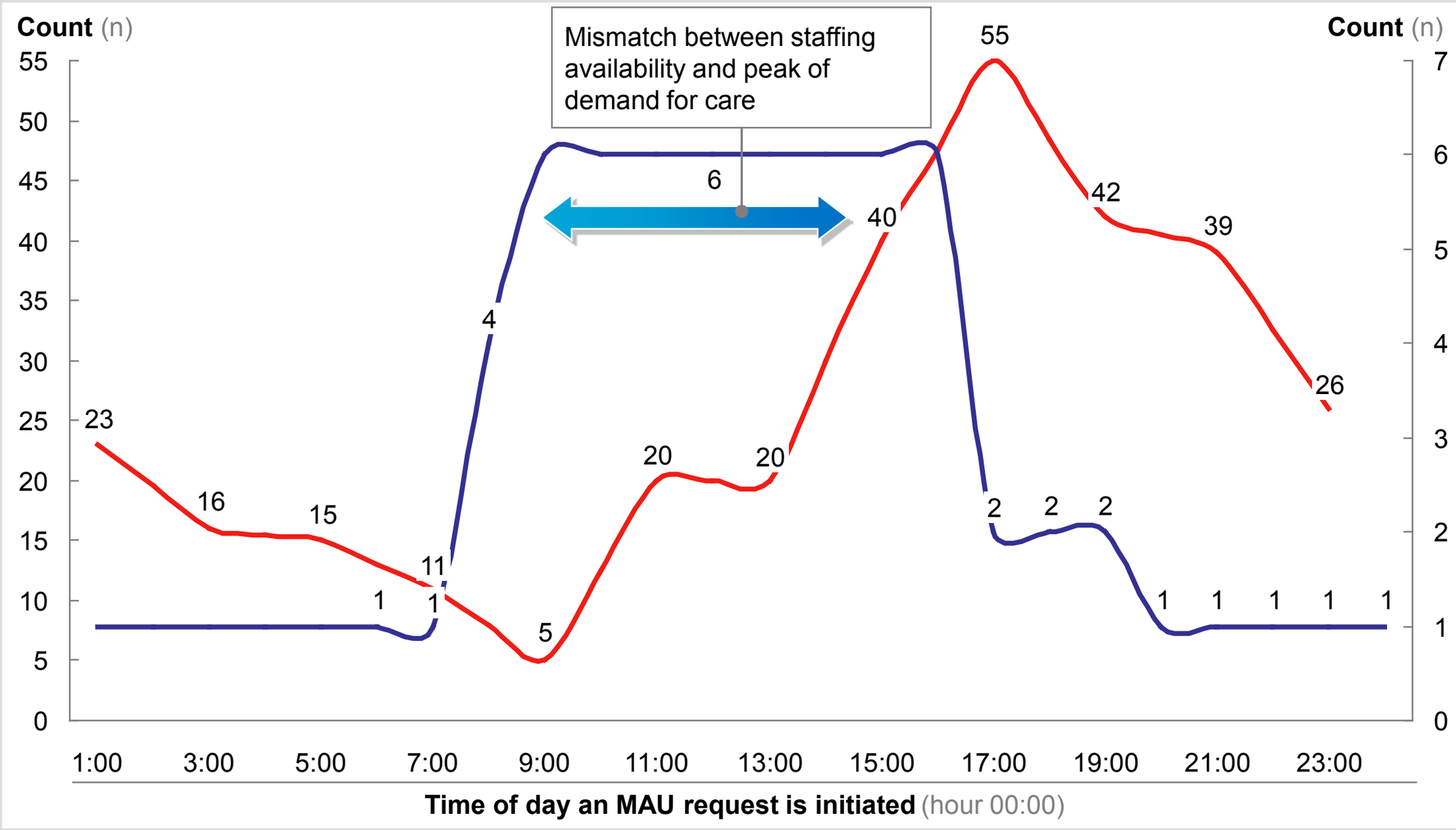
EXAMPLE

Staff measurements – a trust comparing staff availability with demand for care

24-hour profile of patients needing acute medicine and Medical Assessment Unit (MAU) input over 1 week



Source: Anonymised NHS provider example

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EXAMPLE

Staff measurements used to identify opportunities to improve how midwives spend their time by reducing activities that do not affect patient care

Average midwife time and activities per birth delivery (inpatient care) Hours

Time element	Current average time per birth, Hours	Comments	Inefficiencies identified[2]
Total hours	44.7		
Delivery unit / Midwifery Led Unit	13.7	• Patients spend an average 9.8 hours in the DU or 10.2 in MLU	• Administration (eg computer shortages) • Time spent looking for equipment, notes etc
Wards	6.4	• Patients spend an average 2.2 days in the maternity wards	• All midwives required for ward rounds • Long discharge process for each patient
Triage	3.2	• Patients spend an average 2 hours on triage	• No senior midwife to turn away early presentations and no senior doctor present
Management team	3.0	• 8 band 8 matrons full time on management	• Information duplication due to a lack of linked IT system
Induction bay	1.9	• Patients spend an average 25 hours in the induction bay	• Administering Propress and then Prostin?
Birth centre	1.3	• On average 6 births per week	• High midwife to patient ratio as need sufficient staff to run, but low number of births
High Dependency Unit (HDU)	0.8	• 1-on-1 patient care required in HDU	
Theatre	0.4	• Theatre procedures take 1 hour on average, 20% CS rate	• Patient specific needs not communicated beforehand, so preparations made on the day
Other[1]	14.0	• 30% of time spent on annual leave (11%), training etc.	

1 Other category includes activities such as annual leave and educational training
2 Based on staff interviews, not exhaustive

Source: Anonymised NHS provider example

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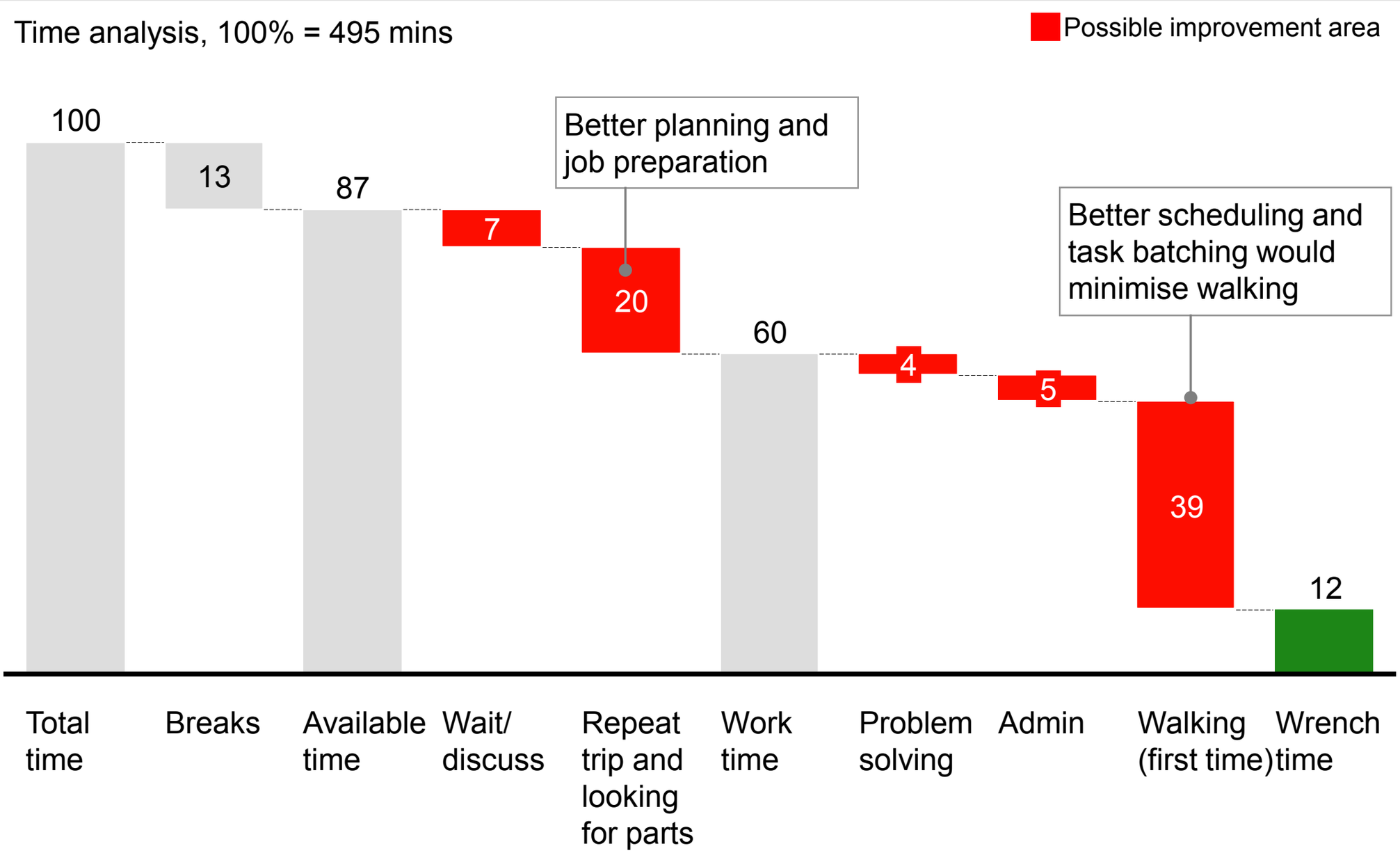
EXAMPLE

Staff measurements used for detailed analysis of use of time by estate maintenance staff



Source: Anonymised NHS provider example

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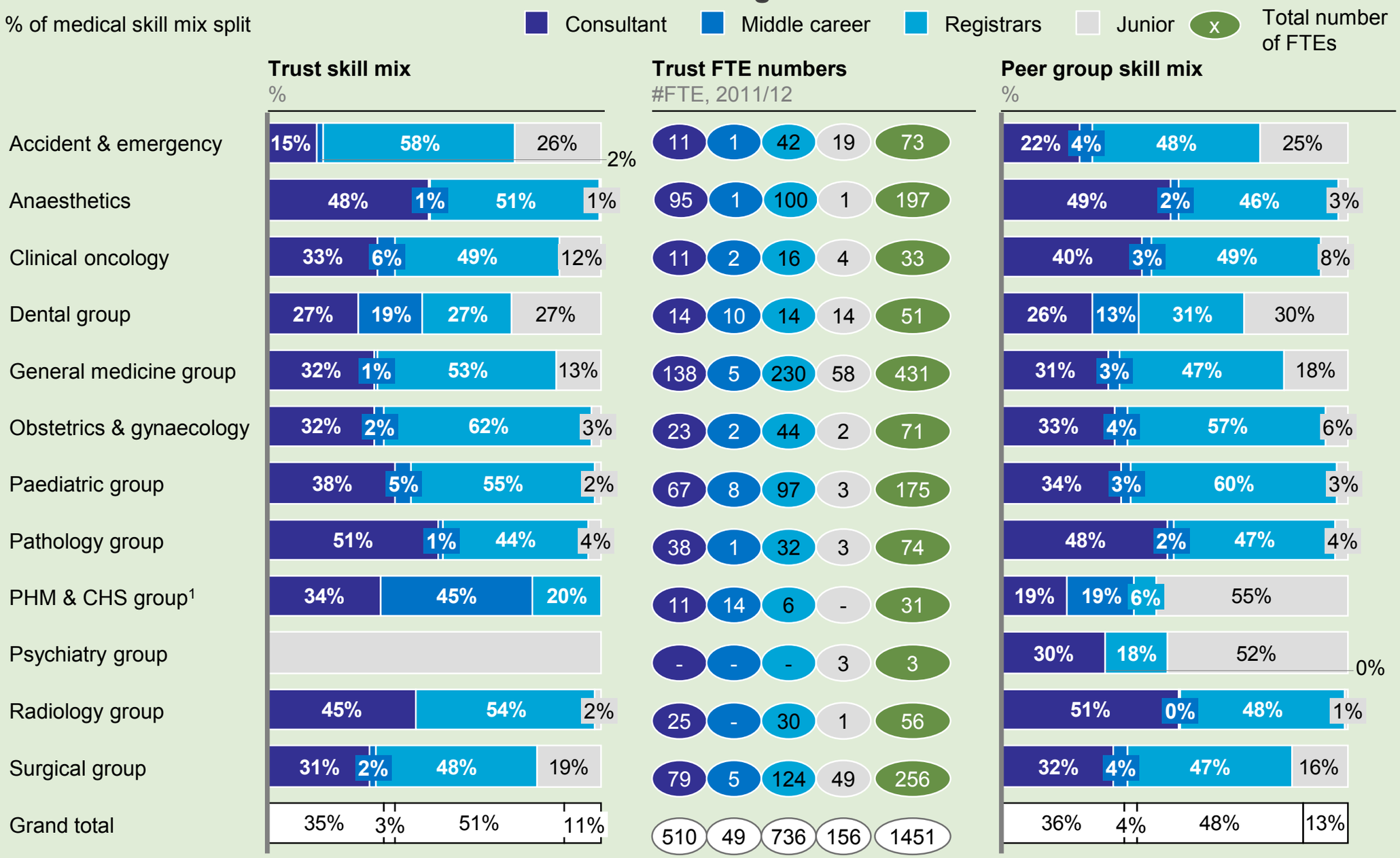
EXAMPLE

Staff measurements used to benchmark skill mix among medical staff



1 Public Health Medicine and Community Health Services

Source: Anonymised NHS provider example

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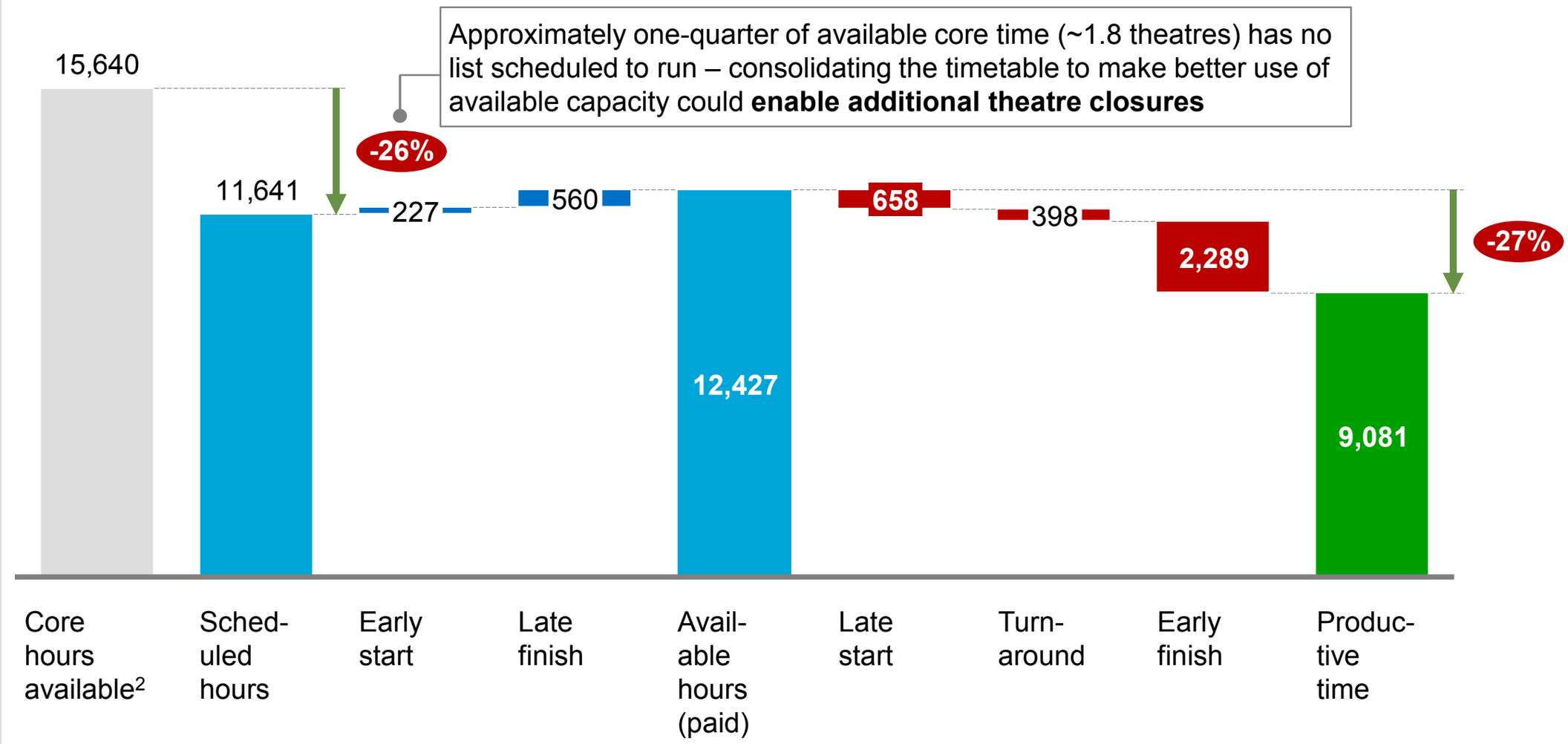
EXAMPLE

Operational resources – reducing unproductive time in theatres through detailed analysis of theatre time use

Theatre usage and losses

Hours of theatre time[1]



1 Period of analysis from January – September 2013

2 Core hours represents running all theatres from 07:30 – 19:00, 5 days a week, every week

Source: Anonymised NHS provider example

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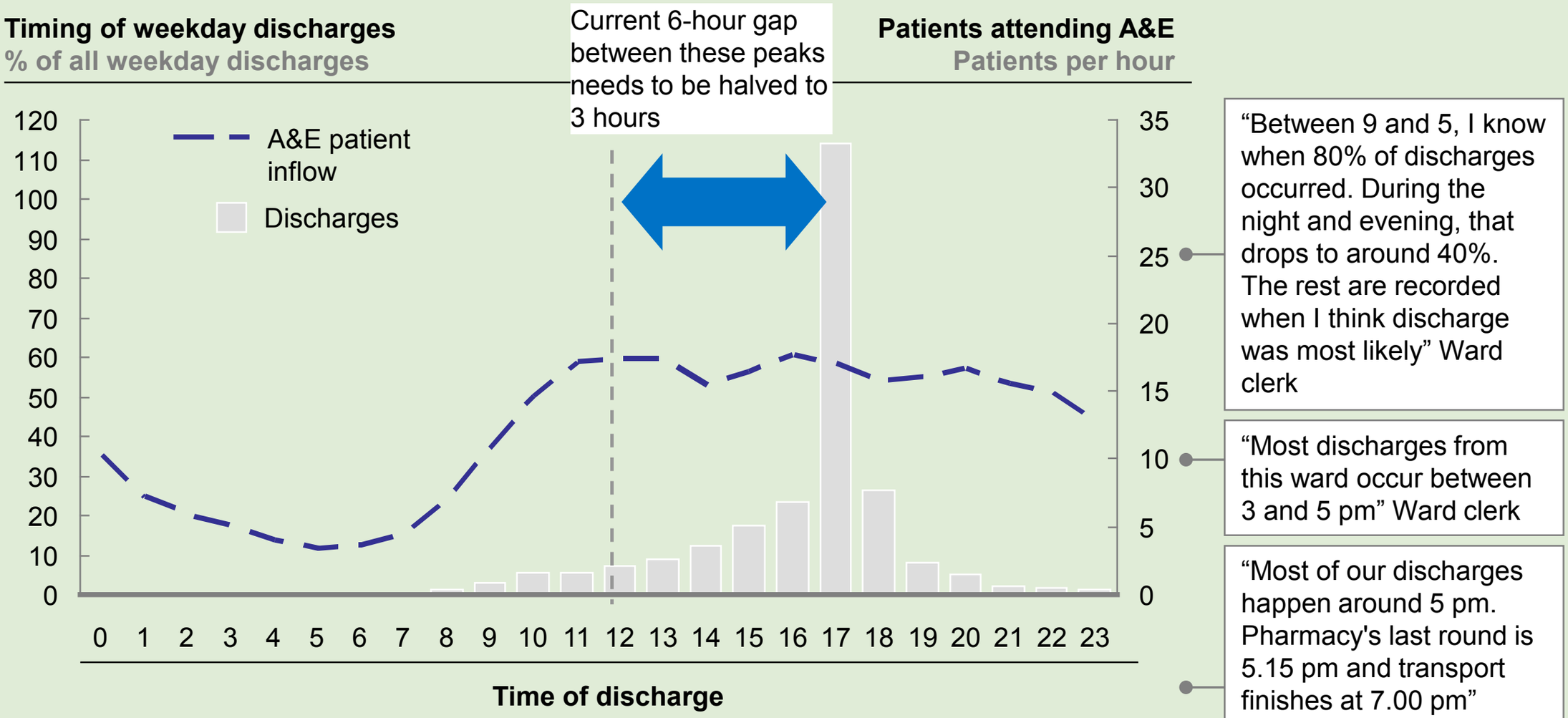
EXAMPLE

Operational resources – this analysis of patient flows shows how a greater number of discharges are required by 11am to meet patient demand



"Between 9 and 5, I know when 80% of discharges occurred. During the night and evening, that drops to around 40%. The rest are recorded when I think discharge was most likely" Ward clerk

"Most discharges from this ward occur between 3 and 5 pm" Ward clerk

"Most of our discharges happen around 5 pm. Pharmacy's last round is 5.15 pm and transport finishes at 7.00 pm" Ward clerk

Source: Anonymised NHS provider example

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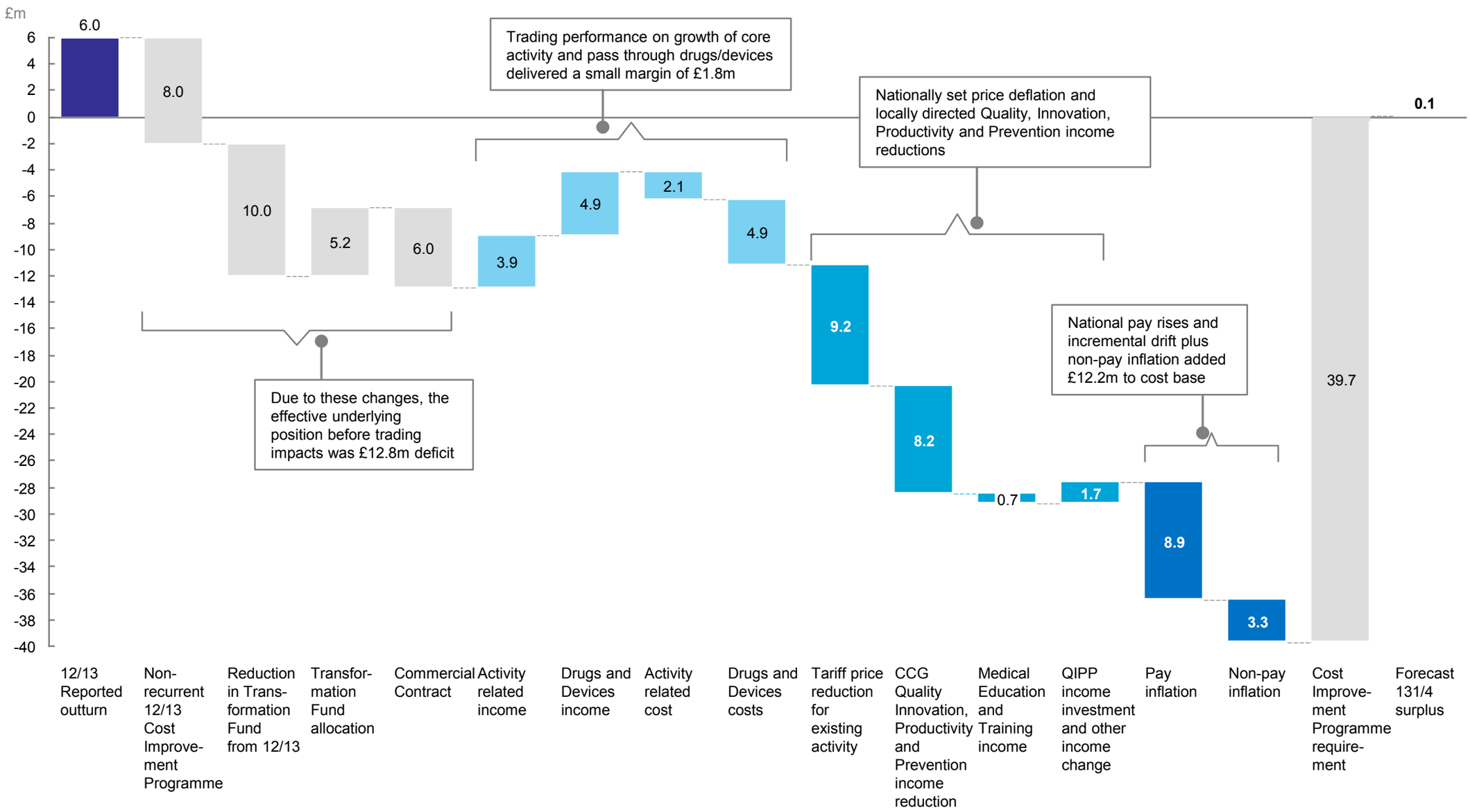
EXAMPLE

Income and cost analysis of changes to cost and income over a year

Actual 2012/13 to forecast outturn 2013/14



Source: Anonymised NHS provider example

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EXAMPLE

A cost driver tree you can use to understand the underlying drivers of costs

Worse than peers - savings opportunity

Better than peers

Cost categories	Cost drivers	Trust value	Peer performance: Top quartile trust	Peer performance: Average top 3	Gap to peers, £m: Top quartile trusts	Gap to peers, £m: Average top 3	Current operating cost, £m	Gap to top quartile trusts as % of cost
Medical pay	WTE[1] per £1m total income	2.2	1.9	1.7	11.5	13.6	89.7	13%
	Cost per WTE, £k	93.1	96.1	102.7				
Nursing pay (qualified)	WTE[1] per £1m total income	4.8	5.7	4.7	5.2	14.4	94.6	5%
	Cost per WTE[1], £k	45.4	35.8	38.6				
Scientific, therapeutic and technical pay	WTE[1] per £1m total income	1.6	2.7	2.3	-6.7	3.2	36.2	-19%
	Cost per WTE[1], £k	51.3	36.1	32.2				
Other clinical pay	WTE[1] per £1m total income	4.1	3.4	2.2	16.9	23.5	48.9	35%
	Cost per WTE[1], £k	27.1	21.4	26.6				
Non-clinical pay	WTE[1] per £1m total income	1.3	3.5	3.0	-18.7	-12.0	27.8	-67%
	Cost per WTE[1], £k	47.6	30.1	30.4				
Total cost base								
Drugs & clinical supplies	Cost per £1m total income, £k	157.7	152.1	102.8	2.4	24.0	69.1	4%
General supplies	Cost per £1m total income, £k	24.1	14.8	34.6	4.1	-4.6	10.6	39%
Other operating costs: Establishment; Private finance linitia-tive operating costs; Premises & fixed plant; Other operating costs	Cost per £1m total income, £k	200.4	132.9	222.8	29.6	-9.8	87.9	34%
Non-operating costs: Depreciation; Public dividend capital; Private Finance Initiative interest; Other interest; Other non-operating	Cost per £1m total income, £k	93.5	49.1	48.9	19.5	19.6	41.0	47%
				Total:	63.9	72.0		

1 Whole time equivalent

Source: Anonymised NHS provider example

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EXAMPLE

Cost analysis – another way of displaying year-on-year cost changes for a mental health trust

Size of the bubble:
actual costs – expected costs

Lower than reference cost — Higher than reference cost

Reference cost analysis – mental health

Comparison made with average cost calculated for all London trusts

Services	2011-12	2010-11	2009-10
Non-admitted patient care	-£10.7	£0	£0
Admitted patient care	£1.2	£0	£0
Secure units	£2.4	-£3.0	-£14.5
Outpatients	-£8.4	-£1.8	-£13.1
Inpatient – specialist services	£2.7	-£2.2	£1.6
Mental health community contacts	£5.2	£0	£0
Inpatients	£0.6	-£0.8	-£33.6
Specialist teams	£3.5	-£14.2	-£15.0
Daycare	-£0.2	£2.4	£3.1

- Reference costs have improved for most of the services
- Non-admitted patient care and outpatients have very high costs relative to average

Source: Anonymised NHS provider example

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EXAMPLE

Cost analysis – using the cost driver tree to identify overspend in costs compared to peers

Units: £m, %

Category	Current operating cost 11/12	Cost reduction opportunity: Matching trust [1]	Cost reduction opportunity: Matching average of top 3 teaching hospitals	Cost reduction opportunity: Matching average of top 3 peers
Medical pay	147	-5 (-3%)	-15 (-10%)	-16 (-11%)
Qualified nurses pay[2]	159	-39 (-25%)	-40 (-25%)	-59 (-37%)
Scientific, therapeutic, and technical pay	69	-5 (-8%)	-10 (-15%)	-8 (-12%)
Non-clinical pay	93	-32 (-34%)	-33 (-35%)	-40 (-43%)
Clinical supplies	220	-25 (-11%)	-57 (-26%)	-93 (-42%)
Other variable costs[3]	19	-7 (-38%)	-10 (-53%)	-6 (-34%)
Cost categories not benchmarked[4]	199	n/a	n/a	n/a
Total[5]	906	-113	-166	-223
Savings (% of total costs)		-13%	-18%	-25%
Savings (3-year CAGR[6])		-4.4%	-6.5%	-9.0%

Largest immediate opportunity likely to be non-ward based nursing

Stripping out £125m for all pathology and pass through drug costs the FT would be +£11m vs peers

1 Bed day opportunity estimated at £150/day. 2 Nursing WTE level not capped at minimum of 8 nurse hours per occupied bed day
3 Other variable costs include catering, cleaning and laundry 4 Cost categories not benchmarked include: other clinical pay (due to inconsistency in reporting), premises, establishment cost and non-operating costs (public dividend capital, interest, depreciation, etc) 5 Total trust expense used to arrive at net surplus
6 Compound annual growth rate

Source: Anonymised NHS provider example

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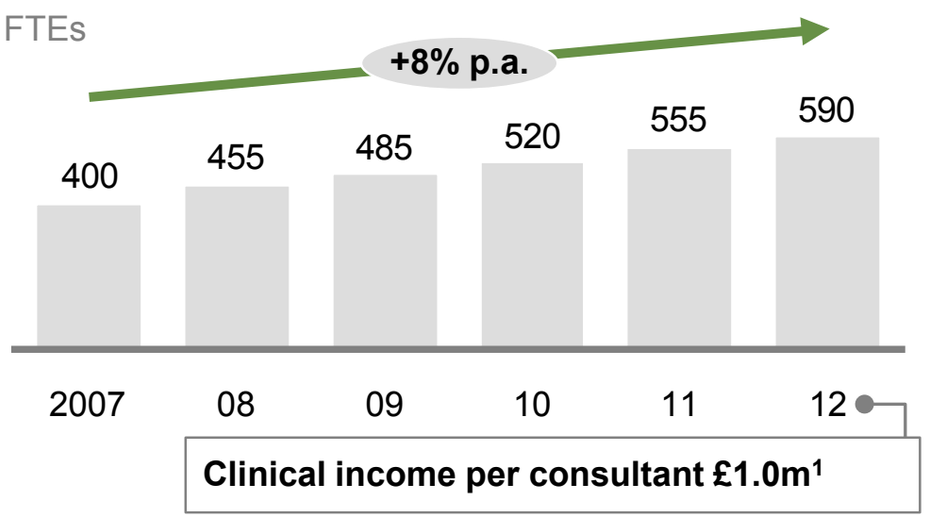
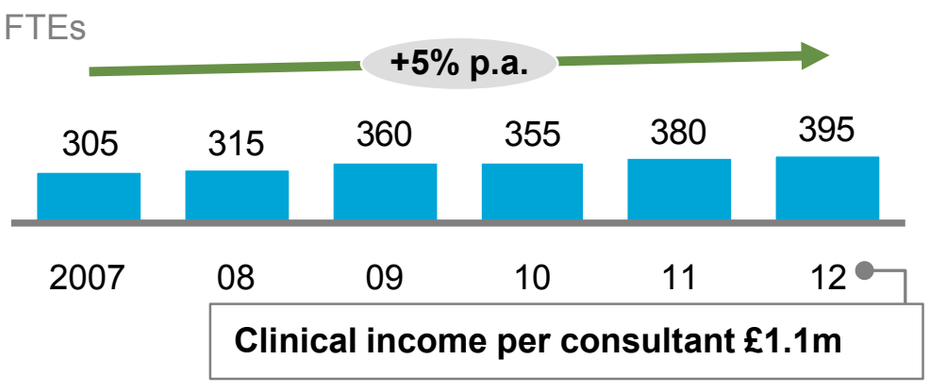
EXAMPLE

Cost analysis – benchmarking one trust's consultant numbers against peers to understand medical cost drivers

Trust 1 consultants, 2007–2012



Trust 2 consultants, 2007–2012



Peer group full-time equivalent growth, 2007–12 and clinical income/consultant, 2012

Trust	FTE CAGR[1] (%)	Clinical income/ consultant (£m)
Brighton & Sussex Uni	8.7%	0.9
Guy's & Thomas'	8.1%	1.0
Central Manchester Uni	7.7%	1.7
St George's	7.5%	1.2
Cambridge Uni	6.1%	1.1
Southampton Uni	5.9%	1.0
Uni College London	5.8%	1.3
Royal Liverpool & Broad Uni	5.5%	1.2
Oxford Uni	5.5%	1.3
Royal Free London	5.5%	1.3
King's College	5.3%	1.1
Bristol Uni	5.3%	1.1
Birmingham Uni	5.2%	1.3
Norfolk & Norwich Uni	5.1%	1.2
Derby Hosp	4.8%	1.3
Chelsea & Westminster	4.7%	1.2
Nottingham Uni Hosp	4.5%	1.1
Newcastle-Upon-Tyne	4.3%	1.3
Sheffield Teach Hosp	3.1%	1.4
Barts & London	3.1%	1.4
Leeds Teach	2.2%	1.2
Imperial College	1.7%	1.2

1 Compound annual growth rate

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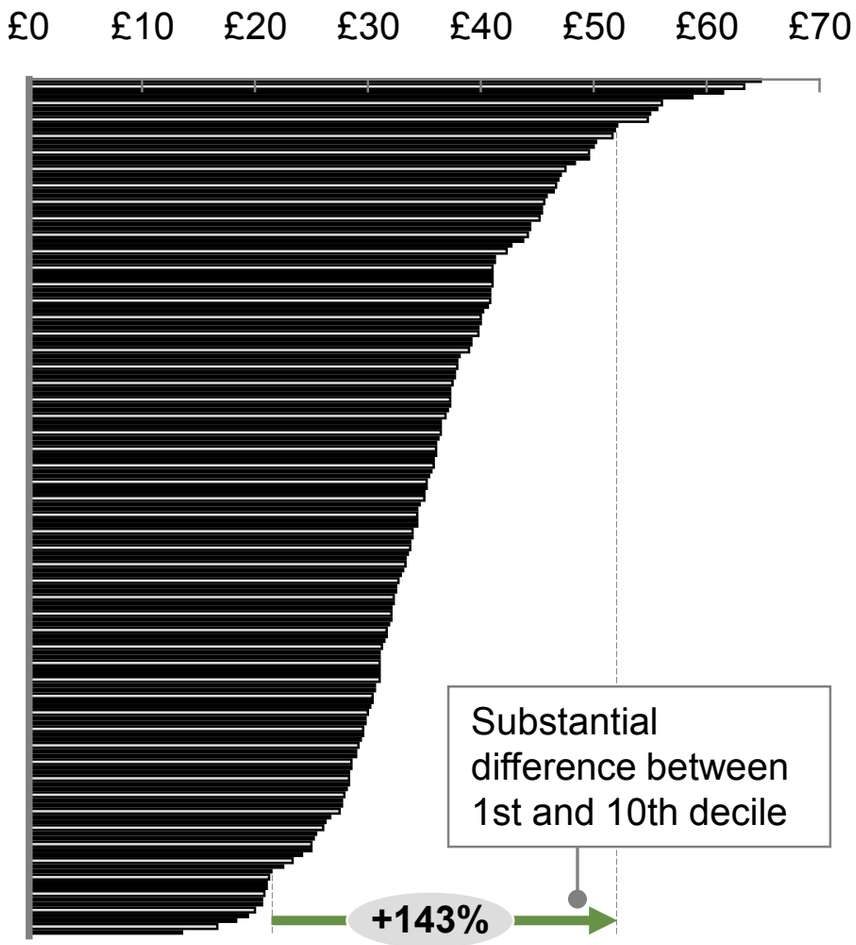
EXAMPLE

Cost analysis – community care (1/3)

Within district nursing, cost per contact varies widely across commissioners

District nursing face-to-face visits

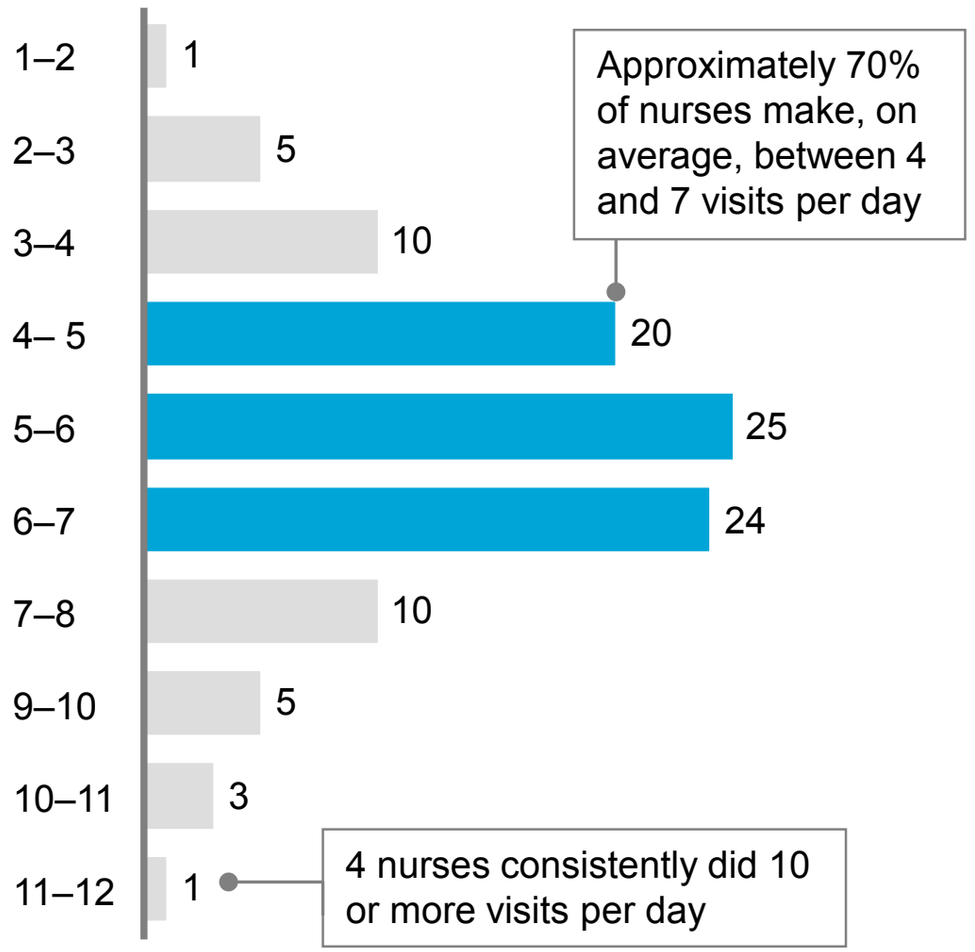
Cost per contact, £



Within a commissioner, productivity varies between nurses

Visits per district nurse per day[1]

%



1 Includes activity of 80 generalist district nurses over ~3 month period

Source: Anonymised NHS provider example

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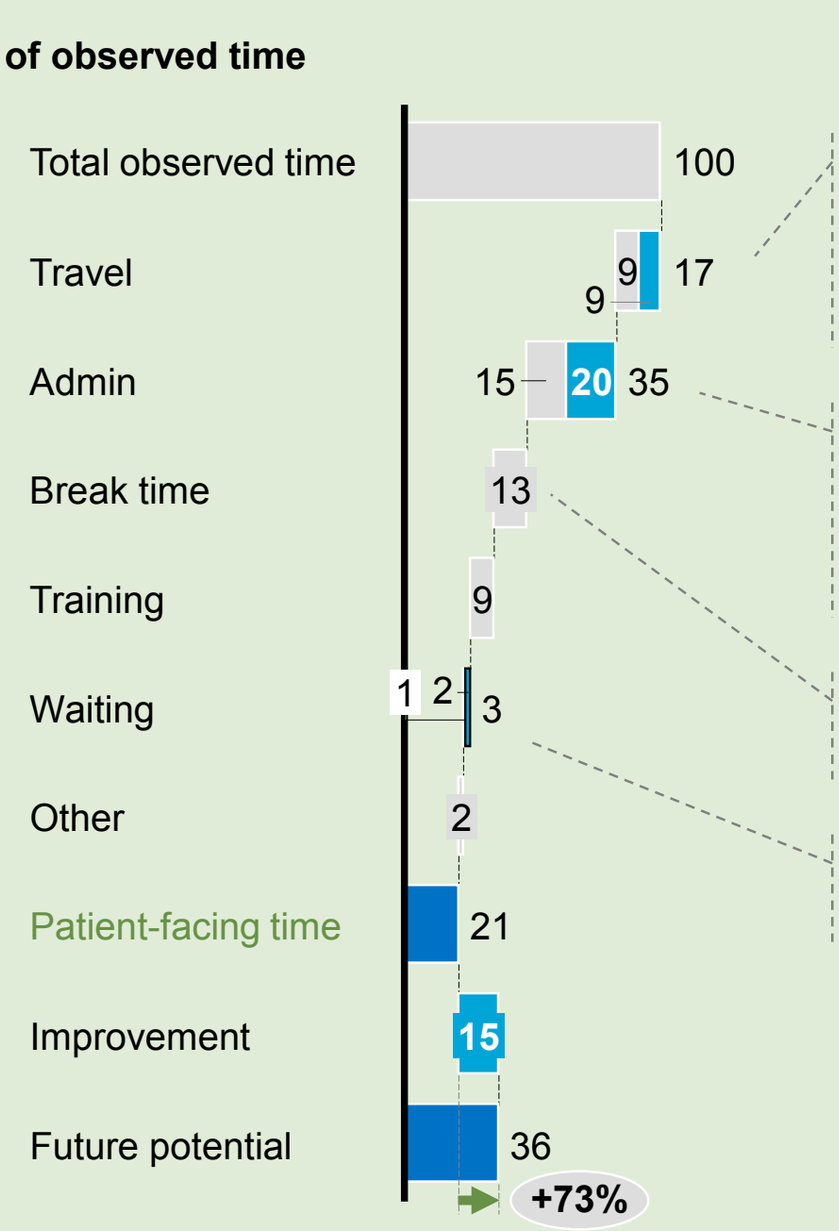
EXAMPLE

Cost analysis – observations indicate it is possible to almost double the time community nurses spend with patients (2/3)



Improvement potential	Suggested improvements
50%	• Optimise routes to minimise distance • Reduce Do Not Attends • Use collect and deliver prescription service • Standardise kits to reduce missing equipment
65%	• Introduce effective mobile technology • Pre-populate forms with existing data • Eliminate duplications • Improve referral quality
	• Define skills required • Provide structured training
70%	• Reduce Do Not Attends • Improve communication with acute provider
50%	• Improve handovers • Improve multi-disciplinary team relationships
	• Organise equipment in the patient's home

Source: Anonymised NHS provider example

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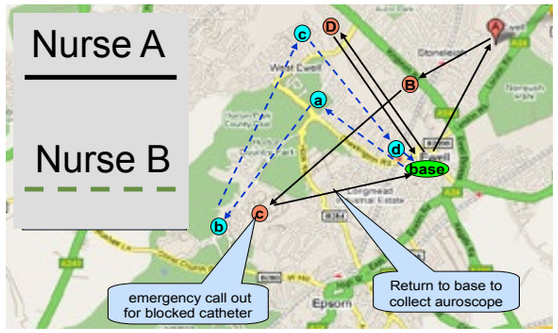
EXAMPLE

Cost analysis − analysing community care costs to improve staff utilisation (3/3)

Observation

- Planned routes are inefficient, with more distance travelled than required
- Individual nurses and specialists decide their own route for the day. There is no route planning across the whole team each day

Eg returning to base after each visit



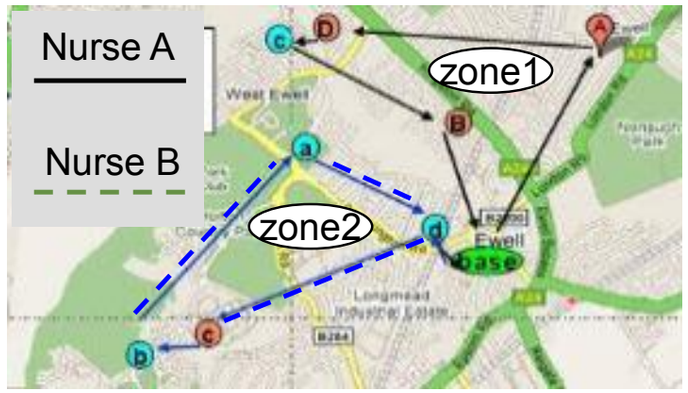
Eg overlapping routes

- Nurses and specialists have to spend time to find out how to get to the next patient – eg, a new patient or when covering another nurse's patients
- Nurses allocate patients by GP not address

Potential improvement opportunity

- Establish guidelines on how to schedule a day and plan routes to reduce travel, within the constraints of patient urgency, etc.
- In-car GPS for each nurse or specialist, preloaded with each day's route
- Plan patient visits looking at all the work across the team, grouping geographically as much as possible to reduce driving

Potential impact



- Analysis showed nurses spend 25% of daily time driving
- 20% improvement potential could save 23 minutes driving for a nurse each day

~20% productivity improvement potential through route optimisation

15

Hours per week for a team of 8

Source: Anonymised NHS provider example

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EXAMPLE

Identifying common suppliers across departments and spend by supplier

Top 10 med & surg suppliers	Cardiothoracic annual spend £k	Top 10 med & surg suppliers	Theatres annual spend £k	Top 10 med & surg suppliers	Radiology annual spend £k
Guidant Ltd	1,663	Squadron Medical Ltd	579	Cook UK Ltd	363
Medtronic Ltd	1,251	Boston Scientific Ltd	229	Boston Scientific Ltd	265
Boston Scientific Ltd	885	Keymed (Medical & Industrial Equip)	178	Axis Healthcare	141
St. Jude Medical UK Ltd	506	Tyco Healthcare U.K. commercial	175	Philips Medical Systems	126
Johnson & Johnson Medical Ltd	448	Karl Storz Endo-scopy UK Ltd	175	Siemens	116
Terumo UK	378	Nikomed Ltd	150	Johnson & Johnson Medical Ltd	100
Edwards Life-sciences Ltd	364	Cook UK Ltd	78	Pyramed	98
Kimal Plc.	336	B Braun Medical Ltd	53	Medrad UK	73
Squadron Medical Ltd	299	Datex-Ohmeda Ltd	49	Asset Investment Group	45
Dideco SpA U.K. Branch	290	Johnson & Johnson Medical Ltd	48	Medtronic	44
Total spend, £m	**8.5**		**3.5**		**2.5**
Spend covered by top 10, %	**75**		**49**		**55**

Common suppliers

- Hospitals typically do not have a co-ordinated sourcing strategy
- Opportunities exist to:
  - bundle volumes across the departments
  - consolidate volumes to the main suppliers within departments

Source: Anonymised NHS provider example

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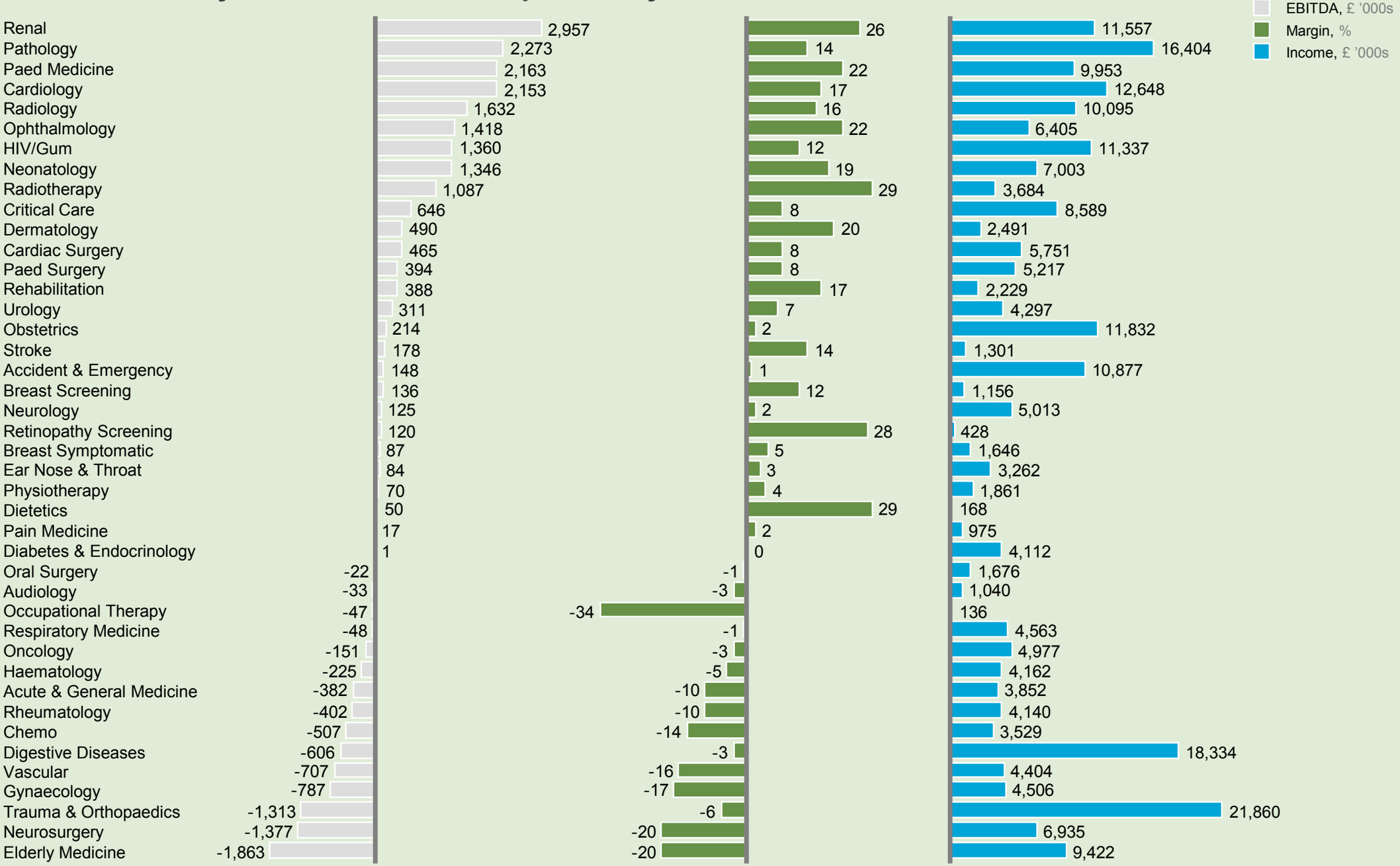
EXAMPLE

Financial ratio analysis – income and surplus analysis of service lines for one trust



Source: Anonymised NHS provider example

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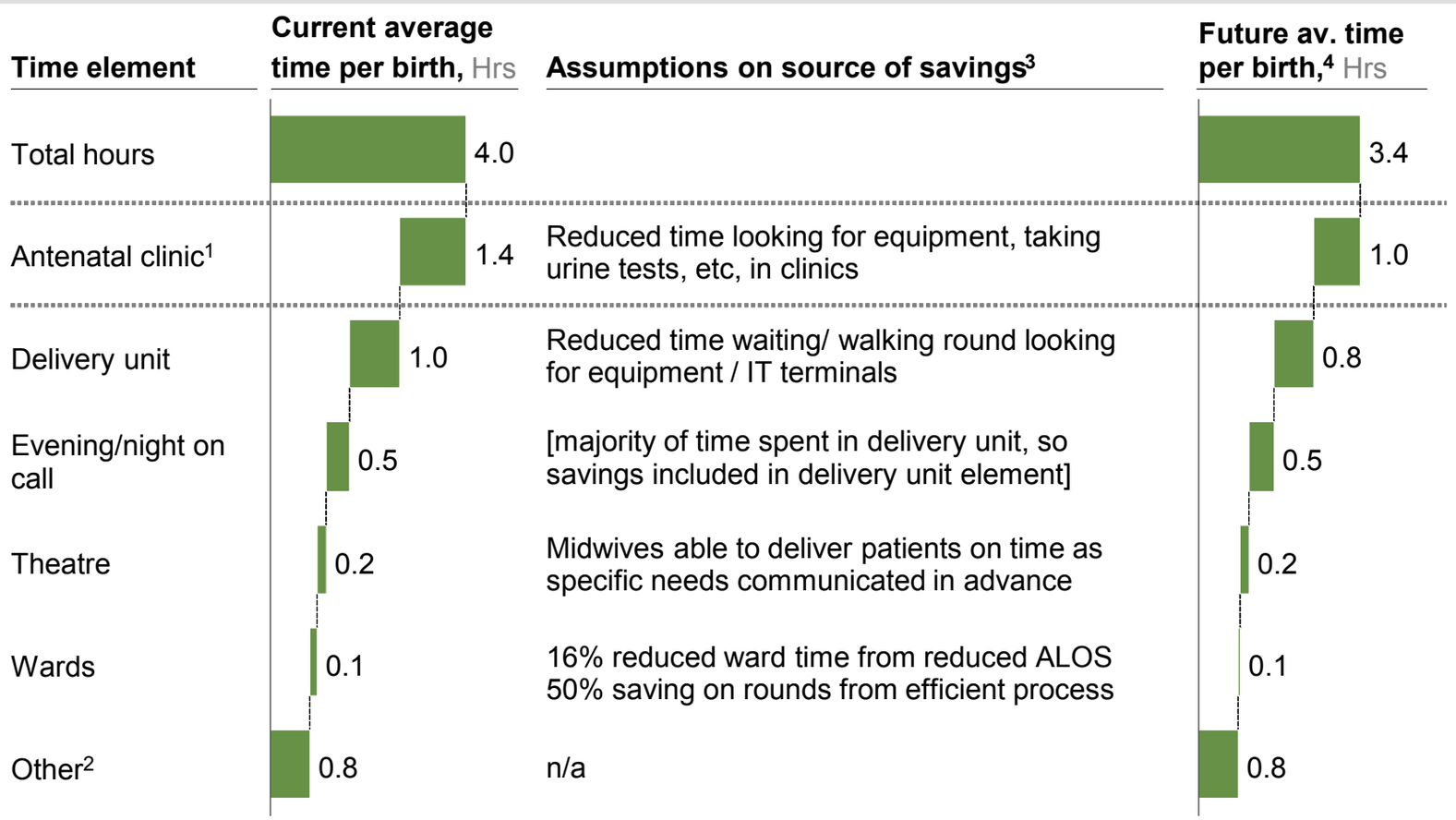
EXAMPLE

A detailed 'ideal cost' analysis

This exhibit demonstrates the potential savings in moving from existing practice to ideal practice. Savings identified are based on interviews with staff, patients and administration. You could do more analysis on the implementation of each area.

Comparison of obstetric care costs in current and ideal state

Average consultant staff time and activities per birth in obstetric care
Hrs



1 Includes antenatal clinic, multi-disciplinary team meetings, and direct patient clinical administration; 2 Other category includes activities such as annual leave, educational training , meetings and governance; excludes all gynaecology and teaching activity; 3 Based on staff interviews, not exhaustive; 4 Upper end of the potential savings identified

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EXAMPLE

Presenting trust performance against quality and financial measures

Service	Consultant cover on site: WTE	Consultant cover on site: Hours/days of the week	Scale: Non-elective inpatient spells	Efficiency: Reference cost index	Access: Blue light driving time (mins) to nearest larger provider
A&E (Attendances)	5.4[1]	9/7	76,907[3]	93	25-30
Acute paediatrics	6.8	24/7	4,484[4]	79	25-30
Maternity (Births)	9.0	24/7	~3,000	96	25-30
Emergency general surgery	7.0	24/7	3,424	122	25-30
Stroke	4.0[2]	8/5	421	98	25-30

	Paeds and A&E: >10 Maternity: >5 Emergency gen surg & stroke: >8	24/7	A&E: 80k+ Stroke: 600+ Other: 1st, 2nd, 3rd, & 4th quintile	RCI < 95	>40 minutes
	Paeds and A&E: 8-10 Maternity: 4-5 Emergency gen surg & stroke: 6-8	>18/7	A&E: 60+80k Stroke: 500-600 Other: 4th quintile & negative growth	95 < RCI < 105	20-40 minutes
	Paeds and A&E: <8 Maternity: <4 Emergency gen surg & stroke: <6	<12/7	A&E: <60k Stroke: >500 Other: 5th quintile	105 < RCI	0-20 minutes

Source: Anonymised NHS provider example

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EXAMPLE

Presenting trust performance against quality and financial measures and assessing progress against each of the trust's strategic aims

Trust overall performance dashboard

Favourable Neutral Unfavourable

Strategic aims	Indicators	Comparing current top quartile to current performance	Year target expected to be reached
Clinical Outcomes	Summary Hospital-Level Mortality (SHMI) - Index	Target 93.0, Current 91.4	
	MRSA cases per 100,000 bed days	Target 1.1, Current 0.4	
	Clostridium Difficile cases per 100,000 bed days	Target 14.0, Current 17.9	2016
Patient Experience	Standardised emergency readmissions within 28 days of discharge	Target 96.0, Current 91.0	
	Patient Experience: Friends and Family test	Target 76.0, Current 79.0	
	Performance Aggregate (number of performance targets not achieved)	Target 3.0, Current 3.0	2014
Research and Development	Patients recruitment into clinical trials (per 1000 outpatient first attendances)	Target 60.0, Current 65.0	
Staff satisfaction	Staff engagement measurements	Target 3.8, Current 3.9	
Teaching and Learning	Percentage of staff receiving job-relevant training, learning or development in last 12 months (staff survey)	Target 84.0, Current 82.0	2014
	General Medical Council survey of doctors in training - Overall Satisfaction Score [2]	Target 81.3, Current 80.2	2016
	Nurses & Advanced Health Practitioners - league table university courses (Complete University Guide: overall satisfaction score)	Target 97.0, Current 98.0	
Value for Money	Monitor Financial Risk Rating (FRR)	Target 2.8, Current 3.0	N/A
	Reference Cost Index (RCI) Market Forces Factor Adjusted	Target 97.0, Current 99.0	2014

Source: Anonymised NHS provider example

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EXAMPLE

Analysis of other providers in health economy and how strategies may impact a trust

Mental health competition summary

	Adult acute	Adult community	Dementia	Rehab and recovery	Substance misuse	Improving access to psychological therapies
Number of providers	11	11	10	15	14	11
Direct/ indirect	0/11	2/9	0 direct (excl community groups)	5/10	3/11	2/11
NHS/other sectors	8 NHS	8 NHS	8 NHS	8 NHS	8 NHS	8 NHS
Trends anticipated	Growth in private sector competition for sub-specialisms. NHS providers to compete if main contracts tendered	Growth in individual funding packages, both for complex/long term and for wellbeing. Third sector competing for wellbeing	GP federation competition for diagnosis work. Commissioner tendency to see post-diagnosis support as third sector work — not yet seeing value in co-ordination role	More individual packages, strong independent sector and housing provider competition. Commissioners moving towards repatriation and community reprovision	Movement towards outcome based Payment By Results lead provider arrangements. Third sector partnership required. Inpatient detox price competition driven hard by commissioners	Consolidation of major third sector provider models, NHS partnering with third sector. Growth in alternative organisational forms

Source: Anonymised NHS provider example

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EXAMPLE

Analysis of competitor provision of specialist services

Major provider of specialist services

Treatment specialty	Your specialist rank nationally[1]	Annual activity, spells: Your trust – Qualifies for specialist commissioning	Your trust – Does not qualify for specialist commissioning	Another trust 1 – Qualifies for specialist commissioning	Another trust 1 – Does not qualify for specialist commissioning	Another trust 2 – Qualifies for specialist commissioning	Another trust 2 – Does not qualify for specialist commissioning	Another trust 3 – Qualifies for specialist commissioning	Another trust 3 – Does not qualify for specialist commissioning
• Gastroenterology	4 / 76	190	8,070	35	5,990	66	6,499	65	9,153
• Endocrinology	N/A	*	68	15	238	39	544	…	…
• Diabetic medicine	2 / 31	182	2,454	10	85	…	17	*	12
• Clinical immunology and allergy	N/A	…	*	…	…	…	…	…	…
• Rehabilitation	24 / 34	7	308	…	…	…	…	21	919
• Cardiology	33 / 130	961	4,193	523	2,831	119	1,520	222	2,794
• Anticoagulant service	N/A	…	*	…	…	…	…	…	…
• TIA Medicine	N/A	…	6	*	14	…	…	…	*
• Dermatology	N/A	8	1,190	*	138	*	772	…	10
• Thoracic medicine	14 / 99	195	3,044	32	549	95	1,558	12	471
• Infectious diseases	14 / 28	47	121	…	…	…	…	…	…
• Genito-urinary medicine	N/A	…	6	…	…	…	…	…	…
• Nephrology	14 / 58	640	503	…	…	…	…	…	…
• Rheumatology	19 / 44	56	788	57	1,149	169	1,033	25	635

1 Ranked against all UK trusts based on number of inpatient spells of activity which qualifies as specialist under 2013/14 commissioning guidelines

Source: HES 2012/13

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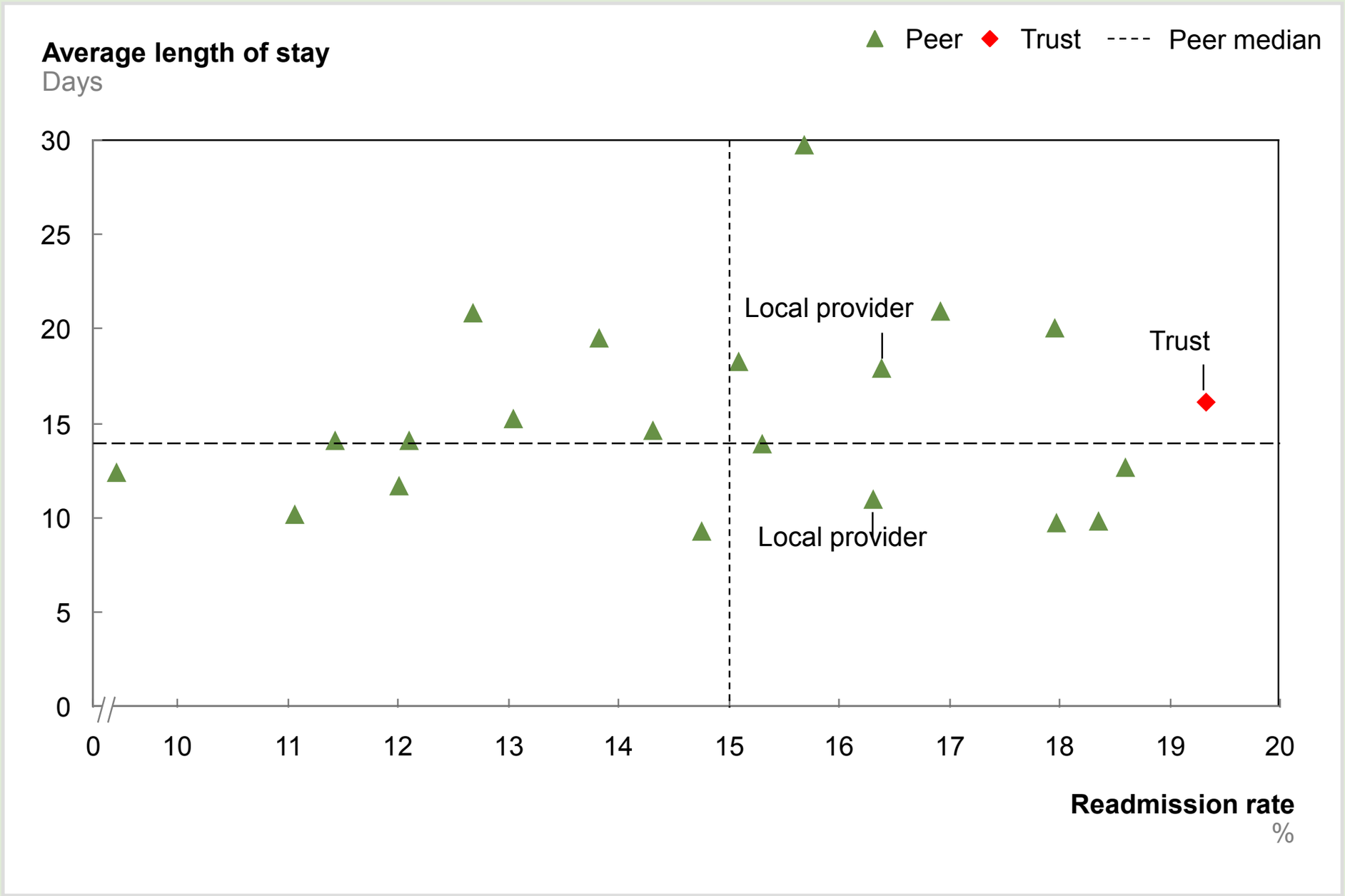
EXAMPLE

Analysis of trust performance on Elderly Care service length of stay and readmissions



Source: HES 2011/12

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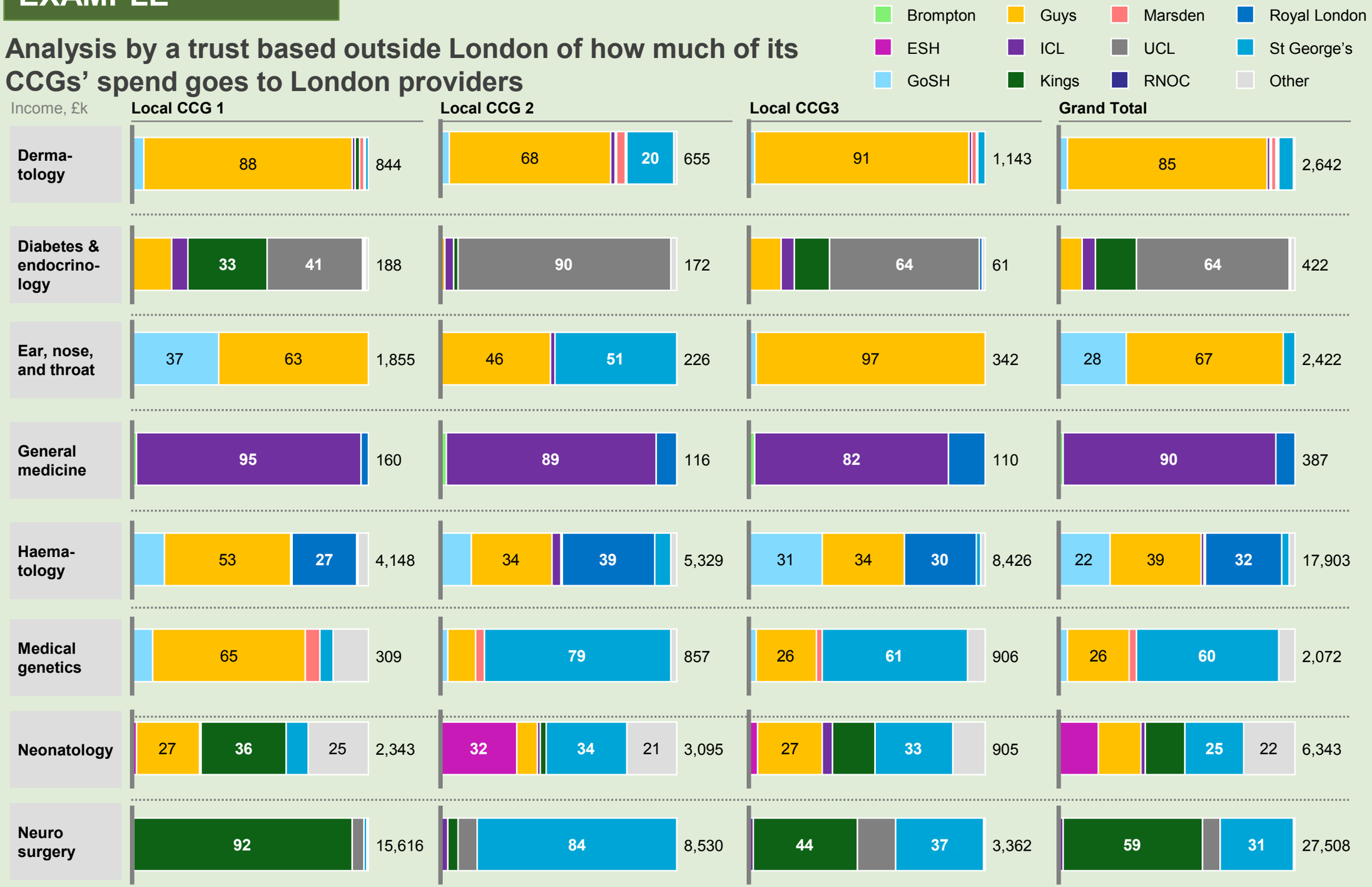
EXAMPLE

Analysis by a trust based outside London of how much of its CCGs' spend goes to London providers



Source: NHS England

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Making the health sector work for patients

Forecast

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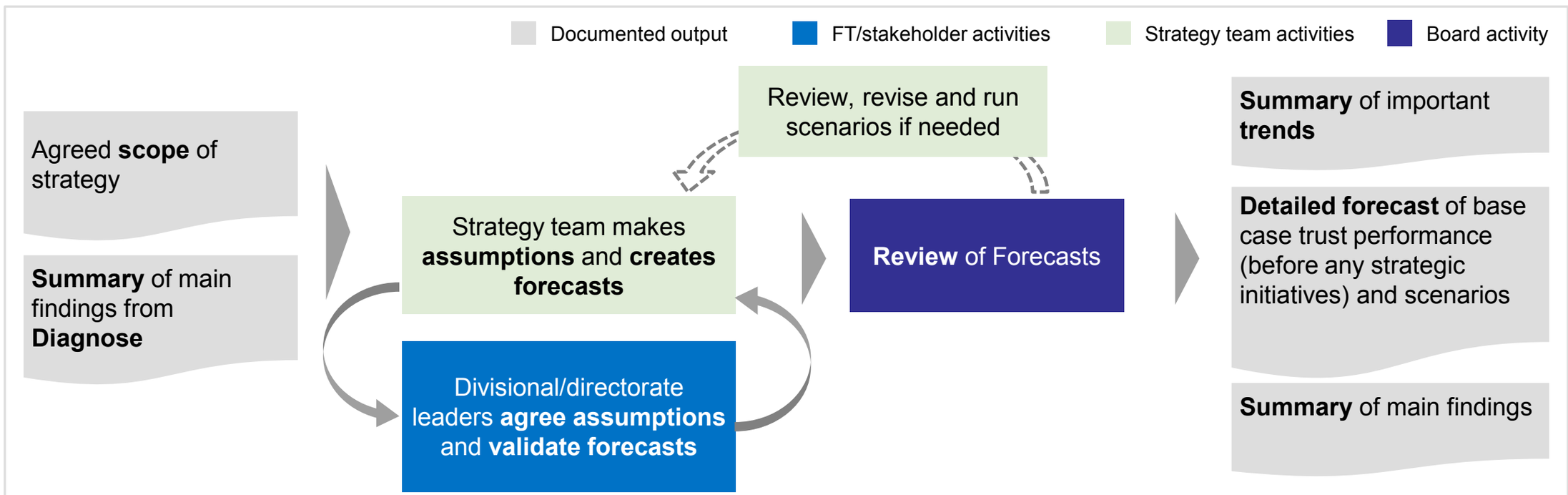
Introduction

In the Forecast stage you will develop a view of the future trends in the health economy and create a comprehensive ‘base case’ forecast for your FT before making any strategic changes.

Forecasting demand allows you to forecast your FT’s future activity. Forecast activity will determine forecast income and costs, and therefore overall financial performance. The toolkit contains an Excel tool to collate and summarise your forecast, accessed **at this link**. Forecasting demand and other key trends in the health economy will widen your perspective – this is important for identifying opportunities and challenges at the Generate Options stage. In developing a base case forecast, you will build scenarios for future activity, income and costs, while gaining an understanding of how sustainable the FT’s services will be in future.

NHS base case forecasts of financial performance often suggest a significant deficit, even before including extra costs from new treatment approaches and/or enhanced quality standards. If your trust is in this position, you will focus in the Generate Options stage on changing how care is delivered in order to protect quality and affordability. Alongside the base case forecast, you will run a sensitivity analysis to define, for example, high-growth and low-growth cases. After agreeing your strategy, at the Prioritise stage you will model the impact of initiatives on the base case to find out whether your strategy is expected to meet your performance goals.



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Base case forecasting – summary of key steps

Activity

- Activity can be split by
  - point of delivery (POD), eg A&E, non-elective, elective, day care, outpatient
  - specialty categories, eg medicine, surgery, women, children
  - specialty, eg cardiology, dermatology, trauma and orthopaedics
  - sub-specialty or individual health resource group (HRG) codes

In some cases you will want to split activity by site as well.

The toolkit contains a model to support your activity forecasting work, accessed **at this link**

Income

- Activity-based clinical income should be split in the same way as activity (by site, POD, specialty categories, specialties, sub-specialties or HRG codes)
- Non-activity-based clinical income (eg block contract) is rarely available by site and can be kept consolidated at the trust level
- Non-clinical income (eg R&D, teaching) is typically only available at the trust level

Costs

- Operating costs should be split in two dimensions
  - in the same way as activity (by site, POD, specialty categories, specialties, sub-specialties or HRG codes)
  - and by cost category
    - pay v non-pay
    - variable, semi-variable and fixed categorisation
    - if available, full categorisation (consultant, nurses, other medical, supplies, estates, etc)
- Non-operating costs are typically split at trust level
- Depreciation, amortisation and capex are typically at trust level

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Forecasting your FT's demand and activity

At this stage the aim is to create a base case model of activity before implementing any changes. Using a forecast tool will enable you to include all your assumptions. An example tool and associated guidance is available here: **Demand Forecast Summary**.

Historical information on activity at the level you decide to forecast is an important starting point. The following pages show the factors to analyse when forecasting your activity from this starting point – use them as inputs to the Excel tool – and offer guidance on information sources.

To keep this forecast as a 'base case', some inclusions and exclusions are recommended.

Suggested inclusions are:

- Forecast demographic changes
- Expected activity changes from new best practice, mandated standards or changes necessary to meet care standards previously agreed with commissioners; impact on your activity of tenders won or lost. These are often referred to as 'non-demographic changes', but you will need to state the reasons for them in specific services before adding them into the overall effect on your activity
- Commissioners' intentions – you should include these in the base case and may decide to test their potential impact

Suggested exclusions are:

- Service changes being considered in the strategy development process
- Any uncompleted competitive procurement

Level of activity modelling

You can forecast activity at multiple levels – trust, point of delivery (POD), specialty or health resource group (HRG). You can also segregate demand and activity in different ways – for example, by patient group rather than specialty or type of treatment (and technology used in the treatment). How you decide to cut demand for services and activity will depend on available data and on which segregation best helps you understand future demand changes.

The Demand Forecast Summary Excel tool assumes you may want to forecast activity by treatment specialty, or even HRG for high-volume work, and then include a ‘remaining activity’ line.

- Forecasting all activity at HRG level is likely to be too detailed for strategic decisions.
- Forecasting all activity at POD is likely to be too broad and may not allow you to identify different factors driving demand between subgroups.

Factors driving activity changes

The main factors affecting an FT’s future demand and activity are set out on the next page.

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Factors affecting an FT's future activity

Separate input sheet in the tool

Conceptual consideration

Factors that affect future demand and trust activity volumes

1. Demographic changes
   - Growth in population
   - Change in age profile
2. Non-demographic changes
   - a. Disease prevalence changes (on top of demographic change)
     - Risk factors; epidemiology
     - Adherence to best practice care pathways
     - Technology changes and clinical innovations
   - b. Diagnosis and treatment rate changes (including via technology changes)
     - National diagnosis/treatment policy changes
     - Increased patient awareness
     - Complementary provider (eg GP) changes
     - Supply-induced demand changes
   - c. Other changes
     - Service changes at neighbouring providers
     - Changes in referrers' choices
3. Commissioners' plans
   - National commissioning changes
   - Local commissioning changes
4. Changes due to FT's strategic initiatives

+ Catch-up on waiting lists/existing backlog – one-off effect

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Sources of assumptions for demand forecasting

		Sources of forecasting assumptions
1	**Demographic changes**	• Office for National Statistics (ONS) age/sex population forecasts • To be aligned with commissioners – clinical commissioning groups (CCGs) and NHS England (NHSE)
2a	**Age-specific disease prevalence**	• Public Health England; director of public health • FT's proprietary data, eg analysis of patient administration systems (PAS) • Health and social care information, eg historical hospital episode statistics (HES) • Discussions with clinicians for observed changes in local and lifestyle factors
2b	**Diagnosis and treatment rate changes (including via technology changes)**	• Discussions with the FT's medical, nursing and other clinical specialists • Guidance/standards from professional colleges and other national bodies • Academic literature • Reviews of practice at leading-edge healthcare providers in England and abroad • Most recent device/drug/treatment approvals from National Institute for Health and Care Excellence • Central government policy/Department of Health; NHS England • Regulators: Monitor, Care Quality Commission (CQC) • Think tanks, eg Nuffield Trust, King's Fund • Complementary provider changes: discussions with commissioners and providers • Supply-induced demand: FT experience with local population; patient surveys; clinician discussions; academic research
2c	**Other changes**	• Changes at neighbouring trusts (eg increasing or reducing services, regulatory issues or Monitor Contingency Planning Team); impacts of other trust-published strategic plans • Changes in referrers' choices: analysis of GP and secondary referral patterns
3	**Commis-sioners' plans**	• Commissioners' plans (CCGs and NHSE specialised commissioners) including integrated care and out of hospital initiatives • Adherence to best practice care pathways/national guidance (as described under 2b above) • Local authority plans (eg Better Care Fund) • Commissioner-led regional reconfiguration (CCG or NHSE specialised commissioning)

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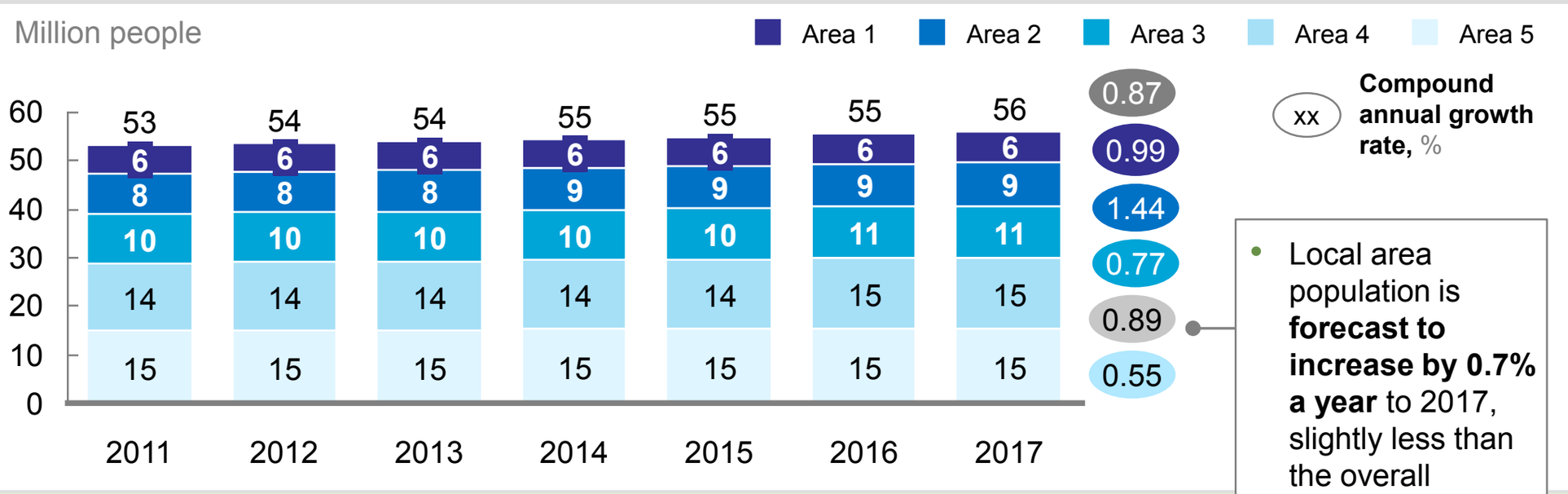
EXAMPLE

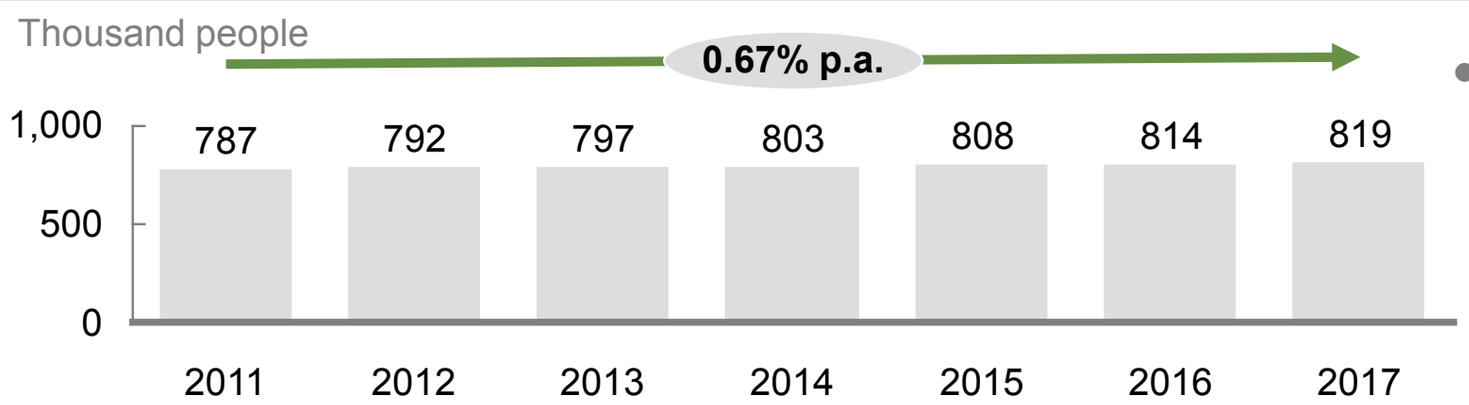
Demographic analysis: a trust's analysis of population change in the UK and relevant areas (1/3)

England population (ONS population growth)



- Local area population is **forecast to increase by 0.7% a year** to 2017, slightly less than the overall forecast population growth
- This is largely similar to the demographic growth assumption used by this trust for activity increases

Local area population (ONS population growth)



Source: Anonymised NHS provider example

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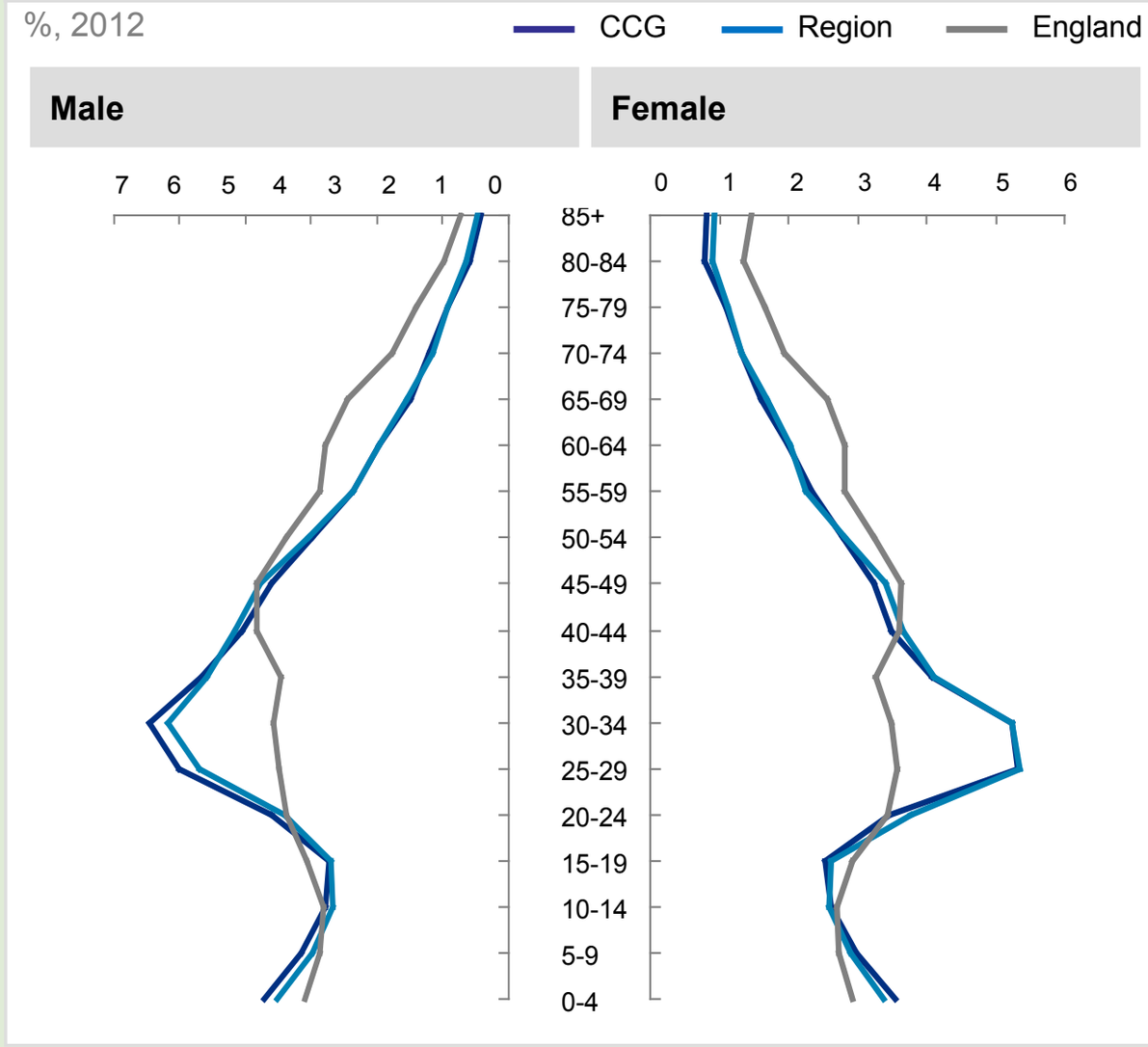
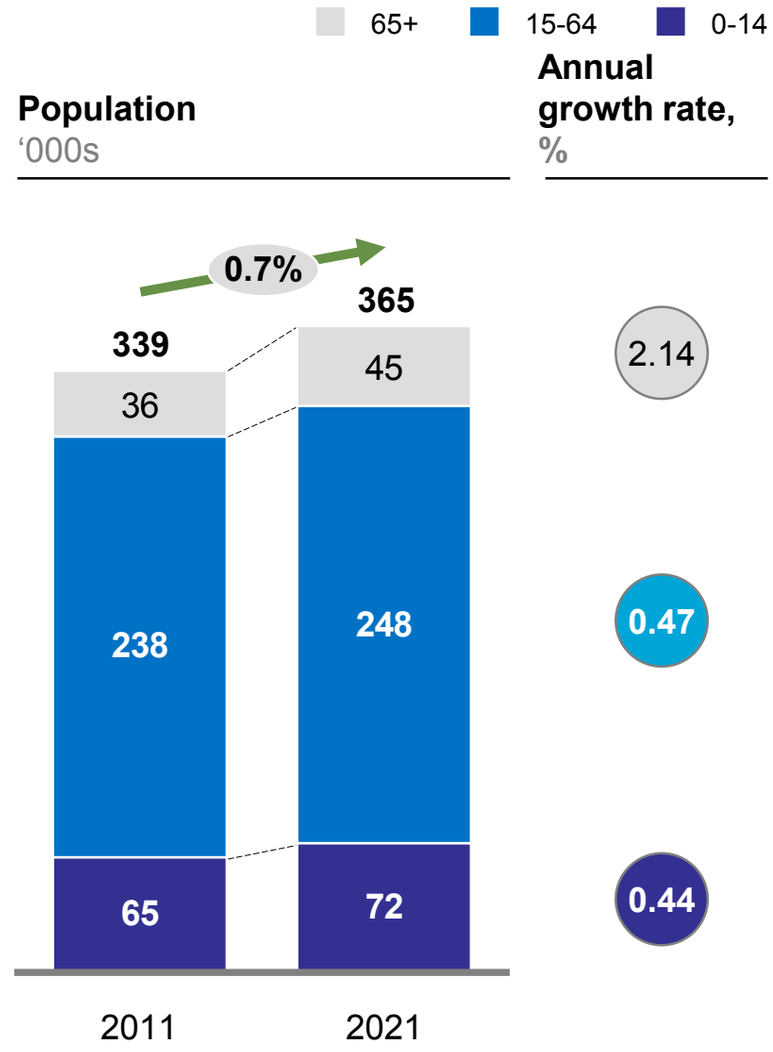
EXAMPLE

Demographic analysis: a trust's analysis of population change in the UK and relevant areas (2/3)

Age distribution of population



Population growth



Source: Anonymised NHS provider example

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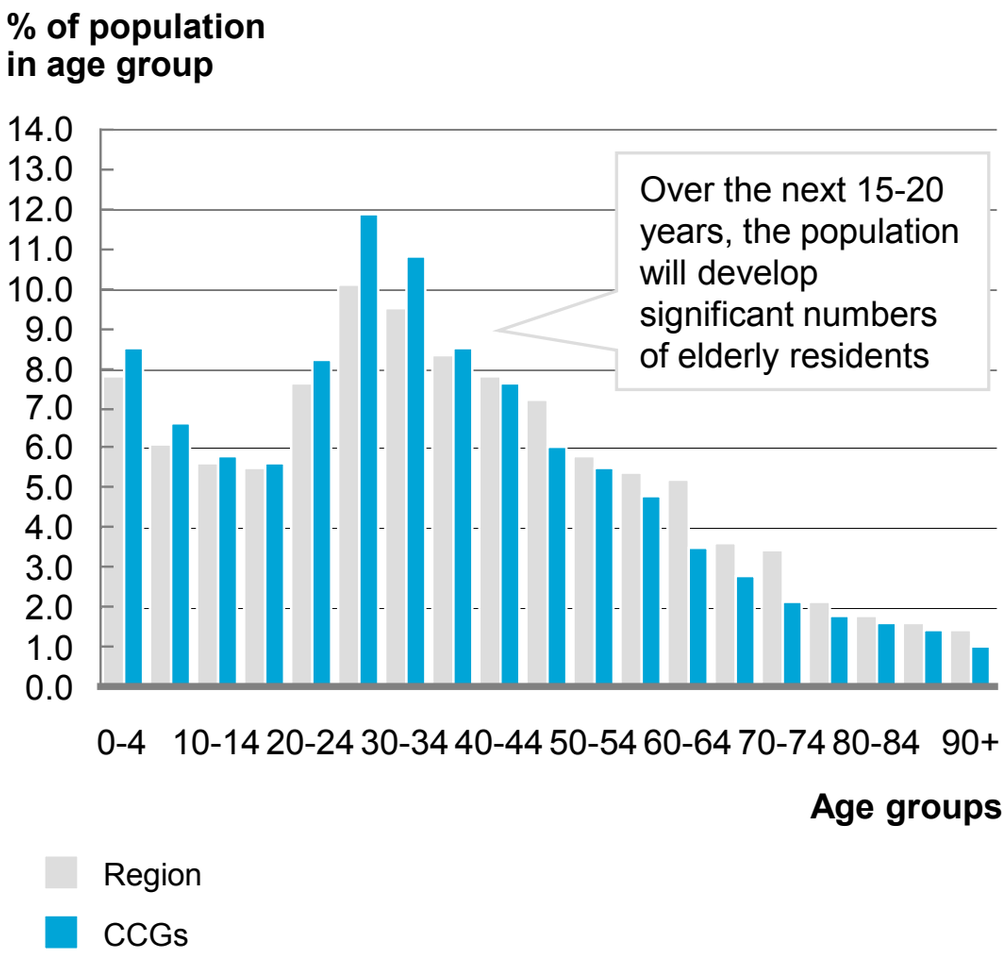
EXAMPLE

Demographic analysis: a trust's analysis of population change in the UK and relevant areas (3/3)

The trust has a young population with a high birth rate…

Age profile of three boroughs



…with high population turnover and population growth…

Population growth forecasts 2011 to 2021

CCG	List size	Net change	% net change	Turn-over	Turn-over rate, %
CCG 1	258,790	10,254	4	88,670	34.3
CCG2	261,469	3,194	1.2	71,898	27.5
CCG3	347,211	10,476	3	109,918	31.7
Total	**867,470**	**23,924**	**2.8**	**270,486**	**31.2**

Population churn

	CCG 1	CCG 2	CCG 3	Total
2011	268,854	254,246	232,726	755,826
2021	318,242	312,396	249,875	880,513
% change	18.40%	22.90%	7.40%	16.50%

Source: Anonymised NHS provider example

Non-demographic changes

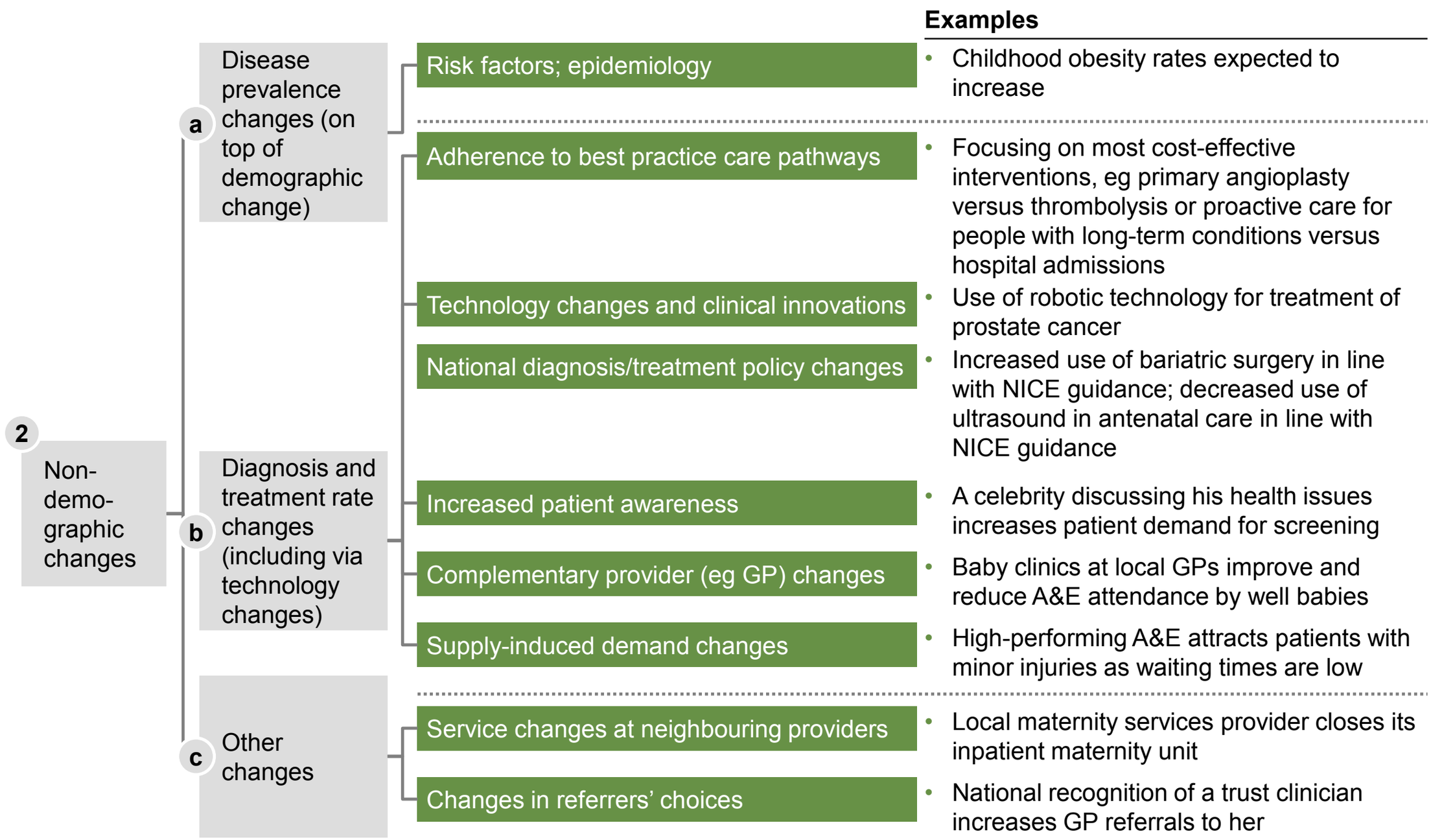
Many factors can influence demand. The summary of factors affecting an FT's future activity (page 128) includes some of these as 'non-demographic changes'.

It is important to agree where your trust can make an overall assumption about activity changing due to non-demographic factors and where you will need to consider some of the factors in detail separately for specific services (because major change is expected).

Knowledge of these trends will depend on working in partnership with local commissioners and keeping up to date with national reports and regulatory standards. Frequently involving your FT's clinical leaders and other clinical experts will help you understand these factors.

The following pages contain examples of what you need to consider.

Non-demographic changes



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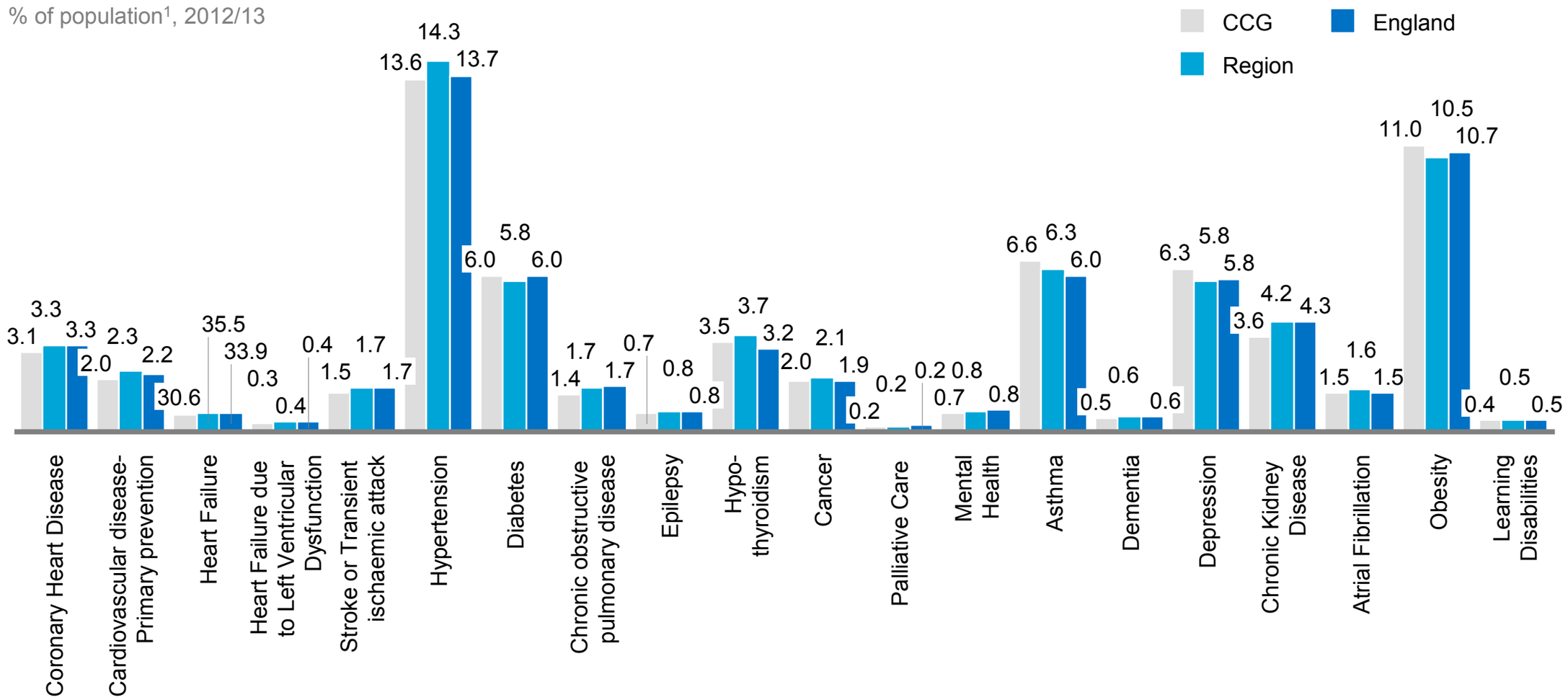
EXAMPLE

Disease prevalence changes: prevalence rates for key conditions, in CCG's patients, region and England

Prevalence of diseases



1 Age groups used for percentages differ as follows: diabetes (17+), epilepsy (18+), chronic kidney disease (18+), depression (18+), obesity (16+), learning disabilities (18+)

Source: Anonymised NHS provider example

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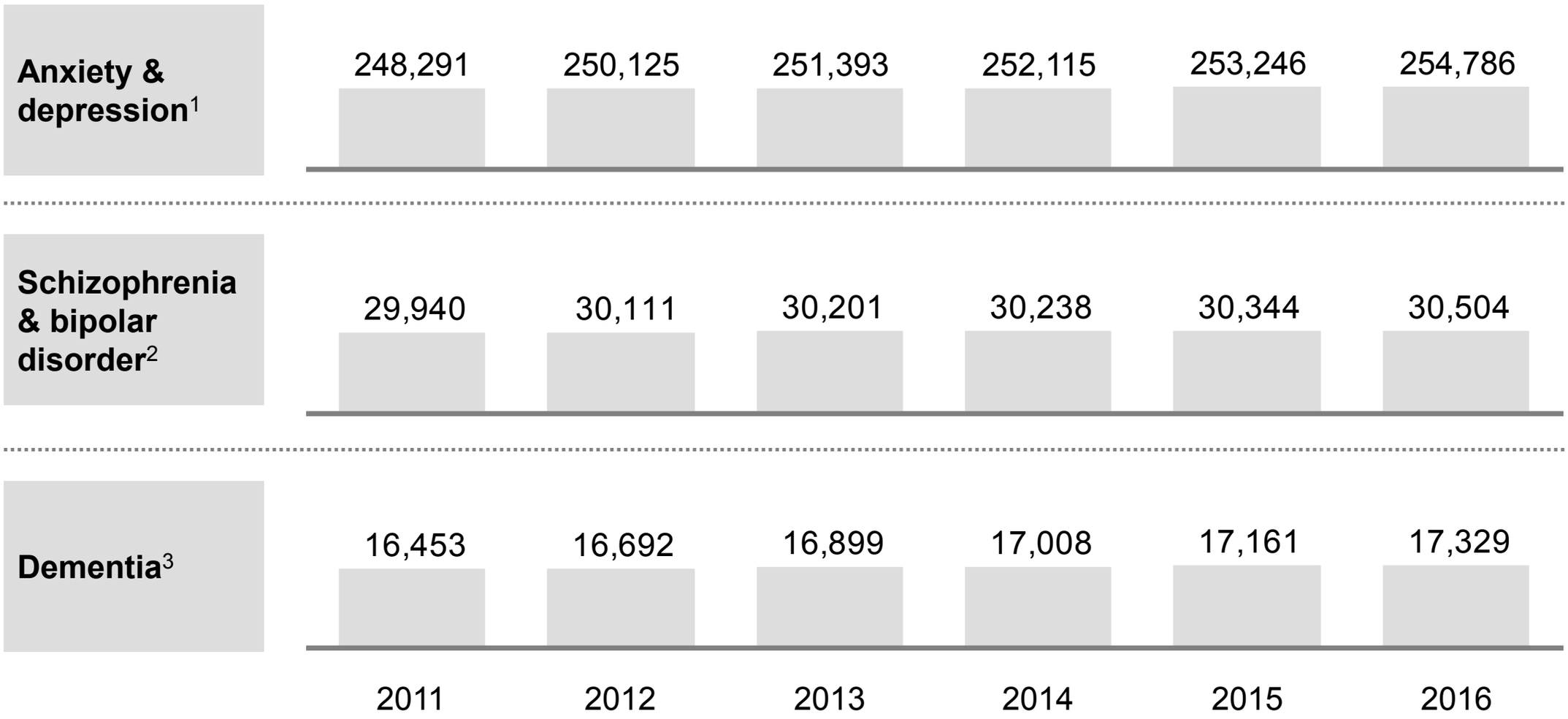
EXAMPLE

Disease prevalence changes: projected changes in prevalence rates for key conditions treated by the trust

Prevalence in region and projections 2011-2016



1 includes mixed anxiety and depression; depressive episode; and generalised anxiety
2 includes type I and type II 3 includes early onset

Source: Anonymised NHS provider example

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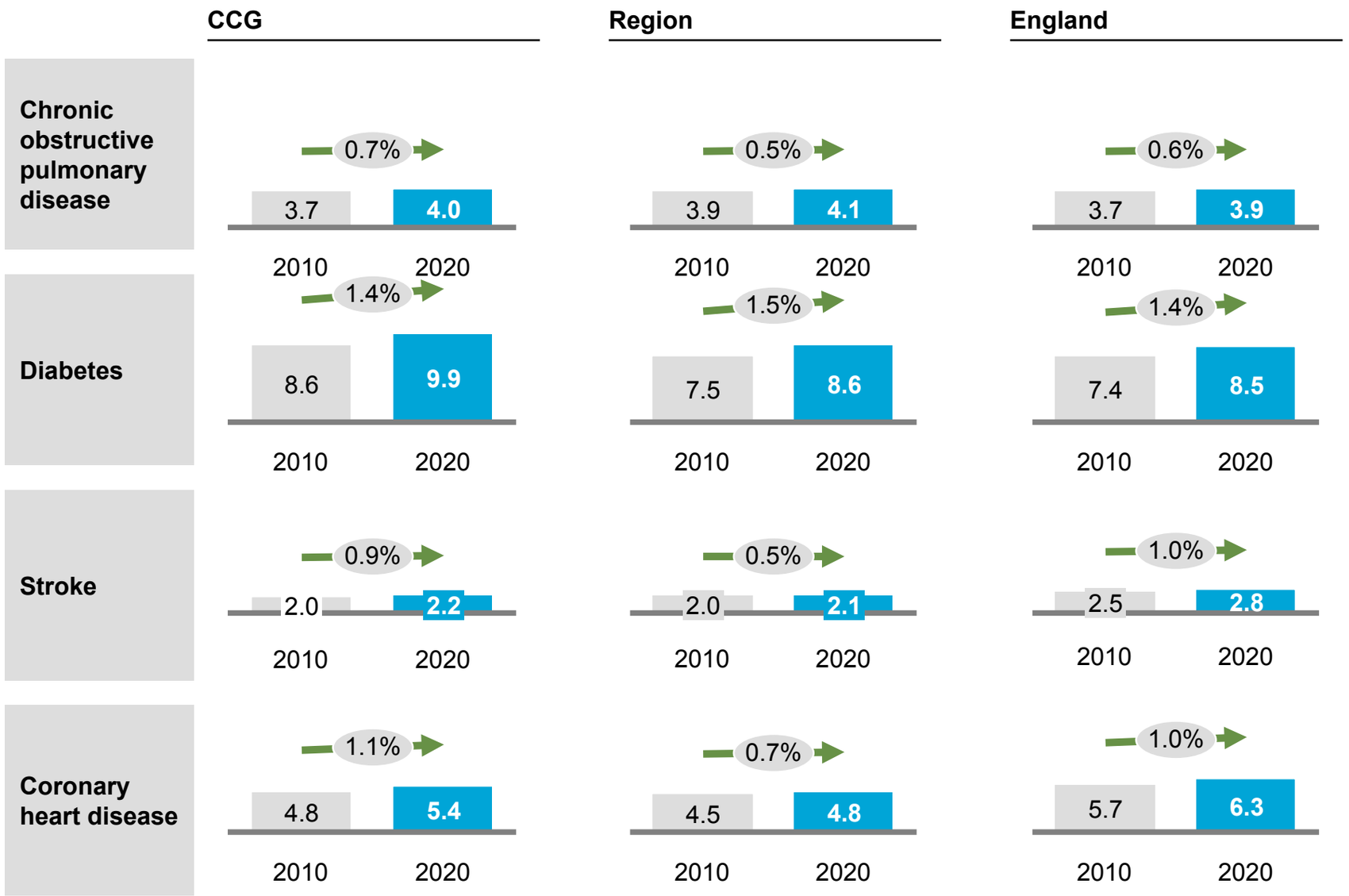
EXAMPLE

Disease prevalence changes: projected changes in prevalence rates for key conditions treated by the trust

Prevalence in 2010 and projected growth rates for selected diseases



Source: Anonymised NHS provider example

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Commissioners' plans

Commissioners remit is to 'secure the needs of patients who use services and improve the quality and efficiency of those service'. Your FT will need to understand how your commissioners' priorities and strategic plans will affect demand.

Commissioners must take account of how services affect health. They should examine clinical evidence for services and cost/benefit ratios. They need to address changing health needs. You should aim to work closely with them to develop a shared view of ideal care pathways for your patients.

You need to know about:

- Key national priorities – eg the NHS mandate, NHS England's characteristics of high-quality sustainable health systems.
- Key local priorities – eg addressing health inequalities, improving care for people with long-term conditions and/or frail elderly people outside hospital, ensuring greater adherence to evidence-based care pathways
- What best practice care could look like – commissioners must seek the best possible services for their population.
- Priorities built around current quality of care – eg a clinical commissioning group could invest in services according to their clinical outcomes by using the Spend and Outcome Tool (SPOT).
- Commissioners' financial situation and constraints – their overall position and their relative spend on different types of healthcare.

The following pages give examples of the kind of information that may be useful to trusts in planning for the impact of commissioners' plans.

EXAMPLE

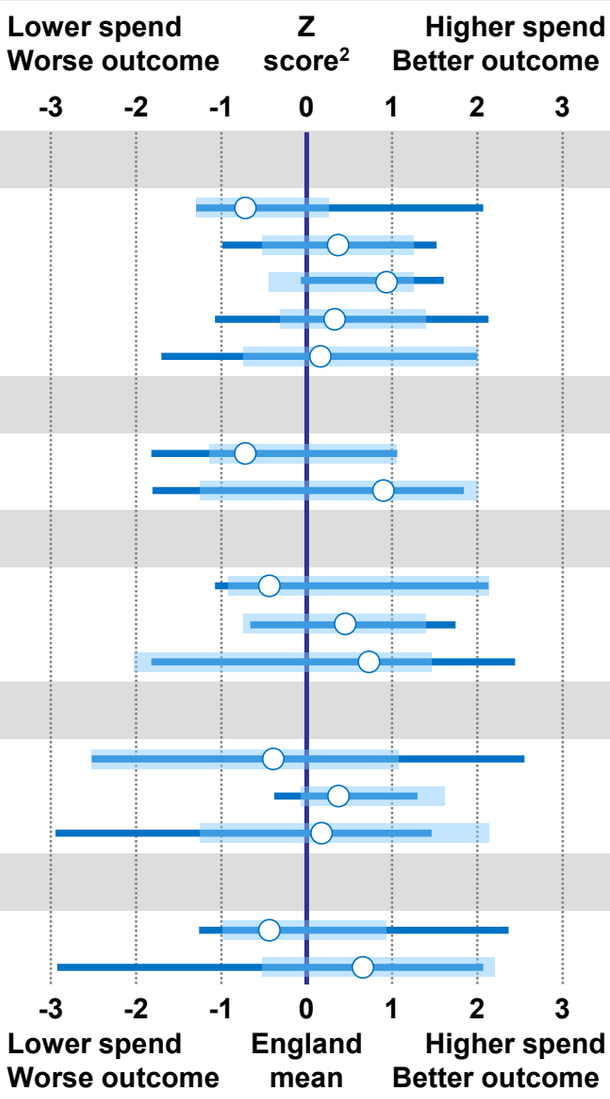
Understanding commissioner priorities: NHS mandate

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm
6. Freeing the NHS to innovate
7. Recognising the broader role of the NHS in society
8. Ensuring good financial management and improvement in value for money across the NHS
9. Assessing progress and providing stability

Source: NHS England

EXAMPLE

Understanding commissioner priorities: analysis of a CCG's quality of care and health outcomes,[1] which the commissioner may use to set priorities for investment or reductions in expenditure (1/2)



	2011/12 values				
	CCG 10/11	CCG 11/12	ONS cluster	SHA	England
Overall					
Overall spend per weighted head of population	£1674	£1687	£1687	£1705	£1755
All-age, all-cause mortality	541	522	498	500	537
Deprivation – index of multiple deprivation 2010	14	14	14	16	22
Slope index of inequality in life expectancy (males)	7.8	7.8	7.8	7.4	8.8
Slope index of inequality in life expectancy (females)	5.5	5.5	5.4	4.9	5.9
Mental health					
Mental health spend per weighted head of population	£152	£178	£185	£194	£212
Mortality from suicide and undetermined injury, DSR[1,2]	6.2	6.3	7.7	7.4	8.8
Circulation					
Circulation spend per weighted head of population	£127	£124	£137	£136	£131
Mortality from circulatory diseases, DSR[1], under 75 years	63	59	53	55	63
Patients with CHD whose last blood pressure <150/90	91%	91%	90%	90%	90%
Cancers and tumours					
Cancer spend per weighted head of population	£106	£98	£108	£92	£105
Mortality from all cancers, DSR[1], under 75 years	106	105	100	100	109
% cancer patients receiving treatment within 2 months	87%	87%	86%	86%	86%
Musculoskeletal system					
Musculoskeletal spend per weighted head of population	£73	£91	£103	£98	£98
PROMs[1] EQ-5D hips health gain	0.43	0.43	0.41	0.42	0.41

1 DSR: direct standardised rate (mortality); CHD: coronary heart disease; PROMS: patient reported outcome measures

Source: Anonymised NHS provider example from Spend and Outcomes Tool analysis

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EXAMPLE

Understanding commissioner priorities: analysis of a CCG's quality of care and health outcomes,[1] which the commissioner may use to set priorities for investment or reductions in expenditure (2/2)

	Lower spend Worse outcome ← Z score[2] → Higher spend Better outcome	2011/12 values CCG 10/11	CCG 11/12	ONS cluster	SHA	England
	-3 -2 -1 0 1 2 3					
Gastrointestinal disease						
Gastrointestinal spend per weighted head of population		£88	£83	£87	£87	£87
Mortality from gastrointestinal disease		17	16	15	14	19
Genitourinary system						
Genitourinary spend per weighted head of population		£77	£90	£83	£89	£88
Genitourinary deaths within 30 days of admissions, DSR[1]		2748	2536	2747	2830	2722
% CRF[1] with hypertension on ACE[1]/ARB[1] therapy		90%	91%	89%	89%	90%
Respiratory disease						
Respiratory spend per weighted head of population		£84	£73	£81	£ 83	£84
Mortality from bronchitis, emphysema & COPD[1], DSR[1], u75		12	11	8	8	11
Neurological disease						
Neurological spend per weighted head of population		£ 67	£63	£81	£80	£81
Mortality from epilepsy, DSR[1], under 75 years ↑		1.2	1.2	1.4	1.4	1.5
Maternity						
Maternity spend per weighted head of population		£ 73	£68	£57	£64	£68
% low birth weights		6.7%	6.7%	6.4 %	6.9 %	7.3 %
Other						
Primary care GMS[1]/PMS[1] spend per weighted head of population		£190	£160	£150	£154	£149
Miscellaneous spend per weighted head of population		£ 104	£205	£155	£156	£160
	-3 -2 -1 0 1 2 3					
	Lower spend Worse outcome ← England mean → Higher spend Better outcome					

1 DSR: direct standardised rate (mortality); CHD: coronary heart disease; PROMS: patient reported outcome measures; CRF: chronic renal failure; COPD: chronic obstructive pulmonary disease; ACE: angiotensin-converting enzyme; ARB: angiotensin receptor blockers; GMS: general medical services; PMS: personal medical services

Source: Anonymised NHS provider example

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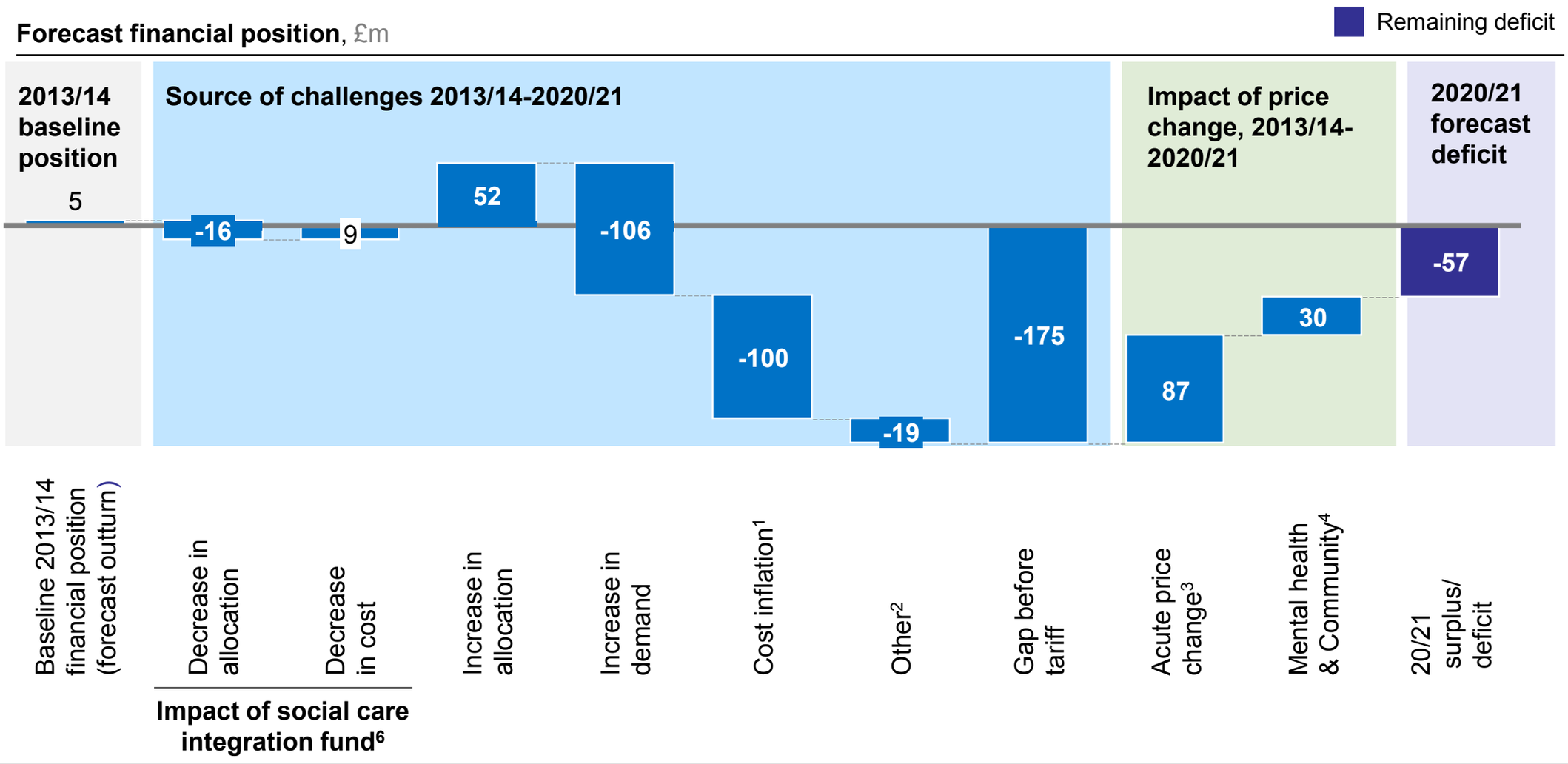
EXAMPLE

Understanding commissioner priorities: a CCG's financial outlook

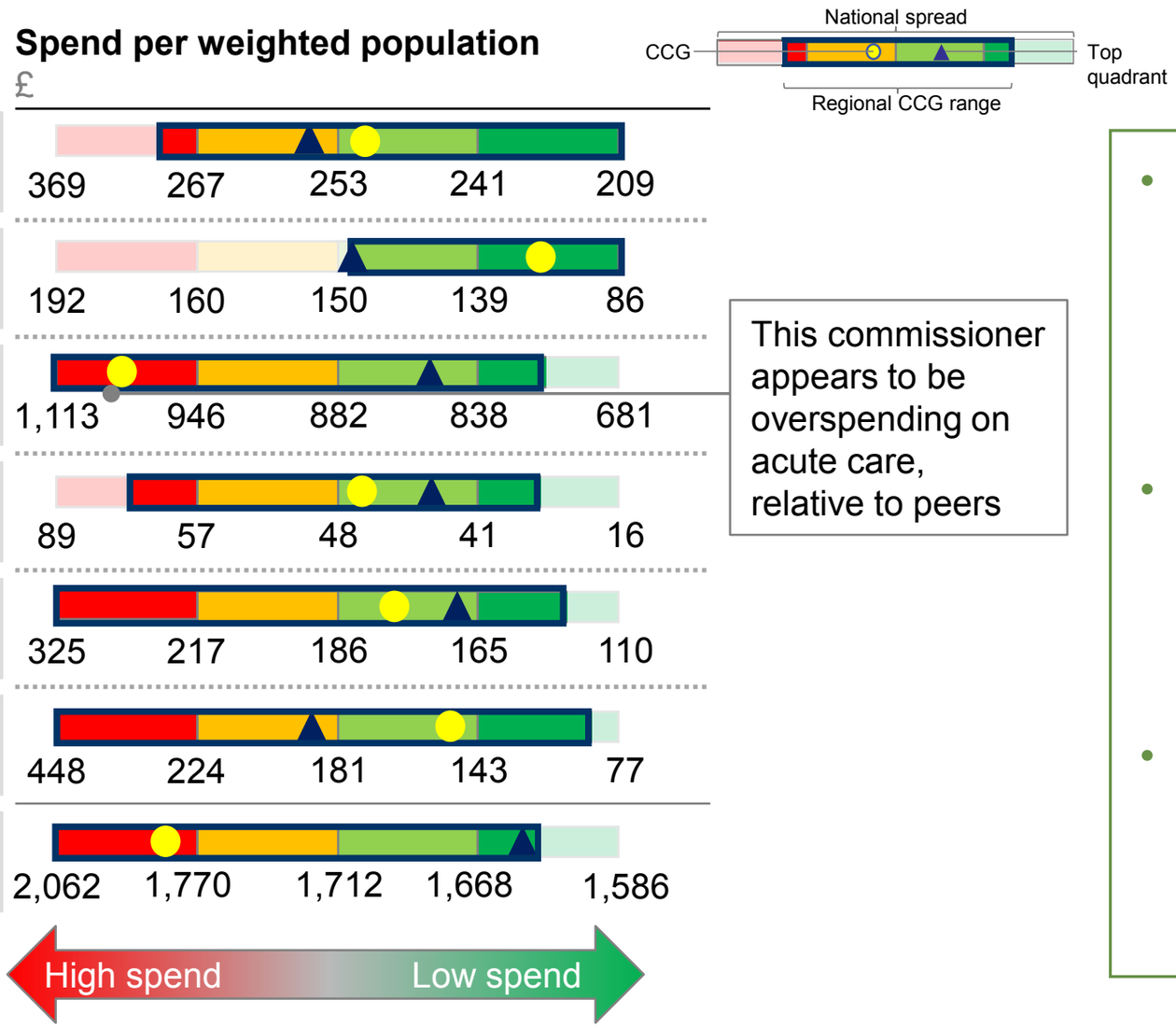


1 Cost uplift: prescribing 5%; continuing care & learning disabilities at 4%; acute, community & mental health vary by year - see detailed assumptions
2 Adjustment to underlying position, and impact of business rules including 0.5% contingency fund (new recurrent spend) each year and non-recurrent headroom
3 Impact of 4.0% efficiency on acute, applied to both payment by results (PBR) and non-PBR
4 Impact of 4.0% efficiency on mental health and community
5 Modelling assumes 2015/16 £64m reablement & carers break is 100% cost-neutral, and £304m CCG top-slice is 50% cost-neutral

Source: Anonymised NHS provider example

EXAMPLE

Understanding commissioner priorities: analysis of a commissioner's spending profile, indicating possible future savings



This commissioner appears to be overspending on acute care, relative to peers

- Are local commissioners (yellow dot) overspending or underspending on specific services, compared to well balanced peers (blue triangle)?
- Some areas may need investment, eg primary or community care where higher spend could deliver better outcomes and net savings
- Other areas may be targeted for savings, eg overspend on acute services due to poor out-of-hospital care

Source: Anonymised NHS provider example

EXAMPLE

Understanding commissioner priorities: summary of a CCG's priorities

A 

Improved access to primary care

- Seven days a week for routine care and diagnostics
- Ability to see urgent cases at short notice

B 

Proactive care of people living with long-term conditions and of frail elderly people

- Focus on preventive care and early intervention for high-risk individuals
- Delivered by a multidisciplinary team that proactively supports patients to self-care

C 

Supporting people in their homes

- People will be supported to live independently in their own homes
- When things go wrong, people will spend an appropriate time in the right care setting before returning to their own homes with health and social care support plans designed to promote recovery

D 

Consistency and quality

- Consistent standard of high-quality services across the CCG, wherever and whenever people choose to access care

Source: Anonymised NHS provider example

EXAMPLE

Understanding commissioner priorities: CCG commissioning intentions

Strategic priority initiatives

1. Accelerate the redevelopment of urgent and unscheduled care
2. Improve quality and choice within maternity care
3. Improve performance of mental health, with a focus on dementia
4. Improve quality and performance of primary care
5. Improve screening and early diagnosis of cancer
6. Integrated care and long-term conditions
7. Staying healthy – in particular obesity, teenage pregnancy and childhood immunisation
8. Reduce acute planned care costs and reduce GP referrals to hospital consultants
9. Joint commissioning for continued care and reablement

Savings forecast from strategic initiatives

Cumulative savings to 2014/15 (£000)	**QIPP levers** (Quality, Innovation, Productivity and Prevention) levers					
Strategic initiatives	**Clinical overheads**	**Demand manage-ment**	**Integrated care**	**Productivity**	**Reduc-ing drugs**	**Total**
Urgent care	0	0	5,967	0	0	**5,967**
Maternity	0	7,434	0	438	0	**7,872**
Mental health	60	5,454	876	3,450	0	**9,840**
Primary care	0	0	811	0	9,612	**10,423**
Cancer	0	0	0	0	0	**0**
Integrated care	233	7,661	10,665	8,676	7,346	**34,581**
Staying healthy	0	0	2,412	600	0	**3,012**
Planned care	1,819	3,177	10,703	13,204	-857	**28,046**
Joint commissioning	0	0	0	3,801	337	**4,138**
Other	3,654	501	2,319	0	2,102	**8,576**
Total	**5,766**	**24,227**	**33,753**	**30,169**	**18,540**	**112,455**

~ 70% of QIPP levers affect secondary care

In addition, the long-term financial model predicts a 1.2% reduction in tariff

Source: Anonymised NHS provider example

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EXAMPLE

Understanding commissioner priorities: analysis of a commissioner's performance against a national framework, highlighting gaps the commissioner will plan to address

Primary care trust self-assessment against the national service framework reveals gaps in:

- **Focusing on the community's mental health** and not reactive services for mental ill-health
- **Seamless service and breakdown of traditional barriers** between primary/secondary care and between statutory and third-sector providers
- **Reduction in stigma** and ensuring social inclusion is embedded in commissioning
- **Befriending schemes**
- **Crisis house/residential alternatives** to hospital admission
- **Culturally sensitive support** for people from African and Caribbean communities
- **Supported living** as alternative to residential care placements
- **Black and minority ethnic communities' access to psychological therapies**
- **Age discrimination** in terms of older people's access to services
- More **culturally appropriate services in the community** and inpatient services for black and minority ethnic communities

Source: Anonymised NHS commissioner example

Forecasting your FT's income

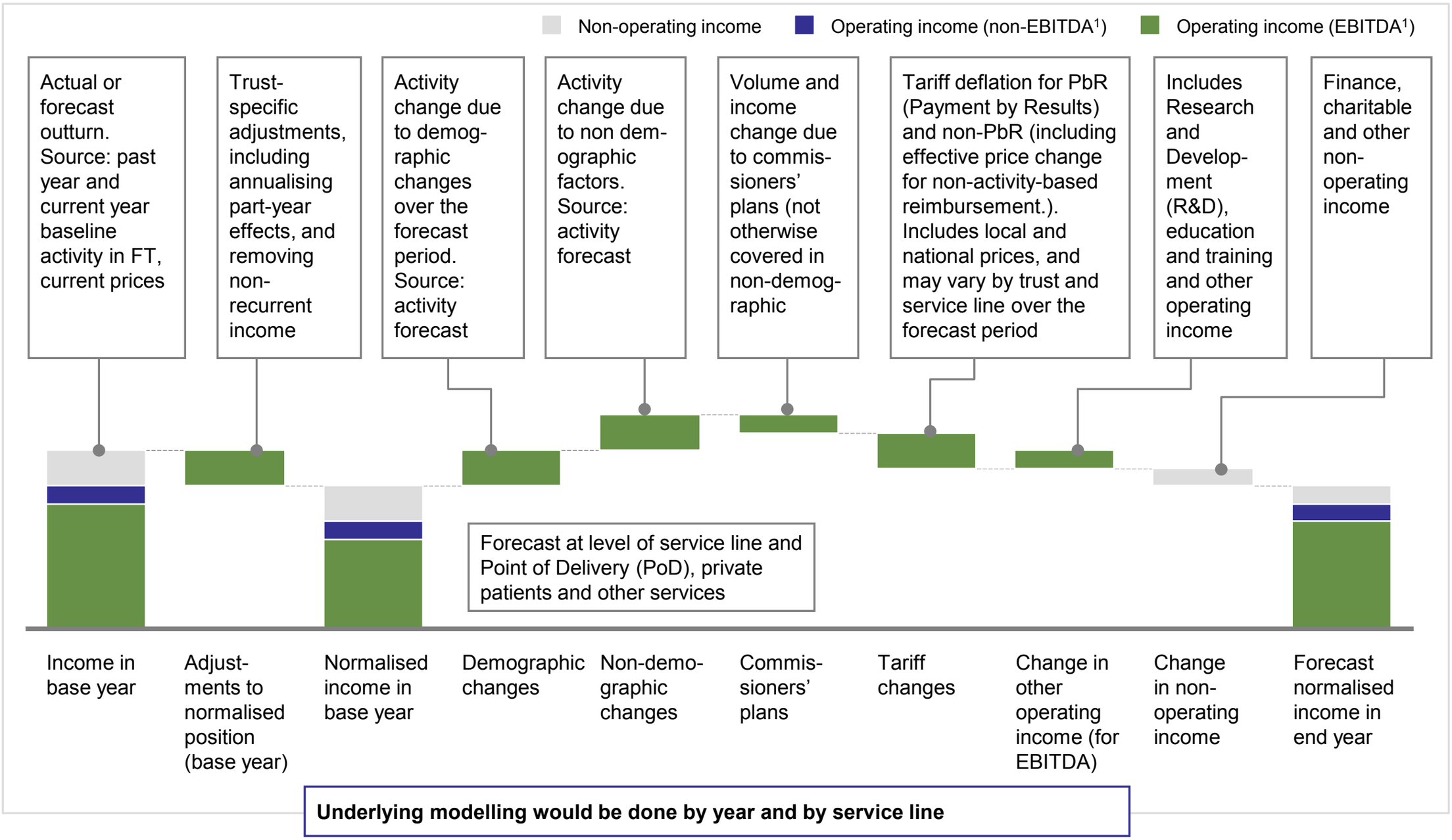
Steps for producing your income forecast are set out on the next page.

Important factors to consider when forecasting income:

- Use the same level of detail as you did when projecting activity so that you can combine the analyses easily: apply pricing at service-line level and at HRG level, where appropriate.
- Divide the categories (eg disease specialty) by type of contract: that is, whether payment by results, local tariff or agreed alternative models, and by commissioner, to allow you to apply differential prices.
- Use national assumptions for NHS tariff work and make assumptions on non-tariff work based on history if necessary, preferably using contract agreements with commissioners.
- Include known changes to research, education, charitable and any alternative funding, based on agreed or implemented changes.

You will need to replicate this approach at service-line and whole-trust level, since overall forecasts of financial sustainability need to be made for individual services. Understanding the effects at service-line level will be important when you consider strategic initiatives for service lines at the later stages of the strategy development process.

Income forecast – a step-by-step approach



1 EBITDA, Earnings before interest, depreciation and amortisation, as defined in Monitor Long-Term Financial Model (LTFM)

Forecasting your FT's costs

Four main factors affect future costs:

1. **Marginal and step-change costs of forecast additional activity** (or the reduction in costs, when activity is forecast to fall). You will need to judge what the marginal cost of providing a service will be. Usually trusts think separately about how variable, semi-variable and fixed costs alter with changes in activity. Discussion with service leaders and data on past costs from service-line reporting can help you decide what assumptions to make. You will need to discuss expected changes in acuity within a specialty to understand the marginal cost. For large changes in activity, you should agree separate assumptions that take into account step-changes in cost, including usually 'fixed' costs.
2. **Impact of cost inflation.** Monitor issues guidance on average expected cost inflation for medical supplies and salaries. You will need to apply local variations from historical analysis or contract changes.
3. **Impact of implemented cost improvement programmes.** For this base case forecast you should include the full-year impact of schemes already implemented and those about to start.
4. **Impact of expected changes in care quality, including new care models and technology.** Many changes to the way care is delivered will affect your future costs beyond those already mentioned. You may set yourself a more ambitious quality goal, based on new national quality indicators or findings from a national quality audit. You may increase costs to achieve an operational standard such as referral-to-treatment waiting times or accident and emergency access targets. Your commissioners may ask for changes to pathways to match best practice.

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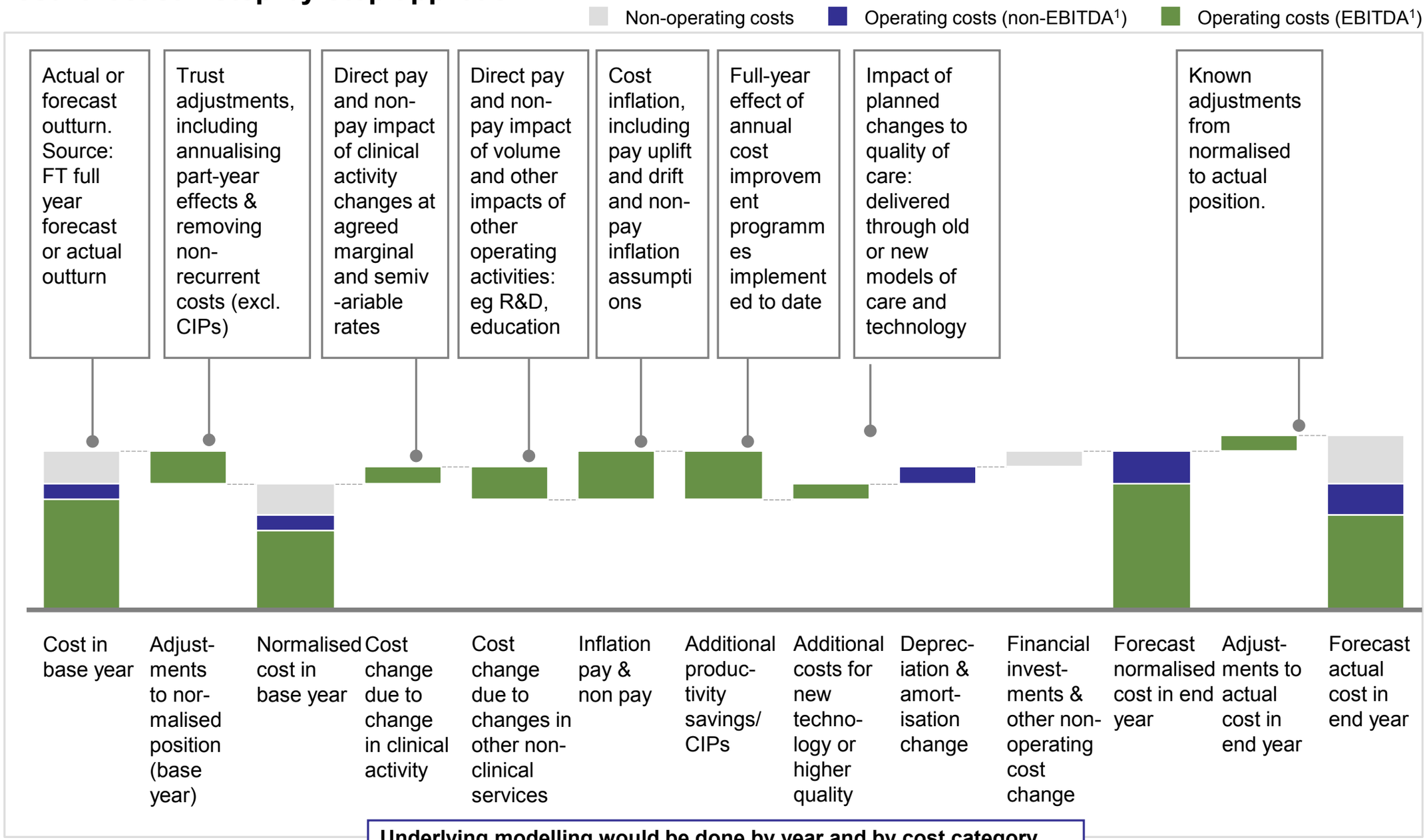
Your clinicians may plan to use a new technology to treat particular patients. The increase in operating costs to achieve seven-day working is one example you would put into this part of the forecast, though you will also want to consider (as part of the **Generate Options** stage) how you can mitigate many of these costs. For example, you could move all services to seven-day working, which would reduce fixed costs through better use of the estate and equipment (and so reducing fixed costs). You could adopt different workforce models or reconfigure services to focus more complex activity onto fewer sites across the local health economy.

You develop the forecast by cost category at the level of detail that you decide (eg separately for medical pay, scientific and technical staff pay, drugs, etc; or at the level of pay costs and non-pay costs) then combine it to create a trust view.

Steps for producing your cost forecast are set out on the next page.

Cost forecast – step-by-step approach



Underlying modelling would be done by year and by cost category

1 As defined in Monitor LTFM

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EXAMPLE

How one trust forecast marginal cost changes associated with activity changes

Cost changes with activity (or income) for base case

Cost categories	Cost change associated to 100% change in activity %
Consultant expenses	
▪ If activity increases	70%
▪ If activity decreases	30%
Other employee expenses	
▪ If activity increases	70%
▪ If activity decreases	60%
Clinical supplies	
▪ If activity increases	100%
▪ If activity decreases	100%
Non-clinical supplies	
▪ If activity increases	70%
▪ If activity decreases	60%
Premises and fixed plant	
▪ If activity increases	0%
▪ If activity decreases	10%
Other expenses	
▪ If activity increases	0%
▪ If activity decreases	0%

Source: Anonymised NHS provider example

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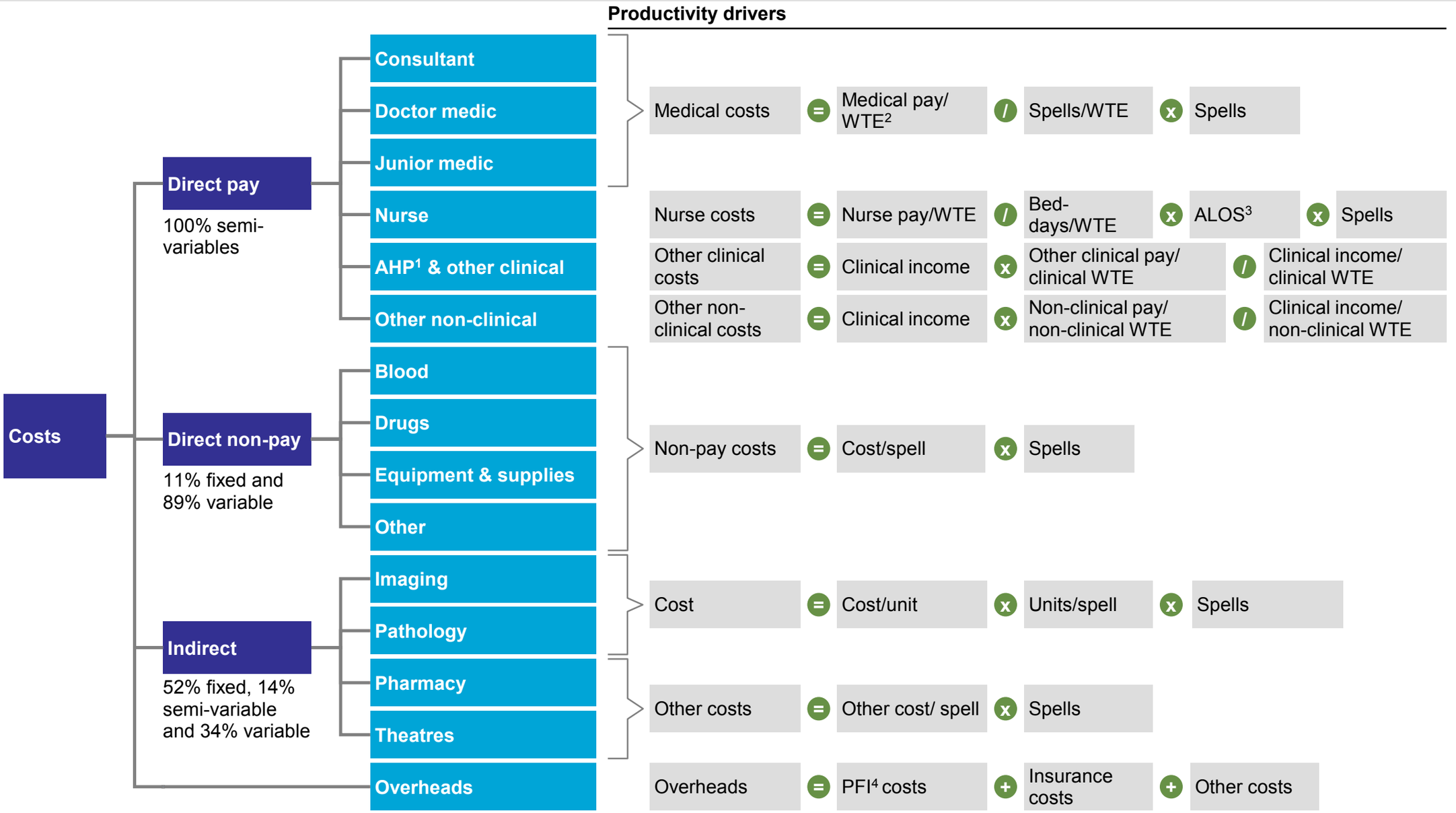
EXAMPLE

Cost productivity drivers per service line, which could form part of cost improvement programmes



1 Allied health professionals
2 Whole-time equivalents
3 Average length of stay
4 Private finance initiative

Source: Anonymised NHS provider example

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Forecasting your FT's financial performance

The final **Forecast** stage combines your activity, income and cost forecasts into a consolidated view of the trust's financial performance. The important outputs from your base case model for use in developing your strategy will be:

- Full forecast annual surplus and deficit for the trust for five years ahead; this will identify gaps to be closed through productivity, which you will plan for in the **Generate Options** and **Prioritise** stages
- Income and cost bridge diagram by year, to help you understand the effect of various factors
- Forecast service-line income and expenditure, including variable and semi-variable costs at least, and preferably a split of fixed costs
- Activity forecast by service line for the full period, including length of stay assumptions and new-to-review attendances ratios
- Activity and income from each commissioner and other funding sources
- Capacity needs forecasts for the biggest categories (sites for community, beds, outpatient clinic rooms and theatres where relevant)

Your choices when allocating shared costs will have a large impact on the apparent viability of different service lines. Incorrect or unrealistic allocations can have a significant effect on the strategy development process. The assumptions on which you allocate costs should therefore be very clear.

The following pages illustrate the kind of inputs and outputs from FT forecasting that you should consider, both to aid the process and to clarify the implications for strategy development. The main guidance focuses on income and expenditure (I&E) forecasts. You may also need to make balance sheet and cash flow forecasts at later stages. You will need to reforecast your trust's projected position so as to understand the impact of your strategic initiatives on the baseline, after completing the Generate Options and Prioritise stages.

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EXAMPLE

Assumptions table for trust-level forecasts

Trust's assumptions are similar to those prescribed nationally

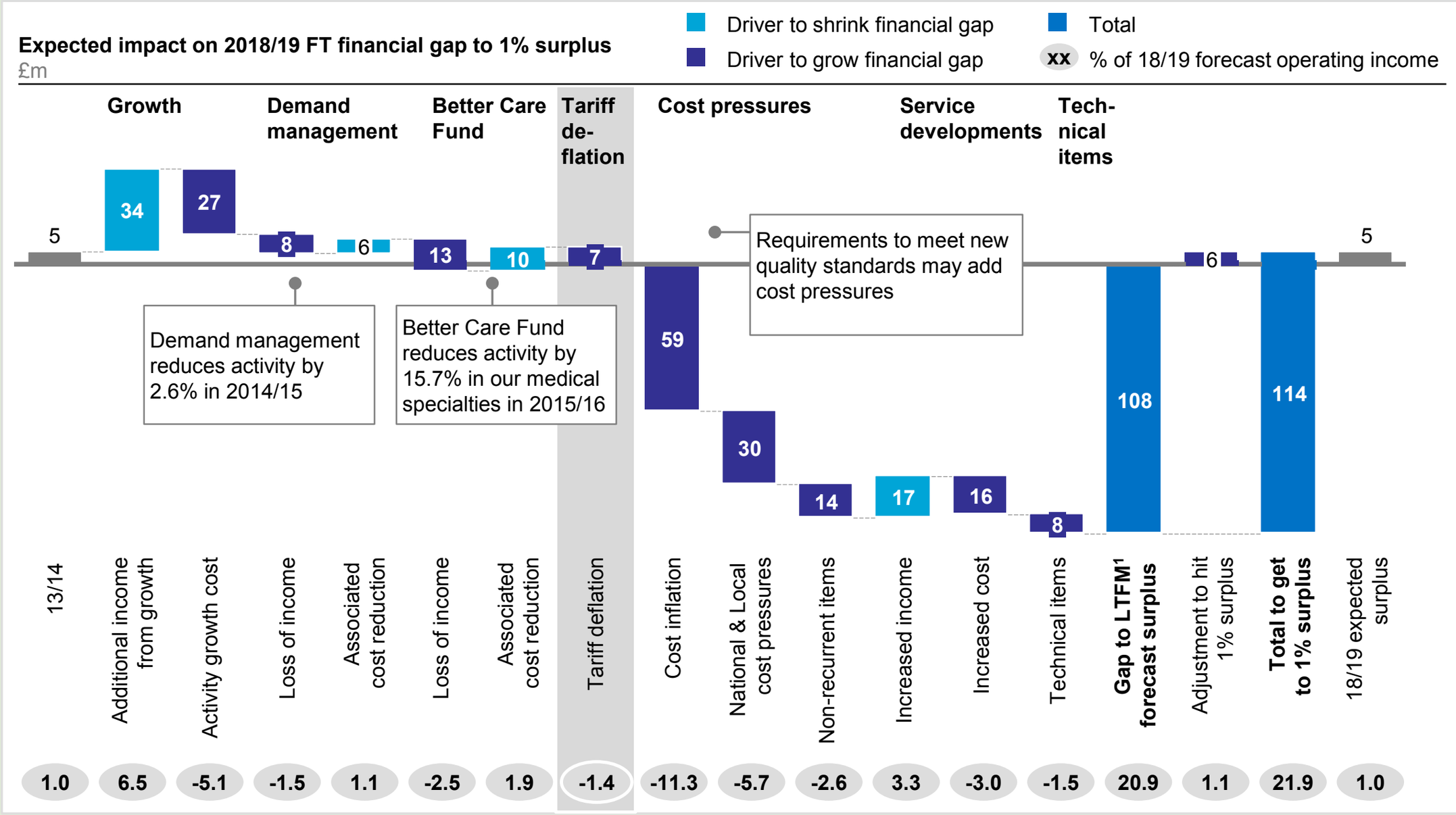
		This trust assumptions Net Impact	Other example trusts Net Impact	Regulatory/ external assumptions Net Impact	Assumption consistency	Comments
	Net change	**1.8%**	**3.4%**			
Activity	• Demographic growth	0.6%/0.7%	1.4%	0.7%	✓	• Office National Statistics UK population forecast
	• Planned growth	1.2%	2%	N/A	?	• Trust assumption based on specific 2013/14 growth initiatives requiring updating for 2014/15
Revenue	• Clinical					• -1.2% built up from required efficiency of 4%, less 2.5% cost inflation and 0.3% Clinical Negligence Scheme for Trusts (CNST) provisions
	– Tariff	-1.2%	-1.2%	-1.2%	✓	
	– Non-tariff	-1.5%	-1.5%	-1.5%	✓	
	• Non-clinical					
	– Education	0.0%	0.0%	0.0%	✓	
	– R&D	0.0%	0.0%	0.0%	✓	
	– Other	0.0%	0.0%	0.0%	✓	
Operating costs	• Scale with activity					• Prudent assumption of incurring 80% of costs
	– Increases	80%	70%	N/A	✓	
	– Decreases	60%	70%	N/A	✓	• ~40% of costs are fixed which cannot be exited
	• Inflation					
	– Pay inflation	1.0%	2.6%	1.0%	✓	• Overall pay inflation higher for example trust due to London wages
	– Pay drift	0.8%	-	0.5%	✓	• Trust calculated drift higher than guideline
	– Drugs	7.2%	5.0%	7.2%	✓	• Trust calculated drug inflation of ~7%
	– Clinical supplies	2.5%	2.2%	2.1%	✓	• Historical assumption used of 2.5%
	– Other non-pay	5.0%	2.2%	2.1%		• 5% driven by high energy and food inflation
Non-operating and cash	• Asset related costs[1] (depreciation, private finance initiative)	3.8%	N/A	3.8%	✓	

1 Example trust has Public Dividend Capital (PDC) assumption of 3.5%

Source: Monitor National Tariff Payment System 2014-15, ONS, Example trusts/Clinical commissioning groups

EXAMPLE

Forecast activity and income changes in an acute trust



1 Monitor long-term financial model

Source: Anonymised NHS provider example

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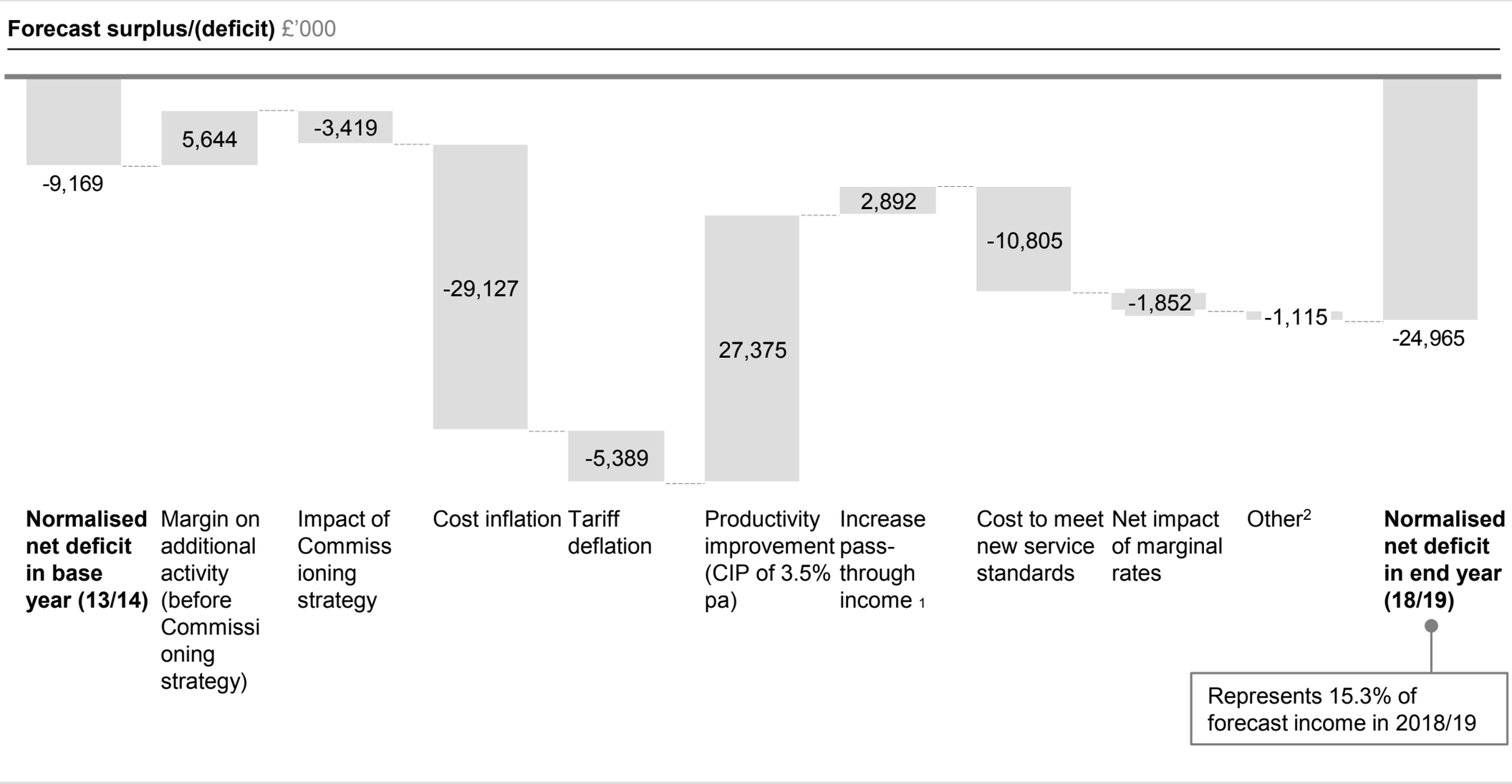
EXAMPLE

Forecast bridge at overall trust level



1 Matches increases in costs from cost inflation and marginal cost on additional activity
2 Includes changes in education and training, R&D, depreciation and other non-operating costs

Source: Anonymised NHS provider example

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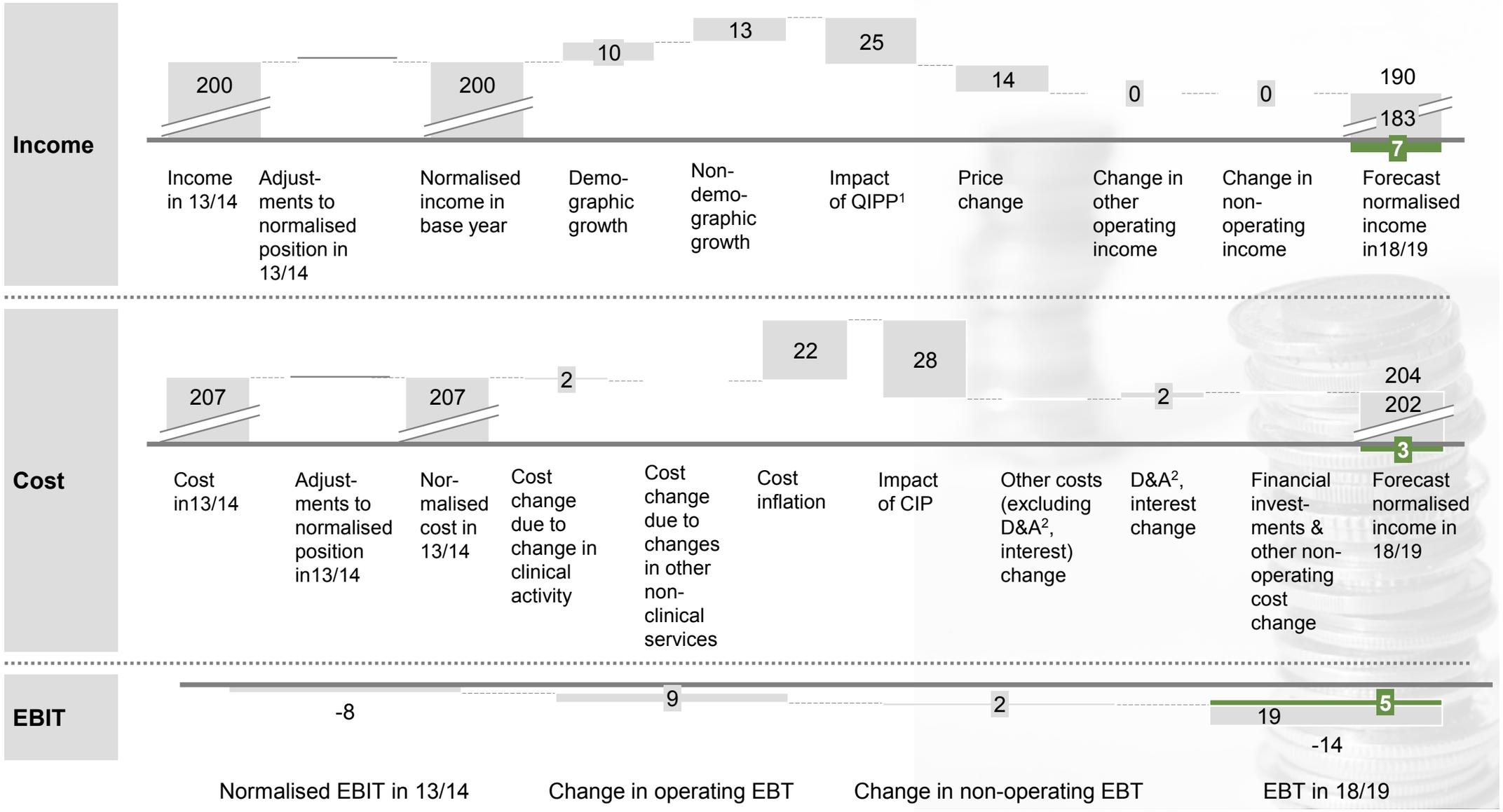
EXAMPLE

Trust summary financial forecast bridge

Constant 3% cost improvement programme (CIP) across years, 3% demand management, £m



1 Quality Innovation Productivity Prevention 2 Depreciation and Amortisation

Source: Anonymised NHS provider; EBIT (earnings before interest and taxes); EBT (earnings before taxes)

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Scenarios, sensitivities and risks

The process described so far will enable you to create a single ‘base case’ financial forecast.

Because forecasting involves uncertainty, you should consider testing your results. Three approaches will help you do this and provide insights for later stages of your strategy review:

- **Risk impact** involves identifying the major board-level risks that could affect your assumptions, then adjusting the forecast to take account of them becoming reality.
- **Sensitivity testing** involves identifying the most uncertain assumptions and seeing how the overall forecast alters when these are changed in various ways.
- **Scenario planning** involves describing significantly different ways in which the local and national healthcare economy might develop away from your base case so that some of your assumptions would no longer apply; new information will flow from forecasting your position in these new scenarios. Scenario planning is different from creating an upside/downside case, and is different again from understanding risks to your strategy.

Why do scenario planning?

Scenarios expand your thinking

- Scenario planning broadens your thinking, so you discover the sequence of events that would lead to change
- It demonstrates how – and why – things could quite quickly become much better or worse, preparing you for different possibilities
- It forces you to look into history – examples of industry failures or NHS trusts getting into difficulty will help identify high-risk scenarios

Thinking about uncertainty helps you understand what is certain

- Scenario planning will help identify predetermined outcomes - the inevitable consequence of events that have already happened or of trends already well developed
- Four kinds of predetermined outcomes are:
  - demographic change
  - unsustainable trends
  - economic action and reaction
  - scheduled events

Scenarios protect against 'groupthink'

- Scenario planning provides a political 'safe haven' for contrarian thinking
- It creates opportunities to challenge the status quo in a less threatening way

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Steps of scenario planning

Identify sources of uncertainty

- Some circumstances are more important to the organisation's future than others
- Uncertainties only matter if they affect your decision-making

Create useful scenarios

- Identify plausible effects of the most important influences on your performance
- Project scenarios for two or three variables
- Ignoring extreme scenarios exposes you to unforeseen dramatic changes

Assess resilience of chosen strategy

- Explore how scenarios would affect your FT's net income
- Gauge how far you can continue to pursue your strategy before assessing early-warning signs that suggest you should adjust it

Determine triggers for changing strategic direction

- Identify the early-warning signs that suggest particular future developments
- Develop indicators that track shifts over time, to help your FT adapt as the future unfolds
- Create a plan for switching strategic direction

Advice on building scenarios

Uncertainties only matter if they affect your decision-making

Consider three types of uncertainty:

- Factors affecting your ability to deliver care affordably
- Key assumptions underpinning your operating model
- Your strategy's rationale

Uncertainty can be compressed to a residual 'core'

Retrospective and prospective analysis can reveal each uncertainty's potential outcomes, leaving a residual 'core' of uncertainty

Typically, an organisation faces two or three critical uncertainties

A simple impact-versus-uncertainty matrix can rank the residual uncertainties you face and help you identify the critical ones

Scenarios aggregate critical uncertainties to test the resilience of your strategy

Four to six scenarios plausibly combining critical uncertainties will test the robustness of your strategy to alternative futures

Scenarios are most useful when they quantify the impact on your FT

Narrative scenarios are easy to communicate, but balancing rich descriptions with quantification will make your scenarios an effective decision-making tool

Identifying sources of uncertainty

Sources of uncertainty

- Uncertainty arises from many sources: macroeconomics, regulation, competitors, technology, customer-related issues, activity changes and internal capability
- To understand which uncertainties are relevant:
  - identify what determines your trust's performance
  - list the specific uncertainties that would have an impact on these

What determines your trust's performance

- High quality delivered efficiently
  - Cost of quality per unit of care
    - Staff costs
    - Non-staff (eg supplies)
    - Capital costs
  - Activity – demand for care
    - Demographics
    - Commissioner plans
    - Health economy share
    - Other
  - Prices you are paid
    - Payment type
    - Level of payment

Sample uncertainties

- Wage inflation, staff shortages
- Technology change
- Financial environment
- Local rapid population growth
- Ability to manage demand
- Degree of centrally driven reconfiguration
- Degree of capitation
- Redesign of national and local tariffs

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Creating useful scenarios

- Concentrate on ‘critical’ uncertainties when developing scenarios: those that are the least knowable and will most affect your outcomes
- Work out which uncertainties are likely to materialise together

Uncertainty — Have I done everything to ‘know the unknowable’?

High	**Outliers** Check strategy for resilience	**Critical uncertainties** Build scenarios to represent possible combinations
Low	**Noise** Not highly relevant for strategy	**Known factors** Address as an imperative
	Low	**High**

Impact — How do these variables affect my performance?

Assessing the resilience of your strategy

Strategy creation and testing

- The objective of creating scenarios is to build a *resilient* strategy, rather than a strategy for every eventuality
- It can be helpful to summarise critical uncertainties on two axes, to show combinations of possible outcomes
- Which two dimensions might be relevant for your FT?

Scenario 2:

Scenario 1:

Eg Changes to demand and activity

Eg Changes to patient behaviours and expectations

Scenario 4:

Scenario 3:

EXAMPLE

Modelling forecast financial gap based on two activity growth scenarios: assumptions

		Scenarios	
Driver	**Details/sources**	**'High growth'**	**'Low growth'**
1 Demographic growth of local population	• 2.3% compound annual growth rate (CAGR) based on trust area	2.3% CAGR	
	• 1.3% CAGR. Average of Office for National Statistics and local forecasts		1.3% CAGR
2 Change in demand-mix due to demographic changes	• Proportion of >65-year-olds decreasing from 13% to 10% in local area	Stays as is	Stays as is
3 Capture of activity by trust	• Assume stays the same – repatriation and other providers' moves captured in separate section	Stays as is	Stays as is
4 Change in demand-mix due to commissioner/provider demand management actions	• Quality, Innovation, Productivity and Prevention demand management	-2%	-4%
	• Better Care Fund implementation in 2015/16 (ringfence 3% of CCG's funds for social care – impact on medical non-elective specialties)	-1% one-off	-2% one-off

Source: Anonymised NHS provider example

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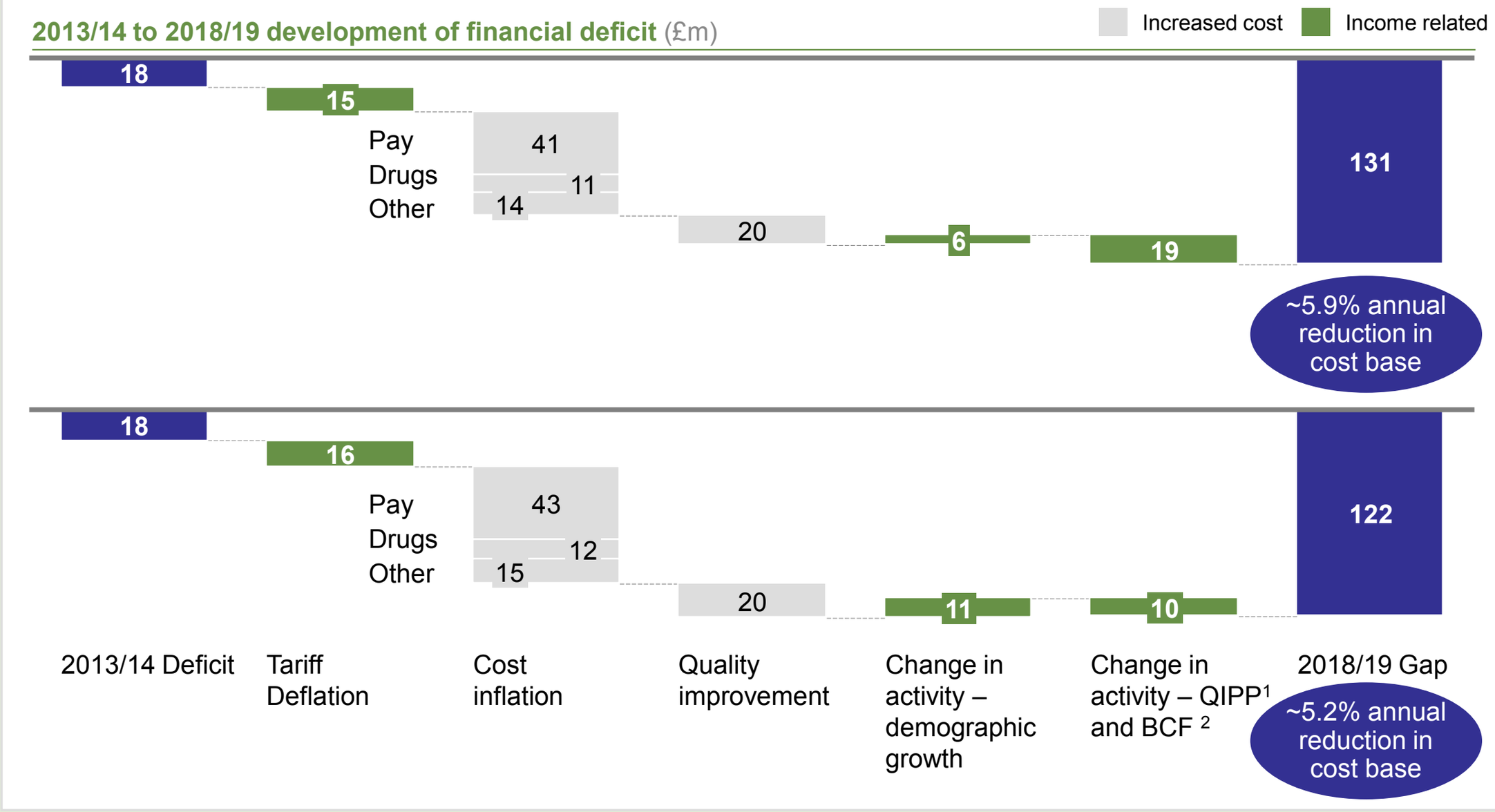
EXAMPLE

A trust with a £131m gap in the low-growth scenario and £122m gap in high-growth scenario



1 Quality, Innovation, Productivity and Prevention
2 Better Care Fund

Source: Anonymised NHS provider example

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Supporting resources

Stage	Monitor resources
Forecast	• Service line management resources • Guidance on locally determined prices • National tariff payment system 2014-5 • Annual plan guidance (issued each year)

Monitor
Making the health sector work for patients

Generate Options

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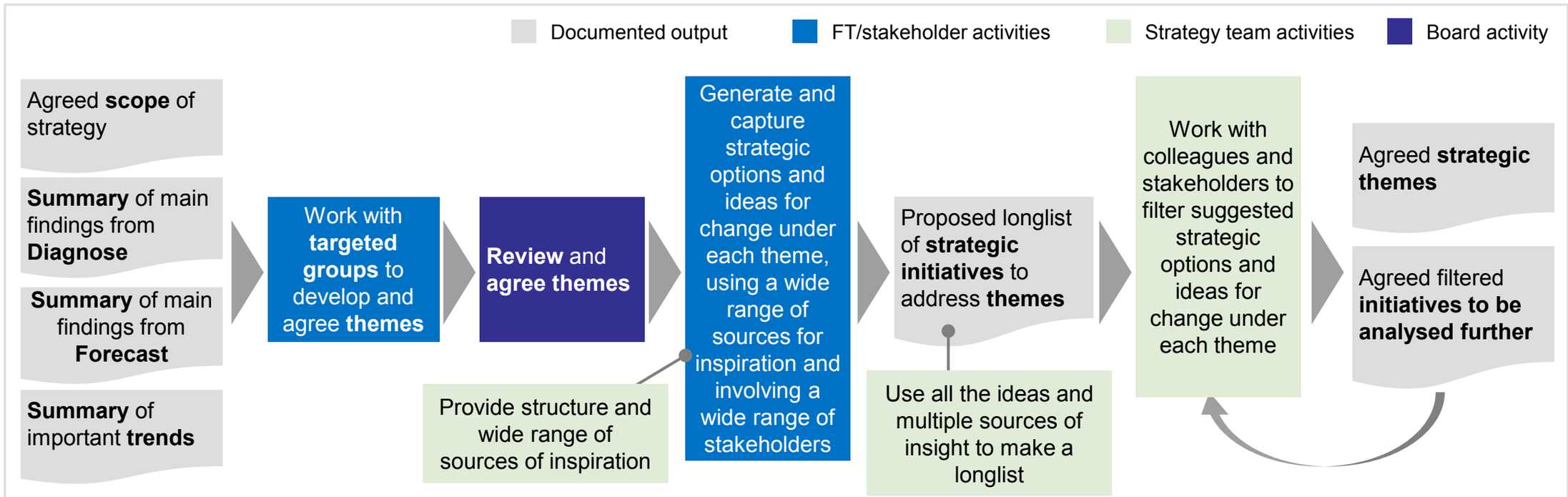
Introduction

At this Generate Options stage you will choose or confirm your strategic themes, then develop and evaluate ideas for change that will address them. Finally, you will create a filtered list that you will then need to further analyse and prioritise.

You will need to draw on the information gathered in the Diagnose stage, where you established your challenges and opportunities and the context of your local health economy, and the Forecast stage, where you looked to the future. Reviewing the strategic questions from the Frame stage – where you established the scope of the review – will make sure that the ideas that you generate fit within the agreed priorities and context of your strategy.

Ideas for improving the performance of your FT should be drawn from and inspired by a wide range of sources; failing to do so will result in a weaker strategy. Current good practice in the NHS can offer excellent ideas for change and adopting good practice from peers is a valid strategy if it helps you to meet your strategic goals. Given the challenges faced by the sector overall, it will be important to look beyond the NHS and be inspired by international and even non-healthcare examples.

Iteration may be necessary in this stage, as shown in the diagram below. In the next stage, Prioritise, you will choose which initiatives to pursue over the next few years.



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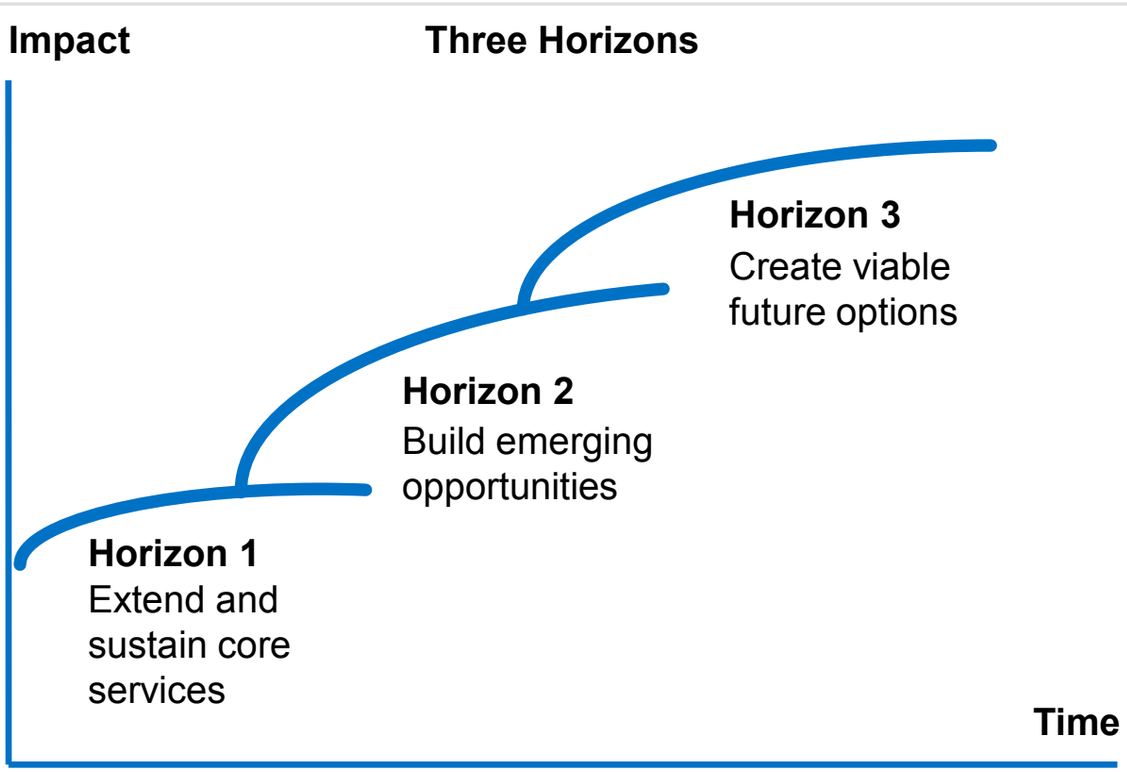
Choosing or confirming your strategic themes

By this point, you will have identified your FT's challenges and opportunities. This information will form the basis of your strategic themes, which you will choose at this stage.

As you develop the themes, you might decide to use the 'Three Horizons' framework . This tool will help you think about various timeframes for change and test that your strategy has the right balance between long-term aspirations and short-term performance. It defines three time horizons: less than two years, 2-5 years, and five or more years. So, it is likely that an investment to create a joint venture with academic and pharmaceutical partners would fit in the third horizon, moving into different services or geographies would fit into the second, while improving today's clinical performance would fit into the first.

Organisations facing immediate operational or financial challenges may be tempted to focus their strategies on critical, near-term fixes that use all available capacity and capability. However, it is unlikely that real sustainability can be achieved without looking further ahead and planning for longer term changes, making Horizons 2 and 3 equally important to consider for organisations under immediate pressure.

The Three Horizons framework was developed to generate ideas for growth. However, you may decide that it is strategically correct to exit or reduce the provision of some services. This would typically done within the timescales associated with Horizon 1 of less than two years.



Source: Baghai, M., Coley, S. and White, D. (2000) The Alchemy of Growth: Practical Insights for Building the Enduring Enterprise. Basic Books

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Strategic themes must be specific, concrete, and include measurable goals.

Most FTs are likely to consider ideas for change within some or all of the following strategic themes:

1. **Internal rebalancing of current service portfolio,** for example, reducing provision in some service lines

2. **Quality improvement in current services**

3. **Productivity improvement in current services**

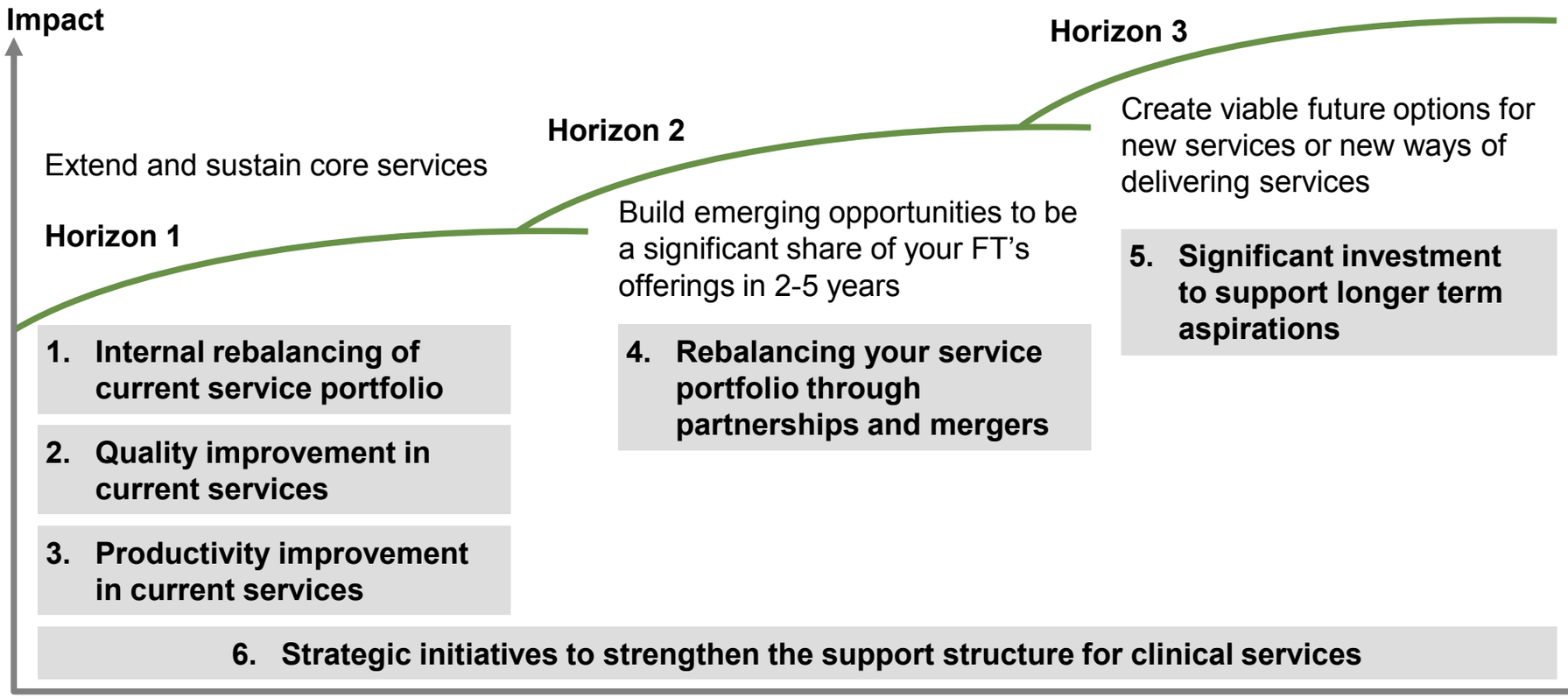
4. **Rebalancing your service portfolio through partnerships, transfers and mergers**

5. **Significant investment to support longer term aspirations**

6. **Strategic Initiatives to strengthen the support structure for clinical services,** for example workforce development, IT or estate strategy

These themes can be aligned with the different horizons, as illustrated on the following page.

The Three Horizons: adapted for the FT context



	Horizon 1	Horizon 2	Horizon 3
Success factors	• Performance focus	• An environment that explores new ideas	• Build on your unique strengths
Measures	• Quality of care, including patient experience • Income and expenditure	• Quality of care, including patient experience • Expected Net Present Value (NPV) of investments	• Quality of care, including patient experience • Expected NPV of investments • Reputational
Processes	• Quality improvement • Financial planning and control • Innovation in delivery of current services, including process improvement, workforce models, etc	• Flexible budgets • Agreed commitments to fund changes • Scanning for new service opportunities	• Hands-on senior involvement to drive long-term projects

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Strategic themes will vary significantly from one organisation to the next. However, most FTs' strategic themes will include the delivery of high quality patient care and affordability of care.

We have provided three examples to illustrate strategic themes, from three different organisations.

Salford Royal NHS Foundation Trust

Toyota

Three themes for strategy to 2020

1. Operating margin of more than 5%
2. Better customer feedback loop
3. Better geared to face another economic downturn

"Toyota will lead the way to the future of mobility"

NHS community health provider (anonymised)

From….		To…
• 20-30% patient-facing time for key clinical staff		• 40-50% patient-facing time for key clinical staff
• Data 'black box' with poor data quality from multiple sources		• Robust community health services data that everyone can believe in
• Block contract commissioning		• Care needs-based commissioning
• Unclear service specifications		• Transparent, detailed service specifications
• Staff uncertainty and cultural misalignment		• Clearly communicated values and vision

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Identifying options for change

The process you follow to generate ideas about options for change within your chosen strategic themes should meet three criteria:

1. Involve many different groups of people

- **Patients** are an important source of ideas for change. Patient groups that you could involve at this stage include your FT's members, your mental health and wellbeing board, representative groups of those specialties which are relevant for your FT (for example, Macmillan Cancer Care). You may also want to involve patients for insights on specific service line. Evidence gathered from patients in the Diagnose stage (eg patient satisfaction scores) can be an additional source.
- **Staff** are also an important source of ideas for change. The section on **Involving the whole organisation in strategy development** (in How to Get This Done) describes various ways in which you can work together with staff groups to create a strong set of ideas for change.
- **Commissioner** support for your ideas for change is critical. In addition to formal reviews of published plans, there may be specific groups that you can discuss and generate options with, such as a joint GP/secondary care commissioner panel. The How to Get This Done section contains further ideas for working with external stakeholders to develop your strategy.
- **Other stakeholders** that it will be helpful to involve could include other providers in the local health economy (LHE) (across primary, community, social, mental health, secondary and tertiary care) and local authority working groups.

2. Draw on a wide range of sources for inspiration

You could use case studies of healthcare providers in the NHS and internationally, published academic research, guidance available from national policy bodies such as NHS England, reports published by think tanks and independent organisations such as the King's Fund in the UK and Institute for Healthcare Improvement (IHI) in the USA. You could also go and see what others do for yourself.

The **Appendix** to this stage includes multiple healthcare provider examples, intended as sources of inspiration. These are organised by strategic theme, and separately include a number of non-healthcare examples. The appendix also includes a list of additional resources and publications that may further inspire you.

3. Make sure the process for gathering and discussing ideas is well understood by everyone

At the start of the strategy development process you should tell staff and external stakeholders how you intend to gather ideas for change, debate them, and make strategic choices. It is important to make sure that people know how and when they can contribute, and how their input will be used.

In addition, gathering ideas for change from your staff, stakeholders and patients should not be a one-off process during your strategic-planning process; there should be a clear and well-known process for capturing ideas throughout the year. Some of these will be easy wins that do not require significant analysis; others will need to be thought about in detail, as part of the next strategic refresh, for example.

We will now look at ideas for change using the six potential strategic themes discussed earlier in this section, to help you generate your own list.

To recap, the six themes are:

1. Internal rebalancing of current service portfolio
2. Quality improvement in current services
3. Productivity improvement in current services
4. Rebalancing your service portfolio through partnerships, transfers and mergers
5. Significant investment to support longer term aspirations
6. Strategic initiatives to strengthen the support structure for clinical services

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Strategic theme 1: Internal rebalancing of current service portfolio

In an overall strategy review, your first decision will be about the services you currently provide.

You may want to reduce the provision of some services, grow others within the current model, and/or transform the way that some services are provided (for example, in order to improve quality). Once you have identified your ambitions for the various service lines, you can develop ideas for achieving them. For those services where you want to improve and/or increase provision, you could consider one of the following:

- improving quality or productivity within your FT
- working differently with other organisations
- making large, long-term investments in developing a radically different model of provision.

Strategic themes 2-5 give examples of these different approaches to strategic service development.

Using your findings from the Diagnose and Forecast stages will allow you to base your decisions about each service line in the reality of your local context. Your decisions may be influenced by facts about:

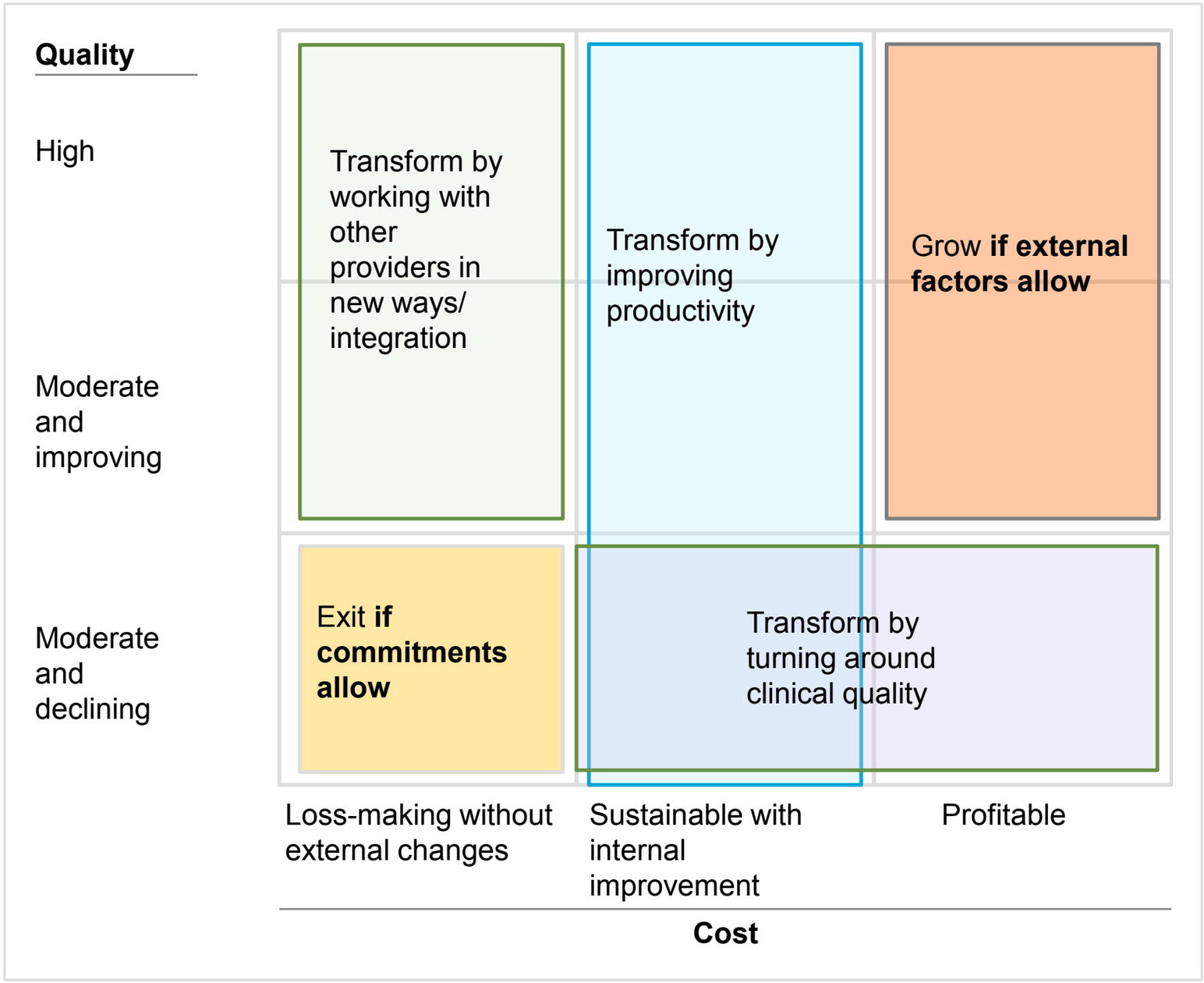
- clinical performance
- financial performance
- your market share, and the strengths and weaknesses of other providers
- expected changes in demand
- expected changes in technology
- expected changes in others who are providing this service, and how they provide it

Foundation trusts are subject to the conditions of Monitor's provider licence and, in particular, the condition about commissioner requested services (CRS). This condition prevents licensees from ceasing to provide CRS, or from changing the way in which they provide them, without the agreement of relevant commissioners. Services are designated as CRS because there is no alternative provider close enough, removing them would increase health inequalities, or removing them would make other related services unviable. All FT services are automatically designated as CRS until April 2016.

It is important to involve commissioners early in any discussions about services you may want to stop providing, and to keep up an ongoing dialogue with them about why this is your intention, and how and when you can do so.

The following page illustrates an approach that you could use to decide what strategic action is most appropriate for each service, based on its quality and cost position.

Strategic theme 1: Example approach that could be used to decide what strategic action is most appropriate for each service



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EXAMPLE

How one trust assessed its service portfolio (1/2)

County Durham and Darlington NHS
NHS Foundation Trust

A comprehensive dataset for each service for fact-based *diagnosis*

All services were analysed under a framework to determine current sustainability, and sustainability in up to two and up to five years.

The framework seeks to understand different aspects of any given service's sustainability:

- demand and capacity
- workforce
- quality and governance
- finance

A comprehensive dataset was developed for each service under each of the above pillars, which relied on the FT's systems being aligned to provide consistent data for each service. This activity was important in allowing each service to understand its baseline position.

Care groups were asked to review each service and categorise	A broad strategic approach was agreed for each category
• Category 1: Service is currently sustainable and will remain so for the next five years	• Where services are currently sustainable, sustainability will be maintained and reviewed on an ongoing basis
• Category 2: Service has issues but these have been addressed in the Integrated Business Plan and will be resolved within two years, from which time the service will be sustainable.	• Where services are not sustainable over a five-year horizon in their current form but demonstrate a fit with FT's strategic themes, and plans have been developed that seek to achieve sustainability over either a 1-2 or 3-5 year timeframe
• Category 3: Service has issues which have not been addressed in the two year plan, but are will be tackled within 3-5 years, from which point the service will be sustainable.	• Where services are not sustainable over a five-year horizon and do not demonstrate a fit with FT's strategic themes, the service will either be integrated, collaboration will take place or the service will be exited
• Category 4: Service has major issues and is not sustainable in its current form. A decision will need to be made regarding the future of the service (integrate, collaborate or exit)	• Where services have been identified by the commissioner as ones they wish to decommission

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EXAMPLE

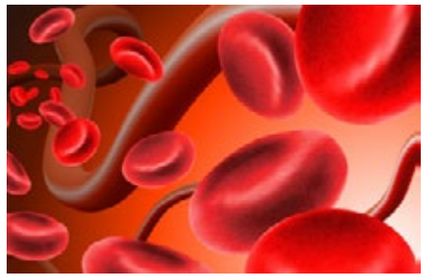
How one trust assessed its service portfolio (2/2)

County Durham and Darlington NHS
NHS Foundation Trust

The broad strategic approach for each category underpinned development of service-specific decisions and initiatives

Gastroenterology: sustainable within 3-5 years

- Clinical teams are working on a strategy for gastroenterology trust-wide, looking at one-site and two-site options and increasing and supporting access to weekend endoscopy as a key diagnostic test.
- The team supports the development of a one-site model strategy within the context of whole service development, and maintaining a NICE-compliant GI bleed rota. The plan is to reduce reliance on locum cover to increase consistency and quality of care, and reduce costs.



Clinical haematology and clinical oncology: collaborate

- A small stand-alone service that has faced recruitment difficulties over several years, and has previously been subject to an unresolved review.
- Recruitment shortages are likely to affect long-term quality and governance of the service, especially if more temporary staff are needed to deliver the service. In addition, the ability to deliver on audits and Commissioning for Quality and Innovation (CQUINs) may be further diminished without adequate staffing.
- Strategic options include buying in consultant haematology time or moving to being a host service via a 'hub-and-spoke model' of operation. Non-delivery of clinics causing a loss of activity could be an issue for the service.

Oral surgery: exit

- This small service is particularly vulnerable to external changes with limited potential to manage workforce, performance and risk.
- The trust depends on the neighbouring trust for consultant cover. Should ability to recruit deteriorate, this could prove challenging.

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Strategic theme 2: Quality improvement in current services

The strategy of any organisation is likely to include initiatives to improve the quality performance of current operations.

Quality improvement can mean a focus on meeting set performance levels, such as those set out in national guidance and recommendations or in locally determined ambitions. It can also mean seeing quality as an important differentiating factor for the organisation, with a focus on achieving 'best in class' quality, perhaps with a focus on some specific services.

In the Diagnose stage you will have built a fact base about the current quality of care within your FT. Quality can be measured across the three dimensions, as illustrated in the framework below. It will be helpful to choose a number of targets to focus on, and set an aspiration for the standard you wish your FT to achieve.

Quality

Safety	Clinical outcomes/effectiveness	Patient experience/encounter
Ensuring that providers do no harm For example: hospital-acquired infection rates	Evaluating clinical quality of care and functional outcomes For example: mortality rates, patient-recorded outcome measures and reduction in inequality	Ensuring good quality of non-clinical care For example: patient satisfaction and waiting times
Will I be OK?	**Will it do me any good?**	**What will my experience be like?**

A patient would ask:

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There are five broad types of change you can make to improve quality. Click on each heading to find out more about:

A. Scope and scale of services: Are there any changes that you need to make to ensure that the scope and scale of the services you offer enable you to provide high quality care in line with your ambitions?

B. Standardised processes: Are there any processes that you can standardise to improve your FT's quality of care?

C. Focused quality improvement: Is there a quality issue that you want to make a particular priority across the organisation?

D. Performance management: Are there changes to performance management that would give better quality measures and clearer incentives?

E. Quality culture: Are there changes that need to happen within the culture of your organisation to support quality improvement?

The pages that follow explore each type of changes in more detail. In addition, the **Appendix** contains examples of how different organisations have used them to improve quality.

Strategic theme 1

Strategic theme 2

A | Scope and scale of services

B | Standardised processes

C | Focused quality improvement

D | Performance management

E | Quality culture

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A. Scope and scale of services

If your FT is to meet its quality aspirations affordably, you will need to understand whether its activity is sufficiently high to enable the provision of a high quality service at a relatively low cost. Scale of activity is important to providing affordable quality for two reasons:

- greater scale will allow you to spread semi-variable costs (eg clinicians' time) and fixed costs (eg a scanner) over a larger volume of patients
- in many cases high activity levels correlate with clinicians' ability to develop and maintain their specialist skills.

For example, there are various ways in which you could offer urgent care, from a minor injuries unit to an acute A&E centre, as set out in the 'Urgent and Emergency Care Review'. When deciding what to offer, you will need to draw on the analysis you completed in the Diagnose stage to understand patient demand for urgent care and the ways your costs would change, according to the level of service you offer. This will help you to identify the scope of the services you can afford to offer at high quality.

In another example, you may have an ambition for your FT to develop a national reputation for high quality care in one or more services. To achieve this, one of the factors you will need to think through is how you can increase the scale and scope of your work in this service to reap benefits in efficiency, quality of care, and attracting and retaining the best clinicians.

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As you generate options for meeting your quality ambitions through changes to the scope and/or scale of services, you will consider:

- What is the demand for this service?
- What are my costs for meeting this demand at target quality?
- Is this affordable in the long term (taking into account any cross-specialty subsidy decisions you could make)?
- Is there a different version of the service that we could offer to ensure that quality targets are met?
- If we consider changes to the services:
  - are there clinical interdependencies that will affect quality elsewhere?
  - what commitments to offer services do I have that I cannot renegotiate?
  - what are the implications for our overall financial position?
- What partnerships or collaboration might provide a high quality service and share the benefits of scope and scale? How could we use technology to support such a network arrangement (eg telemedicine)?

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B. Standardised processes

Your FT may wish to standardise pathways and protocols to improve quality. Standardisation has three main quality-related benefits:

- **Reduced variability of outcomes.** Standardisation helps to improve patients' experience. It helps to reduce bottlenecks by decreasing waiting times, delays, and cancellations. It also reduces the risk of vital steps being neglected.
- **Improved patient experience.** By eliminating duplication and ad hoc co-ordination, standardisation helps to increase the time that clinicians spend with patients. It empowers junior staff to make decisions and so take on more responsibility, and this frees clinicians to make effective choices. Standardisation tends to provide patients with clearer communications about their expected care and reduces the risk of unnecessarily long hospital stays.
- **Integration of emerging best practice.** Standardisation helps to increase the application of best practices, as processes can be updated to reflect new developments.

Processes can be standardised in a number of ways. Two examples of how standardisation was achieved are included in the **Appendix**:

- A group of NHS providers who standardised their tools and indicators, and transferred knowledge between them
- A charity providing eye treatments in India who standardised procedures to enable the very swift and high quality treatment of patients

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C. Focused quality improvement

By giving attention to a significant quality issue you can raise the profile of quality across the whole organisation. You may want to consider whether there is a specific quality issue that your FT could address with a targeted campaign, such as pressure ulcers, adult safeguarding, or prescription errors. This would involve the whole organisation becoming responsible for and being regularly updated on progress towards a set target.

The quality issue that your FT chooses to focus on would arise from factors that you explored in the Diagnose stage. These could include:

- level of measured patient harm, distress, morbidity or mortality
- deviation from a national benchmark
- external scrutiny of an issue and resulting reputational damage
- patient complaints
- staff reporting of incidents
- economic cost

Once your issue has been selected, you can use various tools to generate options for specific initiatives. One of these is an 'issue tree', in which an issue is broken down into its causes so that potential initiatives to combat each can be identified. The **Appendix** includes an example about reducing pressure ulcers that uses an issue tree.

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D. Performance management

To ensure that quality targets are being met, you can track your FT's performance against quality indicators – these should reflect the aspirations that you set at the Diagnose stage. There are hundreds of published measures that you could use.

Your selection of measures should enable you to link your performance management to strategically important goals for quality. You can examine performance at various levels of the organisation: across the whole FT, at specialty level, for specific teams.

It may be valuable to consider publishing the results of your performance measurement, either internally or externally, or both. Transparency allows an organisation to reward success and also highlights areas where greater progress needs to be made.

The **Appendix** contains multiple examples of how other organisations have sought to improve quality; these are intended as sources of inspiration for you. They include:

- A hospital in America that produces a booklet with detailed information on quality by service line
- A German hospital operator that published quality indicators to improve quality

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E. Quality culture

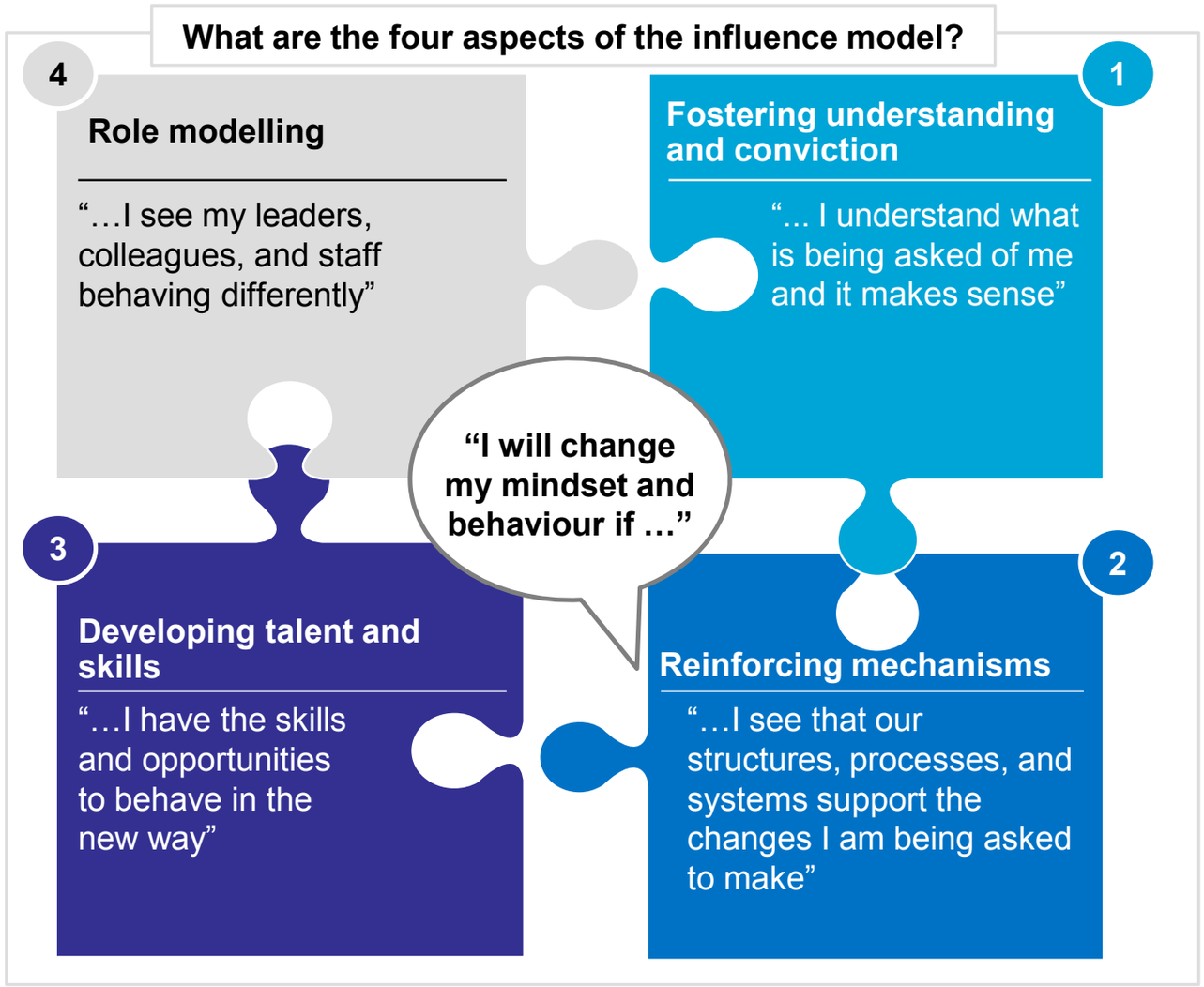
For quality improvement to be effective it must be upheld across the organisation. You may need to create initiatives that ensure that your FT's culture supports a high quality of care.

The 'Influence Model' is a useful tool for planning cultural change. It shows that four aspects are required to bring about cultural change in an organisation. It notes that:

- people must understand what they are being asked to do and believe in it
- mechanisms should reinforce the behaviour
- capabilities must be in place to embed the change
- everyone in the organisation must model the required behaviours

In the **Appendix** you will find the following examples of how the Influence Model has been used in hospitals to improve quality of care:

- A US provider that improved skills on the front line through intensive training
- Some non-financial incentives to recognise staff who have contributed to quality
- Another US provider that embedded quality into a team's work and set up of processes to quickly identify and solve quality issues



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Strategic theme 3: Productivity improvement in current services

In the context of rising costs and funding pressures, all FTs have to look at productivity improvement as a way to help you achieve your strategic goals.

Your insights from the Diagnose and Forecast stages will allow you to identify your biggest opportunity (or the biggest need) to safely improve productivity. You will find it most useful to look at a wide range of sources and involve a wide range of people in developing ideas for ways of meeting the targets you set.

Many shorter term productivity–improvement opportunities are likely to be captured in existing cost-improvement programmes. At this stage, you should look at which of the existing improvement plans can be accelerated as well as finding new opportunities.

A structured approach will ensure that you have considered all aspects of your cost base. In the Diagnose stage, you analysed how your costs break down between the clinical workforce, the non-clinical workforce, procurement and fixed costs. This analysis – and benchmarks in the different cost categories – should be the starting point for generating ideas for further productivity improvements.

Very broadly, providers have three types of cost, and so opportunities to improve productivity fall into three categories:

A. **Pay variable and semi-variable costs: improving workforce productivity**

B. **Non-pay variable and semi-variable costs: improving procurement to reduce non-pay variable costs**

C. **Fixed costs: increasing utilisation and managing estate to reduce fixed costs**

The **Strategic Workforce Planning Tool** gives further ideas for strategic changes in this area.

Improving the productivity of your core services should not be seen solely as an operational move; many organisations adopt operational excellence as their prime strategy.

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A. Improving workforce productivity

The **Appendix** contains examples of how other organisations have sought to improve productivity. They are intended as sources of inspiration and fall into the three productivity improvement categories listed above. Those most closely related to improving workforce productivity are described briefly below:

NHS examples

- An FT found multiple opportunities to improve consultants' productivity
- Best practice productivity improvement initiatives outside of the acute setting identified by one commissioner

International examples

- A Swedish initiative improving productivity through self-dialysis
- In India, Narayana standardised care pathways in order to improve quality and productivity at the same time
- In the US, Kaiser Permanente's use of mobile technology aspires to improve patients' health outcomes and relationships between patients and their doctors as well as save valuable front line clinical staff time
- Also in the US, Montefiore uses mobile technology and data to improve workforce productivity, including reducing time spent by clinicians reviewing patients who did not need to attend a clinic in person
- The Watson computer program uses language capabilities, hypothesis generation, and evidence-based learning to support medical professionals to make decisions, thereby improving productivity and reducing errors

B. Improving procurement to reduce non-pay variable costs

Not all hospitals will meet best practice in optimising procurement in all areas: demand management, supplier management, and procurement processes and capabilities. This leaves opportunity for improvement. The **Appendix** contains examples of how NHS organisations have sought to improve procurement, which are intended as sources of inspiration.

	Traditional procurement	Best practice
Three procurement optimisation levers	• Focus is on unit costs by the buyer without results on other levers eg bulk purchase pricing • Periodic, incremental purchase price reductions by the supplier, hoping to keep up with inflation	• Delivers significant and sustainable total cost of ownership (TCO) reductions (ie including length of use, cost of sourcing, maintaining etc) • Captures 10%-15% initial reduction in TCO, followed by 3%–5% ongoing annual improvements
1 Demand management	• Sourcing involved only after major decisions are made	• Strategic rather than tactical focus (eg decisions made to maximise quality and cost advantage together) • Working together across functional groups
2 Supplier management	• Process orders and minimise the cost of the purchasing function • At a disadvantage to suppliers in negotiations who have better facts about the buy	• Develops and executes sourcing strategies based on a thorough understanding of supply markets • At an advantaged to suppliers, with distinctive insights in: – total cost of ownership (TCO) – supplier economics – supply market options and opportunities
	• Infrequent bidding with some suppliers, and undemanding ‘partnerships’ with too many • Fragmented supplier base	• Builds a world-class supplier network with a few demanding partnerships for goods and services that can truly contribute to competitive advantage
3 Processes and capability	• Purchasing viewed as an administrative function • ‘Last to know’ about key decisions	• Staffed with the ‘best and brightest’ • Respected member of teams formed around core processes such as compliance management • Transparency and consistent decision-making
	• Technology tools rarely applied • Focus on reducing transaction cost and tracking compliance	• Technology enables and accelerates the journey to improve procurement by: – focusing on performance management – enabling better decision-making – integrating suppliers better

Source: Based on UK and US case studies

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C. Increasing utilisation and managing estate to reduce fixed costs

The **Appendix** also contains examples of how other organisations have sought to reduce fixed costs. These include:

An example of three levers considered by a trust faced with urgent need to reduce fixed costs and ideas under each lever.

- An example of a trust's findings on how opening hours of theatres and outpatients facilities can be increased, with dramatic impact on space required
- An example of how one trust worked with a surgical specialty to improve theatre utilisation and length of stay through improved administrative processes and standardisation of clinical protocols
- Another example of a trust that found how reducing down-time in theatres would enable it to close a theatre without impact on care

Most commonly, productivity improvement programmes address each of staff productivity, non-staff variable and semi-variable costs and fixed costs.

We have included in the appendix examples of most powerful changes across such overall productivity improvement programmes from two large university hospitals in Europe.

Strategic theme 4: Rebalancing your service portfolio through partnerships, transfers and mergers

In order to develop a better way to deliver some services, you may want to work with others in the Local Health Economy (LHE) in new ways. When you are developing strategic options that involve working with other providers, such as mergers, acquisitions, joint ventures, service transfers, networks or management agreements you could consider:

A. Changes to how you deliver existing services through horizontal integration

This could be a strategic priority for you if you have:

- **services where your provision is sub-scale** and therefore does not allow you to deliver a quality service in a financially-sustainable way
- **services where your provision is at scale** (or nearly so) **but other local providers' provisions are sub-scale** and you want to explore the possibility of working jointly

You could achieve changes in provision of services through partnerships, networks or a merger. You could achieve changes in provision of services through partnerships, networks or a merger. When developing such proposals its important they work well for patients from both good governance and competition perspectives. Monitor can offer early advice on both these aspects.

The **Appendix** contains links to supporting Monitor guidance (see materials on strategic theme 4) and an example of how an NHS provider debating the right portfolio of services considered five archetypes.

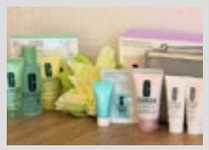
B. A move into new services through vertical integration, so that you directly offer more primary, community, secondary or tertiary services. You could do this through a partnership, network or a merger.

Strategic reasons for considering this would be to provide higher quality, better integrated care to patients in the right place and at the right time, to reduce the expensive use of acute facilities, and to avoid duplication. Some examples of benefit assessments from NHS providers are included in the **Appendix**.

Monitor can offer early advice to ensure these work well from good governance and competition perspectives.

C. Payment system innovation can allow organisations to share risk (and benefit). For example, in order to create lasting incentives and to share risks and gains sustainably, some international organisations are taking integration a step further and providing integrated services under a capitated system rather than fee-for-service. The **Appendix** includes two examples of integrated-care providers in the US: Geisinger and ChenMed.

The 'Seven Degrees of Freedom' framework is designed to help you think through the options for service development.

	Commercial example: Gillette		Ideas applied by an NHS FT
7 New competitive arenas	• Toiletries, stationery, appliances, oral care, batteries		Offer privately paid-for skin treatments via commercial joint venture with Dermatology group
6 New industry structure	• Drove consolidation of stationery industry • Acquired Wilkinson Sword Asia and South America	WILKINSON SWORD	Integrate vertically to offer home care through new payment mechanisms based on capitation
5 New geographies	• Dominant positions in most emerging markets		Set up a 'My FT @ Another Hospital' rheumatology service
4 New delivery approaches	• Use of dual sales channels, eg Oral-B and Braun • Waterman pens via Parkers' corporate gift channels		Deliver Skype enabled outpatient consultation in community settings
3 New products and services	• Migrated consumers to higher margin shavers • Leveraged Gillette brand in other products		Expand into directly delivering primary care on existing estate improving access and integration with hospital services
2 New customers	• Built female customer base with Sensor technology		Access to patients from neighboring CCGs for specific services where FT has higher quality service
1 Existing products/ services to existing customers	• Massive brand and volume building through advertising and promotion		Information campaign and primary care liaison about bowel cancer screening to achieve target access

Source: Baghai, M., Coley, S. and White, D. (2000) The Alchemy of Growth: Practical Insights for Building the Enduring Enterprise. Basic Books and adapted from the plans of anonymised NHS provider

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If you change your service portfolio, you may need to consider the level of integration between your organisation with other providers.

Low ← **Level of integration** → **High**

	Status quo	Status quo	Full merger		
	a	b	c	d	e
	Status quo	**Service line collaboration** (Service lines)	**Opt-in integration of services** (A JV of service lines that want to merge)	**Back office integration** (Separate back-office unit established)	**Full integration** (All service lines move into a new organisation)
Governance	• No change in governance	• No leadership changes • Representation on boards	• A joint venture with single CEO and its board, besides other pre-existing boards	• Single CEO and combined board oversee pre-existing ones	• One combined board • Current boards dissolved • One designated accountable officer
Management	• Idea sharing among management and/or units	• Representation at leadership meetings of partner organisations	• Combined management team is formed for each service line **or** • One organisation's team takes full responsibility	• Best management selected to lead non-clinical integration efforts	• Combined management team is formed for each service line **or** • One organisation's team takes full responsibility
Location	• No change in location	• No change	• Potential change	• Some back-office functions move	• Likely change

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Some benefits of integration can be achieved without formally merging structures through mergers or acquisitions (M&A).

Large scale M&A

1. M&A with in-region hospital
2. M&A with in-region health system
3. M&A with out-of-region health system

Traditional scale models of asset consolidation offer high economies of scale and skill, but at a high cost and with significant implementation risk

Virtual hospital integration

4. Knowledge-sharing with other providers
5. Shared services with other providers
6. Outsourced services

Horizontal organic scale

7. Expanded physician practices (PCP and specialty)
8. Expanded OP facilities

These options offer some economies of scale and/or skill, without high up-front investment or risk associated with mergers and acquisitions

Vertical organic scale

9. Pay or partnership – narrow networks
10. Pay or partnership – risk-sharing
11. Direct-to-employer strategies

These options strengthen a provider's community footprint, facilitate referral growth, and pave the way toward population health management, but offer limited economies of scale. Despite doctors' historical preference to stay independent, there is a greater trend towards physician employment

These options can potentially create high value by enhancing a provider's structural position, with potential for growth and innovation. However, they are challenging to implement because there is no established model

Note: PCP - primary care physicians; OP - outpatient

Setting up **a network of providers** is one way to rebalance your service portfolio without formal organisational change such as a merger. The diagram below describes four features often found in successful hospital networks.

Routing patients across and within sites

- Clearly defined, effective triaging at A&E
- Clear criteria for ambulance service for where to take each case at a specific time of day/night
- Senior decision-making needed upfront

Ability to accept patients

- Commissioning is critical to make emergency centre model work
- Patients that are lower-acuity cases at a major acute site should be moved to let more urgent cases be transferred from another site if required

Cover across sites

- Staff must provide on-call cover across sites (ie within the network)
- Contracts to be tied to network rather than a single hospital/site
- Rotas needed for exposure to major acute in order to make the emergency centre attractive to employees
- Reasonable travelling distance required between sites in network to facilitate safe transfers

Transfer protocols

- Clearly defined protocols
- Accepted by ambulance service and enforced
- Commissioning of services needed to ensure patients in hospital are not de-prioritised against those that are not

Strategic theme 5: Significant investment to support longer-term aspirations

Some FTs may consider significant strategic investments to support longer term aspirations. This could take many forms, some of which are described below.

- **Major estate investment.** Some FTs will need to consider reducing total estate footprint, reducing or increasing number of sites and/or carrying out a major rebuild.
- **Major joint venture/co-operation with a commercial organisation, for example as part of an academic health science centre (AHSC) strategy.** Some FTs will be able to consider a significant joint venture with an academic and/or a commercial to improve current and future patient care.
- **Expanding services to new groups of patients.** Some FTs may consider moving into another part of the country to run a network of hospitals, as private and international providers often do; others may choose to make investments to increase private patient work; yet others may want to pursue commercial opportunities to enter an overseas market. This is especially likely to be relevant to specialist providers.

Your findings from the Diagnose and Forecast stages about your priorities and challenges, along with a review of available opportunities, will guide your decision on whether making a significant investment outside of core current services is appropriate for your FT.

At this stage of generating options, you will want to capture all the opportunities that are suggested, and understand at a high level:

- the expected benefits
- when the benefits would materialise
- required capital and operating expenses
- required management and clinician capacity and capability
- key risks that would arise for your FT

We have provided examples of NHS providers' assessments of options for major strategic moves in the **Appendix**:

- comparing the benefits of a formal merger with a looser integration to develop an academic health science centre
- considering various options for changes to the way clinical services are organised across its multiple sites and the corresponding site-investment strategies

We have also provided international examples of longer term strategic moves and partnerships that healthcare providers might consider:

- A review of the options assessed by an academic health science centre on the future approach to collaboration and integration
- Types of partnerships between healthcare providers and pharmaceutical organisations

Strategic theme 6: Strategic initiatives to strengthen the support structure for clinical services

To deliver the goals behind your main strategic themes, you will need to consider those functions that support clinical services. Your existing strategy and plans for IT, estates, organisational development and HR will need to be reconsidered in light of the proposed strategic initiatives.

IT

As part of developing new strategic ideas, it is likely that you have considered how you can use information technology to change patients' clinical care pathways. However, IT support may be relevant to your strategic themes in other ways. For example, if patient experience is a theme for you, you may want to improve your IT systems to reduce the time patients spend in filling in forms or repeating information.

Estates

In the Diagnose stage, you will have analysed your estates holdings and capacity. If there is spare capacity, you may consider selling it or making use of the space. Using the space could involve launching complementary initiatives (healthcare or non-healthcare), relocating services if necessary, developing it to expand core services, or launching a new joint venture. If your growth initiatives will require additional space, then considering where there might be opportunities to expand, and also developing an estates strategy, will help to avoid a reactive or case-by-case approach to expansion.

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Organisational development and HR

Three elements of your people strategy may require a review as part of your overall FT strategy:

- Your **performance management system** would ideally ensure that individuals' and teams' performance have real effects on the organisation and patient care. This would help align individuals' incentives to the trust's goals. You may feel that in reality there are few consequences in formal appraisal processes – however, you may be able to create your own system of consequences. Rewards such as public recognition of good performance can be very effective incentives.
- **Leadership development** would include making sure that clinical staff who are taking on more managerial leadership work are given the necessary training to do so and that you have a longer term succession planning and development process in place for key positions across the organisation.
- **Workforce development** would consider training more broadly, and ensure that all staff are given the support and training necessary to carry out their existing roles and develop into new roles where appropriate.

Project management

Depending on the degree of change you envisage, you may consider significant investment in your project management/change management capabilities. While implementation questions will be considered at the Deliver stage, broader questions about significant potential changes to your existing project management scheme – for example, investing in a programme management office (PMO) team – should be considered now.

Creating a longlist of strategy initiatives

After collecting ideas and inspiration from a wide range of sources, you will need to describe each potential initiative consistently and in more detail. This brings clarity to what each initiative involves and will achieve – specifically, how it will help your FT to achieve its strategic objectives.

This is likely to be a more effective process if it is iterative, involving direct participation through workshops and individual discussions with clinical and managerial leadership throughout the organisation. For some initiatives, ownership will reside within the departments that those ideas most affect. For cross-FT ideas, a corporate team or a specifically-named individual will own them at this stage.

The decision-making process should be effectively supported by the creation of a common template for reviewing all the potential initiatives. A template will guide the owners of the various initiatives to produce all the information that you believe will be most relevant for your FT's consideration.

The next page provides a sample template for each potential initiative, followed by an filled-in example. At this stage, you will want to make a 'back of the envelope' assessment of the impact and feasibility of the initiatives – this will rely on judgement and estimates rather than the level of rigorous analysis that you will want to undertake for the initiatives that remain after this initial filter.

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Sample strategy initiative template

Rationale

Which strategic theme does this initiative address?

Evidence base

How do you know that this will have the expected impact?

Description of initiative

What is the idea? How will it work? What area of the FT does it impact?

Potential impact

What do you expect the impact to be?

1. On quality of patient care
2. On finances
3. On other factors (eg workforce satisfaction)

High-level estimate of costs and timeframe required

What will this cost to implement – one off and ongoing running costs?

How long will this take to implement?

Risks and feasibility for your FT

How easy will this idea be to implement? What could go wrong?

Key stakeholders

Who should be consulted before we decide whether to go for this idea?

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EXAMPLE

A completed potential strategy initiative template

Rationale

Addresses Theme 1: Improve quality of care and Theme 4: Reduce costs

Description of initiative

Move non-critical patients from HDU to level 1 facilities and wards

Evidence base

- Some specialties have set up level 1 facilities (eg gastrointestinal bleed unit)
- Those level 1 facilities have had good quality of care results (SMR measures) and lower length of stay for equivalent patients (they are better suited to offer expedited service)

Potential impact

Income increase and cost savings

- ~£200k extra revenues from reduction of high dependency unit patients with no organ support
- Potential advantages in coding for patients currently in wards

Quality

- Better care to patients currently in wards
- Reduced inappropriate admissions
- Reduced length of stay

High-level estimate of costs and timeframe required

- Requires investment from each specialty in creating the appropriate facilities
- Phase 1: March to December

Risks and feasibility for your FT

- This has already been started by some specialties, so it is feasible for others
- Risk in quality impact if critical patients are misidentified as non-critical. Improvements in care quality for those in level 1 facilities should mitigate this

Key stakeholders

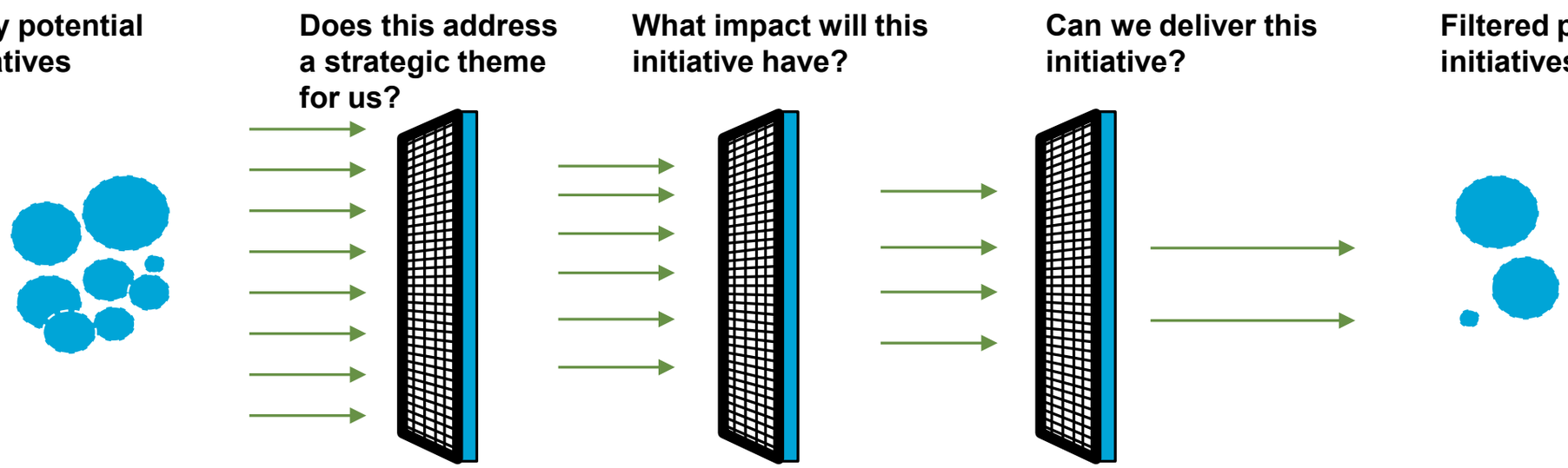
General managers and clinical directors of all specialties without level 1 facilities

Filtering initiatives for further consideration

Once you have a longlist of ideas for change under each strategic theme, you will need to filter the list to find the initiatives worthy of deeper analysis. A filtering process using assessment criteria can be used. This enables you to combine several criteria to gauge the relative attractiveness of each initiative. Many of these criteria will be subjective (eg 'can we implement this easily?'); this does not mean that they are not usable, but that judgments made should be recorded and debated.

At this stage, two things are really important: agreeing on the best selection criteria, and understanding at a high level how each initiative performs against them. In the next stage, Prioritise, you will conduct detailed analyses to enable your final choices.

Multiple filters to create a funnel



Example criteria	1. Will this initiative make a different for one of the areas that we have selected as a strategic theme? 2. Will this service growth or reduction contribute to a strategic theme?	1. Does this initiative change our performance significantly? 2. Does this service change set us up for improvements in our performance, eg due to clinical interdependency with other services?	1. Within reasonable resource constraints, can we deliver this initiative? 2. Are their external factors which will impede delivery of this service?	**Agreeing criteria as a leadership team, eg in a top team workshop, is a crucial part of getting this approach to work**

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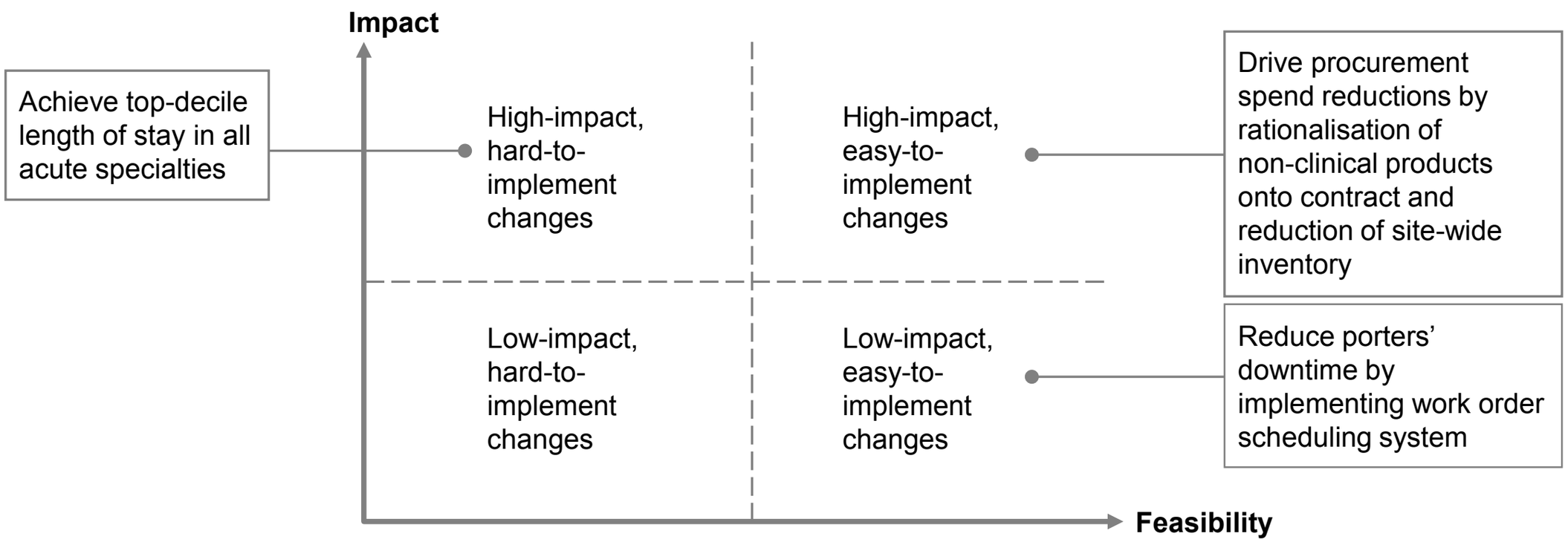
Another approach to filtering initiatives is to review them on paired dimensions, such as impact and feasibility. 'Impact' might either be an assessment of an initiative's combined impact on all the aspects that are important, or its impact on one specific goal, such as quality or financial performance. 'Feasibility' reflects your assessment of the likely ease of getting this idea implemented, given your internal and external environment.

As shown below, this type of assessment enables you to start filtering out initiatives that have low impact and would be challenging to implement, while focusing on that would have high impact, or would be feasible, or both.

The following pages provide you with NHS provider examples of filtering processes undertaken.

Two by two grid: Looking at Impact and Feasibility for productivity improvements



EXAMPLE

Summary of longlist of initiatives by strategic theme and high level 'moons' assessment of each initiative

This can be a combination of impact on various things, or you could use different impact columns for different areas, eg impact on patient experience and impact on workforce satisfaction

Feasibility is your assessment of how difficult this would be to implement for your organisation

Strategic theme	Description of initiative	Impact	Feasibility
Theme One	Initiative One		
	Initiative Two		
	Initiative Three		
	Initiative Four		
Theme Two	Initiative Two		
	Initiative Three		
Theme Three	Initiative One		
	Initiative Two		
	Initiative Three		
Theme Four	Initiative One		
	Initiative Two		
	Initiative Three		
Theme Five	Initiative One		
	Initiative Two		
	Initiative Three		

Full moon (in blue) indicates high impact/feasibility

Source: Anonymised NHS provider example

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EXAMPLE

This scorecard from a charitable foundation illustrates a criteria-based scoring mechanism that can be applied consistently to initiatives (1/2)

Filter	Impact axis 'Should this be done?'			Distinctiveness axis 'Should this be done by us?'		
Criteria	Opportunity over next 3-5 years	Audience reached for spend over time (relative to a scale of other 'like' activities) (campaigns example)	Value of new evidence/knowledge/ approach	Uncommon skills and capabilities	Credibility with external stake-holders, eg donors, press, academics, politicians	Severity of neglect by other funding organisations
Score						
1	• Activity will have same impact regardless of whether undertaken in next 3-5 years or later	• Cost in line with TV ads per person reached (expensive)	• Little external interest; does not alter the value of existing knowledge; does not change our approach	• Widely present in other agencies/ bodies	• Limited credibility	• Multiple sources of funding; activity funded (even if need not fully met)
2	• Identified opportunities in this period but likely to reoccur	• Cost in line with publications per person reached (less expensive)	• Some interest; or may increase value of existing knowledge; or small changes in approach	• Few other organisations possess skills, but not distinct to us	• Credibility with some key stakeholders; some other organisations also credible	• Other funding including long term; adequate to generate findings

Source: Anonymised NHS provider example

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EXAMPLE

This scorecard from a charitable foundation illustrates a criteria-based scoring mechanism that can be applied consistently to initiatives (2/2)

Filter	Impact axis 'Should this be done?'			Distinctiveness axis 'Should this be done by us?'		
Criteria	Opportunity over next 3-5 years	Audience reached for spend over time (relative to a scale of other 'like' activities) (campaigns example)	Value of new evidence/ knowledge/ approach	Uncommon skills and capabilities	Credibility with external stake-holders, eg donors, press, academics, politicians	Severity of neglect by other funding organisations
Score						
3	• Set of aligned opportunities to influence may not reoccur	• Cost in line with media relations per person reached (inexpensive)	• Wide interest; or enhances existing knowledge; or large changes in approach	• We have scarce skills	• Credible with most stake-holders; few other organisations attain same level	• Other funding is short term or inadequate to build knowledge
4	• Analysis confirms that there is critical window of action opening in next 3-5 years	• Cost in line with text message campaign per person reached (very inexpensive)	• Critical to making the case; or substantial • addition that generates • attention; or changes our approach	• We possess – or can acquire – skills and capabilities not present in other organisations	• Recognised as leading expert/ practitioner	• We are likely to be only funder

Source: Anonymised NHS provider example

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Generate Options

Appendix

Learning from published sources: UK and international

Examples from healthcare providers under each strategic theme

Learning from other industries: non-healthcare examples

Learning from published sources: UK and international

Examples from healthcare providers under each strategic theme

Learning from other industries: non-healthcare examples

Learning from published sources: UK and international

National reports and guidance

There should already be a systematic approach across your FT for gathering and using national reports and guidance that relate to the trust and its services. In the Diagnose stage, you will have used these to understand your current position compared to other providers.

In the Generate Options stage it is important that you use this information to facilitate discussion of what changes you may choose to make. For example, if you have already identified that your provision of cardiac services is weak from quality and financial points of view, descriptions of what good quality care looks like will be found within the Myocardial Ischaemia National Audit Project (MINAP) reports. Similarly, if you have identified care integration as a strategic theme, the King's Fund reports on this topic will be helpful in identifying options in this area.

Some examples (but not comprehensive) of useful sources and organisations:

- National Institute for Health and Care Excellence (NICE)
- Department of Health and NHS England guidance
- The King's Fund reports
- Nuffield Trust reports
- Foundation Trust Network (FTN)
- National Cancer Network
- Royal Colleges guidance
- Public Health England
- National Audit Office healthcare reports
- Care Quality Commission (CQC) investigations and reports
- Monitor reports and guidance
- Medicines and Healthcare Products Regulatory Authority (MHRA) reports

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Learning from other healthcare organisations in the NHS and overseas

In addition to national reports and guidance, you should search for information on how other healthcare organisations are tackling the issues that you want to tackle. Staff within the FT will have a wealth of personal contacts and experiences that can be drawn on. Published case studies, articles, reports, study tours can all reveal possible initiatives to consider.

Often it will not be appropriate for you to replicate exactly what other organisations have done, but knowing about what others are doing will help you craft the ideas for change that are right for your FT.

The most common sources for finding out about specific examples of change in other organisations are:

- Case studies of new service design/innovation in new technologies/other effective changes published in Health Service Journal (HSJ), HSJ Transformation channel, Nursing Times
- FTN website, publications and conferences
- NHS Improving Quality (NHS IQ) website, publications and conferences
- Institute for Healthcare Improvement (IHI) website, reports, study tours
- King's Fund
- Nuffield Trust
- UK healthcare improvement organisations, eg AQUA
- University publications, eg Cranfield (UK), Harvard Business Review (US)
- British Medical Journal articles
- The Health Foundation
- British Journal of Healthcare Management
- Benchmarking services such as NHS Benchmarking, Dr Foster, CHKS, McKesson, Albatross

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EXAMPLE

You will also want to review the standards expected from the Royal Colleges

	Policy/guidance	Key recommendations	Implications for staffing
Royal College of Physicians	• Consultant physicians working with patients, 5th edition (2013)	• Round-the-clock consultant supervision of acute medical unit • Consultant reviews of all acute admissions < 12 hrs of initial assessment – twice daily post-take ward rounds	• Increased consultant coverage required when >25 admissions/ 24 hours
Academy of Medical Royal Colleges	• Seven day consultant present care (2012)	• Inpatients reviewed by consultants once every 24hrs 7 days a week • Consultant supervised interventions to be provided 7 days/week if it will change care pathway outcome • Support services in hospital and community to be available 7 days/week to provide next step in pathway	• Consultants and support services should be available 7 days/week
The College of Emergency Medicine	• Emergency Medicine Consultants – Workforce Recommendations (2010)	• 24/7 emergency medicine consultant coverage of A&E	• Min 10 WTE[1] coverage for A&Es providing 16hr/7day consultant coverage; min coverage higher for A&E departments w/ >80k attendances/yr
RCS	• Emergency Standards for Unscheduled Surgical Care (2011)	• Consultant review of high risk patient within 4hours • Consultant surgeon present for operations with predicted mortality >5%	• Consultant available by telephone 24/7 and available onsite within 30 minutes
RCPCH	• Facing the Future: A review of paediatric services (2011)	• Consultant paediatrician review within 24 hrs of acute admission to paediatric unit • Short Stay Paediatric Assessment can access consultant opinion throughout operational hours • Paediatric consultant present during peak hours	• Minimum 10 WTE (whole time equivalents) per rota
	• The Future Workforce in Obstetrics and Gynaecology (2009)	• 60 hr/week consultant coverage for delivery suites with 2.5k-3.5k births/year	• 24/7 consultant coverage for deli-very suites with >5,000 births per year = 12.5 consultant WTE rota
The Royal College of Midwives	• Royal College of Midwives (2009)	• An adequate ratio of midwives to births should be in place as it impacts on both the safety and quality of maternity services and mothers satisfaction	• Recommended annual ratio of births per midwife is 28:1 for hospital births and 35:1 for home births

1 Whole time equivalent

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Materials on strategic theme 1: Internal rebalancing of current service portfolio

Individual reports, policy guidance

Setting services priorities

- Setting priorities – conducting a facility portfolio analysis to assist master planning, Health Facilities Management
- Portfolio analysis for hospitals, Health Care Management Review
- Black holes, cash pigs and other hospital portfolio analysis problems, Journal of Health Care Marketing

Service reconfiguration

- Thinking about acute reconfiguration? The 8 questions you need to consider first, 2020 Delivery
- Reconfiguring hospital services: Lessons from South East London, King's Fund
- Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis, BMJ

Understanding continuity of services

- Guidance on designated commissioner requested services, Monitor
- Monitor's Risk Assessment Framework, Monitor
- Protecting patients' interests: ensuring continuity of NHS services: proposals for a health special administration regime for companies, Department of Health
- All systems go: testing the new licensing system for providers of NHS-funded care, NHS Confederation

Sources of insight, publishers, institutions

Key sources

- Monitor
- National Trust Development Authority (NDTA)
- Health Facilities Management
- Harvard Business Review and other university publications, eg Cranfield in the UK
- Health Service Journal – case studies surrounding services design and reconfiguration
- Foundation Trust Network, publications and conferences

Other sources

- King's Fund, Nuffield Trust and Health Foundation

Materials on strategic theme 2: Quality

Individual reports, policy guidance

Introduction to quality of care

- Crossing the quality chasm, Institute of Medicine
- Evaluating the quality of medical care, Milbank Memorial Fund
- Quality and the Next Stage Review, The Lancet

Measuring and monitoring quality

- Intelligent Board 2006, Dr Foster Intelligence
- Guidelines for providers meeting the Fundamental Standards on CQC enforcement powers, CQC
- Dr Foster Hospital Guide 2013, Dr Foster

Quality improvement

- Changing care, improving quality - reframing the debate around reconfiguration, NHS Confederation
- Two sides of the same coin: balancing quality and finances to deliver greater volume, NHS Confederation
- The new era of thinking and practice in change and transformation, NHS Improving Quality

Further reading

- Consultant physicians working with patients, Royal College of Physicians, 5th edition (2013)
- Seven day consultant present care, Academy of Medical Royal Colleges (2012), Academy of Medical Royal Colleges (2012)
- Emergency Medicine Consultants – Workforce Recommendations, The College of Emergency Medicine (2010)
- Emergency Standards for Unscheduled Surgical Care, Royal College of Surgeons (2011)
- Facing the Future: A review of Paediatric services (2011)
- The Future Workforce in Obstetrics and Gynaecology, RCOG (2009)
- Reconfiguration of women's services in the UK, RCOG, (2013)
- Transforming urgent and emergency care services in the UK, NHS England (2014)

Sources of insight, publishers, institutions

Key sources

- Care Quality Commission – Fundamental Standards
- NICE clinical guidance
- Health & Quality Improvement Partnership (HQIP) eg Clinical Audits
- Health and Social Care Information Centre eg Quality Accounts
- Dr Foster Intelligence
- NHS Improving Quality (NHS IQ) publications and conferences
- NHS England - Operational Standards

Other sources

- UK healthcare improvement organisations eg AQUA, Health Quality Improvement Programme eg Clinical Audits
- Agency for Healthcare Research & Quality (USA)
- The King's Fund, Nuffield Trust and Health Foundation
- NHS Benchmarking, Dr Foster, CHKS, McKesson, Albatross, Methods Analytics
- Institute for Healthcare Improvement (IHI) website, reports, study tours

Materials on strategic theme 3: Productivity

Individual reports, policy guidance

Introduction

- Improving NHS productivity: more with same, not more of the same, King's Fund
- Can hospitals do more with less, Nuffield Trust
- Management of NHS Hospital Productivity, National Audit Office

Workforce productivity

- NHS workforce planning: limitations and possibilities
- Seven day consultant present care, Academy of Medical Royal Colleges (2012) (2012)
- Managing hospitals consultants, Department of Health
- Consultant physicians working with patients, 5th edition (2013)
- Emergency Medicine Consultants – Workforce Recommendations (2010)
- Facing the Future: A review of paediatric services (2011)
- The Future Workforce in Obstetrics and Gynaecology (2009)
- Royal College of Midwives (2009)

Non pay productivity (procurement)

- NHS Procurement Standards, Department of Health
- Better Procurement: Better value better care – a procurement development for the NHS
- Procurement of consumables by NHS Acute and Foundation Trusts, National Audit Office

Capital equipment

- Managing high value capital equipment in the NHS in England, National Audit Office

Sources of insight, publishers, institutions

Key sources

- NHS Productivity – Better Care Better Value
- NHS Improvement [Archived]
- Royal College Clinical Guidelines
- Health Service Journal – case studies surrounding services design and reconfiguration
- Health and Social Care Information Centre eg HES (inpatient, outpatient and A&E admissions) & Hospital and Community Health Services Workforce
- Hospital Estates and Facilities statistics eg Estates Return Information Collection data

Other sources

- The King's Fund, Nuffield Trust and Health Foundation
- National Audit Office and Public Accounts Committee reports
- NHS Supply Chain
- Health Service Journal – case studies surrounding services design and reconfiguration

Materials on strategic theme 4: Rebalancing your service portfolio via partnerships and mergers

Individual reports, policy guidance

Hospital reconfiguration

- The Dalton Review: New options for providers – emerging thinking, Department of Health
- Do's and Don'ts of NHS Reconfiguration, Guardian Health Professional Network
- Reconfiguration of Hospital Services in England, King's Fund
- Health service reconfiguration: debate briefing, Foundation Trust Network

Hospital mergers and acquisitions

- Supporting NHS providers: guidance on transactions for NHS foundation trusts, Monitor and CMA
- Supporting NHS providers: guidance on merger benefits, Monitor and CMA
- Meeting the challenge of hospital mergers, Nuffield Trust
- Experiences of mergers/acquisitions… lessons to take into future planning
- What hospital executives should be considering in hospital in M&A's, Dixon Hughes Goodman [US]

Vertical integration

- What is integrated care, Nuffield Trust
- Integrated care: What is it? Does it work? What does it mean for the NHS, King's Fund
- Developing integrated care: What role do Acute Hospitals play, King's Fund
- Towards integrated care in Trafford, Nuffield Trust
- Accountable Care Organisations in US and England : Testing, evaluating and learning what works , King's Fund

Further reading

- Future hospital: caring for the medical patient, Royal College of Physicians, 2013
- Providing acute care locally – the small, hypermodern local acute hospital, Durrow et al
- Facing the future: smaller acute providers, Monitor

Sources of insight, publishers, institutions

Key sources

- **Monitor and CMA: guidance on mergers**
- **Substantive guidance on the Procurement, Patient Choice and Competition Regulations**
- **Hypothetical case scenarios: Procurement, Patient Choice and Competition Regulations**
- **Choice and competition licence conditions: guidance for providers of NHS-funded services**
- **Choice and competition: hypothetical scenarios for NHS healthcare providers**
- Department of Health eg provider review
- Foundation Trust Network, publications and conferences
- King's Fund, Nuffield Trust and Health Foundation

Other sources

- NHS Confederation, case studies and policy documents
- Individual case studies – Health Service Journal, Harvard Business Review, King's Fund, Nuffield Trust, National Audit Office, and others
- Health Affairs (health policy journal)
- Royal Colleges

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Materials on strategic theme 5: Significant longer-term investments

Individual reports, policy guidance

Investing in new facilities buildings and equipment

- Managing capital project risks in a challenging environment: What healthcare boards and executives need to know, American Hospital Association Centre for Healthcare Governance
- NHS Buildings: Obstacles or opportunities? King's Fund
- Future hospital: caring for the medical patient, Royal College of Physicians, 2013

Creating partnerships

- The Dalton Review: New options for providers – emerging thinking, Department of Health
- Future organisation models for the NHS: Perspectives from the Dalton Review, Department of Health

Expanding work to other parts of the UK

- Making the decision to franchise (or not) – Harvard Business Review
- Franchising of Hinchingbrooke Health NHS Trust, National Audit Office

Further reading

- Providing acute care locally – the small, hypermodern local acute hospital, Durrow et al, 2010

Sources of insight, publishers, institutions

Guidance on investment and capital regime

- HM Treasury The Green Book
- NHS England Business Case Approvals Process
- NTDA Capital Regime guidance

Other sources

- Individual case studies – Health Service Journal, Harvard Business Review, King's Fund, Nuffield Trust, National Audit Office, Future Hospital Commission, and others
- Health Affairs (health policy journal)
- NHS Health Investment Network

Materials on strategic theme 6: Investments in strategic enablers

Individual reports, policy guidance

Information technology

- Strategic Systems and Technology and Integrated Digital Care Fund, NHS England
- Enabler Library (Digital Technology), Health and Social Care Information Centre
- Technology in the NHS, King's Fund

Estates

- Managing capital project risks in a challenging environment: What healthcare boards and executives need to know: American Hospital Association Centre for Healthcare Governance
- NHS Buildings: Obstacles or opportunities? King's Fund

HR/workforce

- Seven day consultant present care, Academy of Medical Royal Colleges (2012)
- NHS workforce planning: limitations and possibilities
- Managing hospitals consultants, Department of Health
- Consultant physicians working with patients, Royal College of Physicians, 5th edition (2013)
- Emergency Medicine Consultants – Workforce Recommendations, The College of Emergency Medicine (2010)
- Facing the Future: A review of Paediatric services, Royal College of Paediatrics and Child Health (2011)
- The Future Workforce in Obstetrics and Gynaecology, RCOG (2009)

Sources of insight, publishers, institutions

Key sources

- NHS England
- Health and Social Care Information Centre (Digital Technology)
- Hospital Estates and Facilities Management Association
- Hospital Estate Journal
- Case studies and evidence reviews – Health Service Journal, NHS Employers, Harvard Business Review, King's Fund, Nuffield Trust, Health Foundation, National Audit Office, and others
- Health Affairs (health policy journal)

Strategic theme 2 | Quality improvement in current services

Learning from published sources: UK and international

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EXAMPLE

Improving quality of current services as a strategic focus

FT's strategic theme

Pursuing quality improvement to become the safest organisation in the NHS

What is already planned 2014/15

- 7-day working
- Safety at night
- Structured ward rounds
- Clinical communication and handover
- Theatre safety
- Medicines management
- Nursing Assessment and Accreditation System (NAAS) equivalent for medics, theatre, outpatients & theatre
- Improve care for patients with dementia and delirium
- Use of technology/electronic patient record to improve safety

Board's emerging five-year focus theme(s)

1 Become a global leader on quality

Deliver:

- Continue to offer outstanding-quality, patient-centred care to our population – ever-safer, ever-better outcomes, and ever-better patient experience
- Go from very good to great quality
- Short-term, 'fix' specific measurements eg, readmissions, delayed discharges, variability especially community care

By:

- Benchmarking vs international peers
- Taking quality management to the ward level – and to the individual consultant/team with an agreed set of quality measurements which are reviewed on a monthly basis
- Continuing to build world-class quality research and management agenda
- Forging alliances with other leading organisations
- Building umbrella quality-management approach across our city and wider region

Source: Anonymised NHS provider example

Learning from published sources: UK and international

Examples from healthcare providers under each strategic theme

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Strategic theme 3

Strategic theme 4

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EXAMPLE

A framework used to address quality

What do we need to do to become a healthy organisation that consistently delivers high quality, safe care?

1. **Create a proper evidence base** with measurements and reliable information to understand our strengths, weaknesses and risks on quality and safety
2. **Surface problems and concerns** quickly and openly based on the over-riding need to protect patients from harm
3. **Balance demand and capacity** to prioritise attention and resource to the sickest and most needy patients
4. **Develop a culture** which is team based where we empower and support each other, and challenge each other when we need to
5. **Organise and manage the hospital** in ways that enable rapid decision-making and create clear accountability
6. **Recruit and develop staff** with the skills to deliver, maintain and improve our quality and safety standards

Source: Anonymised NHS provider example

Learning from published sources: UK and international

Examples from healthcare providers under each strategic theme

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EXAMPLE

Another framework used to address quality

Strategy/ planning	1	Set bold ambition
	2	Reflect clear objectives in measurements tracked at each level
	3	Deploy evidence-based best practices and reduce variability
Organisation	4	Approach finance and quality in an integrated way
	5	Link ownership for quality from board through service line
Information	6	Make performance transparent through timely information
Performance management	7	Hold regular, objective performance dialogues
	8	Reward good performance and ensure consequences for poor outcomes
Culture	9	Empower frontline staff and foster a 'no blame' culture
	10	Develop proactive leaders willing to change and able to solve problems

Source: Anonymised NHS provider example

Learning from published sources: UK and international

Examples from healthcare providers under each strategic theme

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EXAMPLE

How one hospital approached becoming a leader of high quality care, with scale of service a key criterion for deciding which service to focus on (1/5)

1. Criteria selected for choosing which services to focus on

Dimension	Description	Performance indicators	Benchmark	Rating
1 **Scale**	• Patient volumes compared with competitors and internally with other clinical areas	• **# inpatient spells per specialty compared to peers** • Volume share within the trust	• Peergroup • Internal	• High if top 2 in London • Med if top 3 • Low otherwise • High if >10% • Med if > 5% • Low otherwise
2 **Recog-nition**	• Has the clinical area formally been recognised; and how many peers have same recognition?	• **Recognition (compared to # peergroup recognitions)**	• Peergroup[1]	• High if 1 of 4 recognised centres • Med if 1 of 8
3 **Local relevance**	• Is the clinical area especially relevant for the local population	• **Full business case** • **Fits local strategy** • **commissioning intentions**	• - • - • -	• Yes if mentioned in document
4 **Partner priorities**	• Is the clinical area a priority for our partners?	• **Trust 1** • **Trust 2** • **Trust's charity**	• - • - • -	• Yes if mentioned as priority
5 **Growth prediction**	• Is the clinical area expected to grow significantly in the future	• **Historical growth** • **Predicted growth by the NHS region**	• - • -	• Yes if mentioned as growth area

Summary rating:
- High if
  - High on 2 dimensions, or
  - High on 1 dimension and Medium on 2 dimensions
- Medium if
  - High on 1 dimension, or
  - Medium on 2 dimensions
- Low otherwise

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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EXAMPLE

How one hospital approached becoming a leader of high quality care, with scale of service a key criterion for deciding which service to focus on (2/5)

2. Assessment of all services against chosen criteria

Shortlisted

	Scale		Recognition	Local relevance			Partner Priorities			Growth prediction	Summary
Specialty	# inpatient volume compared to peers	volume share within BH	Recognition	FBC	Health for NEL	Commissioner intentions	UCLP	QMUL	Charity	Growth prediction	Summary
Asthma	High	Low	Low	No	No	No	No	No	No		Low
Breast surgery	High	Low	Low	No	No	No	No	No	No		Low
Burns and plastics	Med	Low	Low	No	No	Med	No	No	No		Low
Cancer	High	High	Med	Yes	No	Yes	Yes	Yes	Yes	Yes	High
Cardiology	High	Med	Med	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
COPD	High	Low	Low	No	No	No	No	No	No	Yes	Low
Dermatology	High	Low	Low	No	No	No	No	No	No		Low
Diabetes	High	Low	Low	No	No	Yes	No	No	No	Yes	Med
Endocrinology	High	Low	Low	No	No	No	No	No	No		Low
ENT	High	Med	Low	No	No	No	Yes	No	No		Med
Gastric surgery	High	Low	Low	No	No	No	No	No	No	Yes	Low
Gastroenterology	High	High	Low	No	No	No	No	No	No		Med
Gynaecology	High	Low	Low	No	No	No	No	No	No		Low
Haematology	High	Low	Low	No	No	No	No	No	No		Low
Hepatic surgery	Low	Low	Low	No	No	No	No	No	No		Low
Hepatology (liver)	High	Low	Low	No	No	Yes	No	No	No		Med
IHD	High	Low	Low	No	No	No	Yes	No	No		Med
Maternity	High	Med	Low	Yes	Yes	Yes	Yes	No	No	Yes	High
Neonatology	Med	Low	Med	Yes	Yes	Yes	Yes	No	No		High
Neurology	Med	Low	Low	No	No	No	Yes	No	No		Med
Neurosurgery	High	Low	Low	No	No	No	Yes	No	No		Med
Ophthalmology	High	Low	Low	No	No	No	Yes	No	No		Med
Orthopaedics	High	Med	Low	No	No	No	No	No	No		Low
Other medicine	High	Med	Low	No	No	No	No	No	No		Low
Paediatrics	High	Med	Low	Yes	Yes	Yes	Yes	No	No		High
Pain	High	Low	Low	No	No	No	No	No	No		Low
Renal medicine	High	High*	Med	No	No	No	Yes	No	No		Med
Respiratory	High	Low	Low	Yes	No	No	No	No	No		Med
Rheumatology	High	Low	Low	No	No	No	No	No	No		Low
Stroke	High	Low	Med	Yes	Yes	No	Yes	No	No	Yes	High
Surgery	High	Low	Low	No	No	No	No	No	No		Low
Trauma	High	Low	High	Yes	Yes	No	No	Yes	Yes		High
Urology	High	Med	Low	No	No	No	No	No	No		Low
Vascular surgery	High	Low	Low	No	Yes	No	No	No	No		Med

Source: Anonymised NHS provider example

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EXAMPLE

How one hospital approached becoming a leader of high quality care, with scale of service a key criterion for deciding which service to focus on (3/5)

3. Further criteria to select services from shortlist based on scale

Dimension	Description	Performance indicators	Benchmark	Rating
1 Quality	• Performance on quality indicators specific for that service	• **Specific quality audits per specialty** • Volume per specialty • HSMR[1] per specialty	• National • Peergroup[1] • Internal	• World class if top quartile on all indicators and highest volume in city • Locally relevant if top quartile in half of indicators and top 2 volume in city
2 Repu-tation	• Reputation of each service among patients and among colleagues	• **% of patients from outside area** • **# consultant-to-consultant tertiary referrals** • % patients and staff recommending trust to friends/ family	• Internal • Peergroup[1] • Internal	• World class if above trust average patients from outside catchment and top 2 consultant-to-consultant referrals in city (in absolute terms) • Locally relevant if above trust average patients from outside catchment and top 3 consultant-to-consultant referrals in city (in absolute terms)
3 Recog-nition	• Formal recognition received for specific service areas	• **Formal designations** • Specialist services 'top-up' list	• - • -	• World class if 1 of 4 designated centres in city • Locally relevant if 1 of 8 designated centres in city

1 Hospital Standardised Mortality Ratio

Source: Anonymised NHS provider example

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EXAMPLE

How one hospital approached becoming a leader of high quality care, with scale of service a key criterion for deciding which service to focus on (4/5)

3. Further criteria to select services from shortlist based on scale (continued)

Dimension	Description	Performance indicators	Benchmark	Rating
4 Infra-structure 	• Assessment whether the infrastructure necessary for distinctiveness is present	• # consultants per specialty • Investment in specialist equipment • Profitability	• Peergroup[1] • Peergroup[1] • Internal	• World class if top 2 consultants compared to peers and >10% gross margin • Locally relevant if top 3 most consultants compared to peers and >0% gross margin • Local standard otherwise
5 Research 	• Performance of each area in terms research volume and quality	• **# patients enrolled in clinical trials** • # current trials, # active researchers • PAs per consultant spent on research • **% 4* rated publications** • % highly cited articles	• Internal • Internal • Internal • Peergroup[1] • Peergroup[1]	• World class if top 3 on all indicators • Locally relevant if top 3 on half of indicators • Local standard otherwise
6 Teaching and training 	• Performance of each area in teaching, with high quality indicated by feedback from students; share of consultants who are accredited trainers	• **Reputation/ feedback from medical, midwifery and nursing students** • # of consultants who is accredited trainer • Programmed activities per consultant spent on education • Student numbers	• National • Internal • Internal • Internal	• World class if top 3 on all indicators • Locally relevant if top 3 on half of indicators • Local standard otherwise

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EXAMPLE

How one hospital approached becoming a leader of high quality care, with scale of service a key criterion for deciding which service to focus on (5/5)

4. Identified service options for strategic investment to improve quality to 'world class'

World leading | World class with deep local impact | Expected standard performer | Shortlisted

Services	Dimensions: Quality	Reputation	Recognition	Infra-structure	Research	Teaching and training
Cardio-vascular						
Trauma						
Cancer (sub-specialties)						
Paediatrics						
Stroke						
Maternity		N/A				
Neonatal						

Cardiac, trauma and cancer are the closest contenders for 'world class' distinctiveness.

This ambition would require significant joint effort from the trust and partners, including significant additional funding for long-term programmes

Source: Anonymised NHS provider example

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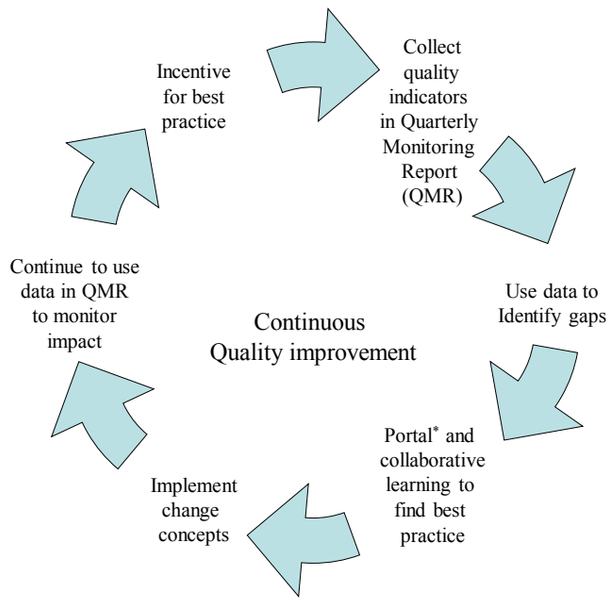
EXAMPLE

An example of how a group of NHS providers standardised their tools and indicators and transferred knowledge between them

Overview

- Advancing Quality is an innovative programme designed to improve the quality of care and experience of NHS hospital services across the North West
- The primary focus of this initiative is 5 disease areas
  - heart attacks
  - pneumonia
  - heart failure
  - hip and knee replacement
  - heart bypass surgery
- The programme aims to save lives, reduce complication rates and the length of stay in hospital.
- The programme will incentivise improvement in clinical outcomes, patient reported outcomes and patient experience

Process



- Standardised tools and indicators will be utilised to measure and analyse data to identify top performing organisations
- Rapid knowledge transfer will occur so all organisations learn from others to deliver highly reliable, consistent care
- Incentive scheme developed to reward organisations

Potential Impact

- Overall benefits anticipated
  - 141 lives saved
  - 159 complications avoided
  - 248 re-admissions avoided
  - 20,811 hospital days avoided
  - £17m in efficiency savings
- £735 in cost savings per patient across all clinical areas
- 1.87% improvement in mortality rates across clinical areas
- If all hospitals in England were to achieve this improvement, the estimated cost savings would be greater than £3.1 billion annually with estimated 70,000 lives saved per year

Source: Anonymised NHS provider example

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EXAMPLE

How a trust thought about reducing pressure ulcers and the resources that were used to identify all the possible causes (1/2)

			Key elements	What do we mean
Eliminating pressure ulcers	Via care providers	Tools	Equipment & supplies	Pressure relieving equipment Supplies at bedside
			Systems & techniques	Visual techniques like Red/Amber/Green cards IT systems for data collection Documentation tools for assessment
		Clinical process	Assessments processes	Skin assessment guidelines Risk assessment guidelines Specialist assessments Nutrition consultation
			Care processes	PU prevention pathway PU Care bundle Practices to minimise pressure Bedside rounding
		Skills and organisation	Training	Staff training and education including online MDT training modules Curriculum developed by nursing staff Creative teaching strategies Nurse-led 'Faculty' assigned
			Approach and practices	Practically-focused and MDT approach Designated "Champions"
		Performance management	Assessment	Time-specific goals set Measures - progress, staff engagement & staff knowledge Involvement and alignment among all staff
			Management	Designated nurse lead of programme Regular case reviews Ongoing performance monitoring and reporting
		Mindsets and behaviours	Leadership	Support by senior leadership Leadership creates momentum
			Staff engagement	Empowerment of staff Engagement and involvement by all staff levels Staff shares pride in process
	Via care user	Education	Patient education	Distribution of education packs on admission Education on complexities of condition for patient/carer Education on prevention techniques for patient/carer
		Information	Empowering patients	Risk assessment results highly visible to patient Self-management Patient feedback
			Access to primary care	Access to primary care and healthcare workers

Source: Anonymised NHS provider example

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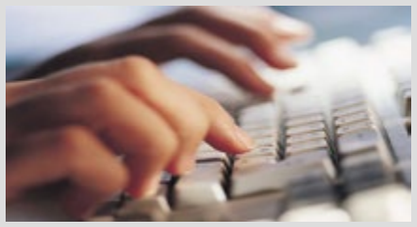
EXAMPLE

How a trust thought about reducing pressure ulcers and the resources that were used to identify all the possible causes (2/2)

	Sources of information	Key insights
Literature review 	• Partnering for prevention: a pressure ulcer prevention collaborative project; 2008, Wekman, H. • Peer-to-Peer Nursing Rounds and Hospital-Acquired Pressure Ulcer Prevalence in a Surgical Intensive Care Unit • Multiplayer medical home PU elimination programme – US Quality and Safety Commission	• Key ingredients for a comprehensive improvement programme delivering sustainable change: – nurse-led training/education programme – staff empowerment/engagement – strong performance management – clinical process standardised across organisation
Case studies 	• New Jersey Hospitals Pressure Ulcers Collaborative, US • Journey to Zero – Ascension Health, US • WoundsWest – Australia • 1000 Lives Plus – Wales	• Clarity of goals and targets • Effective communication with staff and patients • Proactive approach to PU prevention • Designated 'champions' among staff as role models • Clarity of roles and responsibilities • Discrete and manageable sub-projects • Buy-in from senior leadership
Web search 	• Institute for Healthcare Improvement – www.ihi.org • 1000 Lives plus • Ambitions for the NHS in the Midlands and East communications strategy • National Institute for Health and Care Excellence	• Best practice guidelines on the use of equipment and risk assessment tools

Source: Anonymised NHS provider example

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EXAMPLE

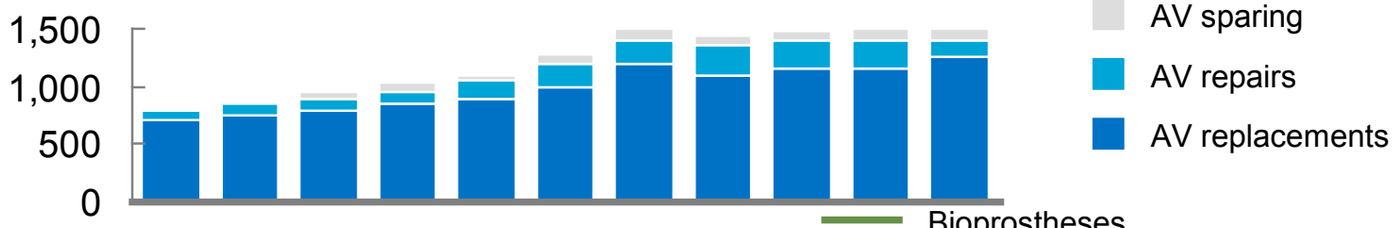
How an American hospital produces comprehensive transparent information on quality by service line

Overview

- Detailed report on quality across the hospital and within each service-line (or alternative organisation unit)
- Includes written commentary, overview of services, priorities and plans for the future and key processes in place to achieve this
- Introduction from the chief executive and/or medical director

Aortic valve surgery volume

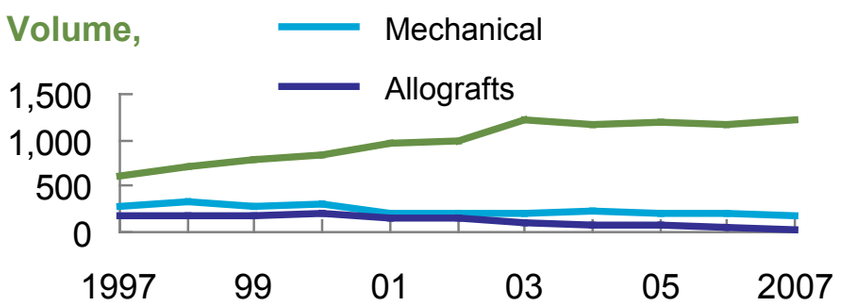
- Cleveland Clinic performs the largest volume of aortic valve-sparing procedures in the nation. In 2007, 88% (N= 1,169) of aortic valve surgeries performed at Cleveland Clinic were aortic valve replacements, and 12% (N=165) were aortic valve repairs, including 79 aortic valve-sparing operations



Aortic valve replacements

- Bioprostheses (biological tissue valves) are the prostheses of choice for both aortic and mitral valve replacement procedures. These valves are durable and allow most patients to avoid lifetime use of anticoagulants after surgery

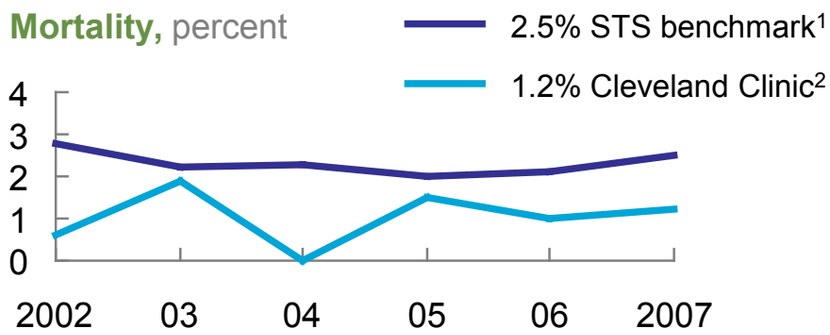
Volume,



Isolated aortic valve replacement mortality

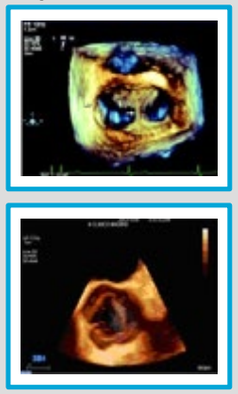
- Mortality for primary isolated aortic valve replacement at Cleveland Clinic in 2007 was 1.2%, significantly lower than the Society of Thoracic Surgeons (STS) benchmark of 2.5%

Mortality, percent



3D

- Live three-dimensional echo of the aortic valve is available for diagnostic and intra-operative imaging, allowing us to perform intricate aortic valve surgical procedures



1 Based on data from January to June 2007
2 Based on four hospital deaths in 325 cases from January to December 2007

Source: Cleveland Clinic cardio-vascular outcomes booklet

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EXAMPLE

How a German hospital operator published quality indicators to improve quality

Overview

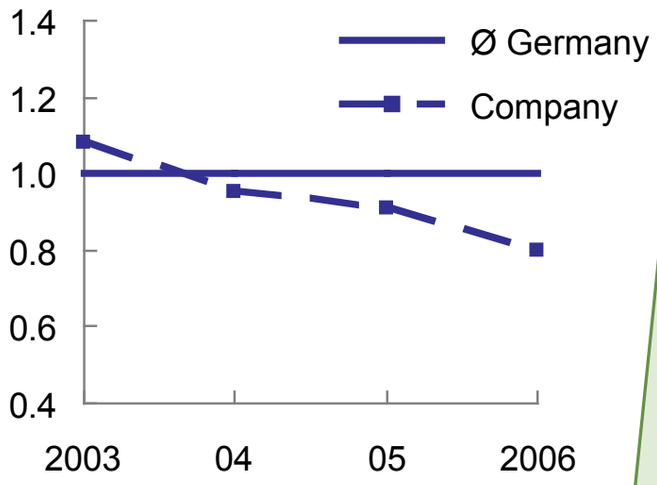
- The hospital operator is a nationwide private German hospital chain, which operates 60 hospitals with 13,045 beds in total
- It promotes quality initiatives and transparency
- Since 2000, the company has systematically analysed regularly collected data, which is usually used for reimbursement and quality control
- The company started publishing a report on medical outcomes, with data on eg, hospital mortality, long before quality reports became mandatory
- In 2007, the company started to integrate outpatient, post-hospitalisation treatment and monitor long-term outcomes

Process

- 670 indicators are regularly monitored for quality management
- Internal benchmarks help identify best practice and under performance to promote a learning environment, eg, chief physicians of under performing hospital departments have to initiate the discussion with chief physicians of top performer (patient record)
- To increase quality-based competition the company publishes data on hospital mortality standardised on German average for 24 indications and procedures, eg for:
  - heart failure
  - hip and knee replacement
  - hysterectomy

Impact

- Decrease of hospital mortality within the company from 2003 to 2005 according to the following indicators:
  - 28.5% heart failure
  - 28.2% aortic aneurysm
  - 22.1% gastrointestinal bleeding
  - 20.6% pneumonia
  - 12.7% apoplexy
  - 4.1% heart attack
- Example: Hospital mortality apoplexy indicator – standardised mortality ratios against German average



Source: Anonymised German provider example

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EXAMPLE

How a US hospital improved skills on the front line through intensive training

Overview

- The Centres for Disease Control and Prevention (CDC) estimates that bloodstream infections arising from intravenous catheters affect up to 250,000 patients a year in the United States, killing 15% or more
- Since 2001, a collaborative effort between CDC and a regional healthcare initiative has led to a dramatic decline in the prevalence of healthcare-associated blood stream infections within the region
- The initiative, called Perfecting Patient Care, involves the implementation of industrial improvement practices to healthcare
- Perfecting Patient Care prevents infections by improving the design and flow of work and eliminating potential errors

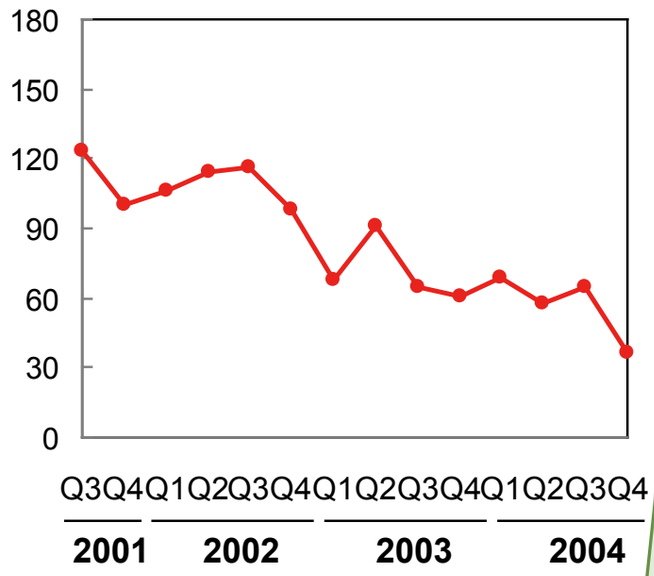
Process

- The hallmark of this method is engaging frontline care givers to examine mishaps immediately and implement preventive countermeasures
- A team of infection control experts repeatedly documented every line placement to identify variations or shortcomings in:
  - line insertions
  - dressing changes
  - medication administrations
  - technique and sterility
- Each time the team observed a problem with the process, it would immediately develop and test some kind of countermeasure, for example:
  - avoid femoral lines
  - use transparent dressings
  - call out every hand-washing lapse
  - prohibit rewiring of dysfunctional lines

Impact

- 63% region-wide decline in blood stream infections from 123 infections per quarter to 36
- Reduction in risk of infection from 4.3 infections per 1000 line days to 1.6 infections per 1000 line days

Reduction in catheter related infections
Number



Source: Anonymised US provider example

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EXAMPLE

How a charity providing eye treatment in India standardised procedures to enable swift and high quality patient treatment

Context

- Avoidable blindness rapidly escalating remained a major cause of concern in the Indian healthcare scenario
- In a developing country the government alone cannot meet the health needs of all, owing to challenges like growing population, inadequate infrastructure, low per capita income, ageing population, diseases in epidemic proportions and illiteracy
- Realising this, the lead doctor wished to establish an alternate healthcare model for eye surgery as well as outpatients' clinics that could supplement the efforts of the government and also be self-supporting.

The impact

- 60% of the volume of the entire NHS
- <1% of the total cost with half the complication rate
- On average 2,000 operations per year per consultant (US average is 125)
- The charity has 4% infection rate; the UK has 6%

How the solution works

- Arranging clinics when and where people will come: outpatient clinics close to patients and satellite vans to broaden the outreach
- Rethinking the workforce: school leavers trained as technicians
- Rethinking the surgery model:
  - Doctors sit between two operating tables: when they finish with one, they just turn to the other patient who is already draped and ready.
  - Everyone knows exactly what they have to do: the clinical staff set the diagnosis; the doctors prescribe and operate; the counsellor staff explain all the procedures to the patient. Every day it is the same procedure over again.

ARAVIND EYE CARE SYSTEM

Source: Aravind Eye Care System, India

Learning from published sources: UK and international

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Strategic theme 3 | Productivity improvement in current services

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EXAMPLE

How a trust identified opportunities to improve consultant productivity (1/2)

Medical pay costs

Medical workforce costs 2013/14, £m		Ways to reduce spend	Impact £m
1 Consultants base pay	41.3	• Introduce consistent job planning process and principles to reduce Supporting Professional Activity levels • Link Direct Clinical Care Programmed Activity allocation to productivity targets	1.8
2 Consultants (WLI and B&A)	4.0	• Reduce extra payments by: – reducing session payments from £450 to £350 – annualising job plans and monitoring performance to increase productivity – approval of Waiting List Initiative (WLI), bank and agency (B&A) at board level only	2.5
3 Non-consultants base pay and rotas	27.4	• Review and redesign all junior doctor rotas across all three divisions • Critically review all 121 non-trainees and 30 NHS FT fully funded training posts	3.1
4 Non-consultants, bank and agency	3.8	• Bank and agency spend to be reduced through rota design and central control	1.9
Total	76.5		9.3

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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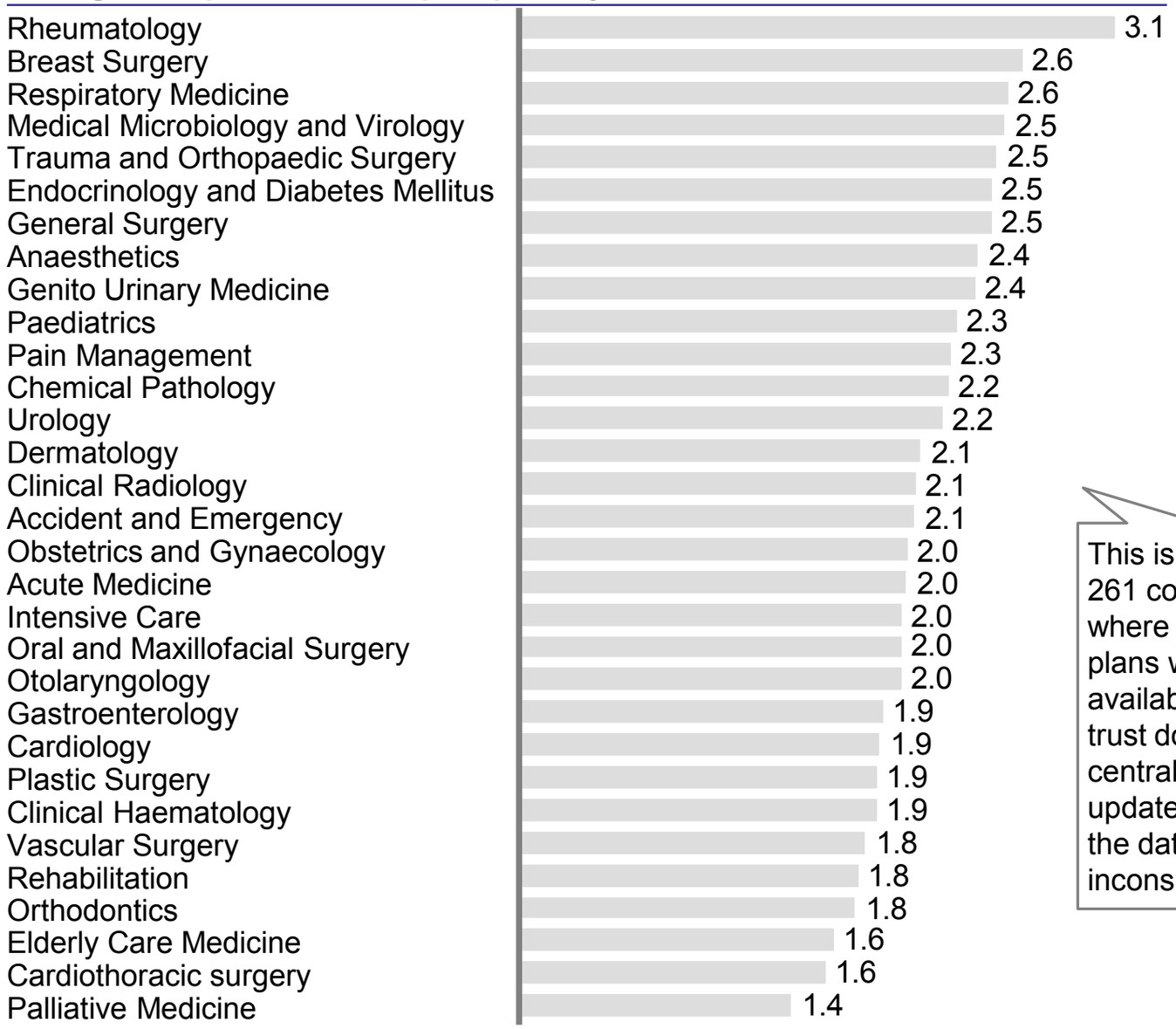
EXAMPLE

Specific analysis performed to inform productivity improvement ideas (2/2)

Average Supporting Professional Activity (SPAs) per consultant at specialty level suggests inconsistent policy

Average SPA per consultant per specialty, 2013



This is based on 261 consultants where detailed job plans were available; as the trust doesn't have a central repository of updated job plans the data may have inconsistencies

- Inconsistent policy regarding job planning and SPA allocation
- Opportunity to introduce consistent process and guidelines, in line with national guidelines regarding SPA allowance

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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EXAMPLE

Good practice productivity improvement initiatives outside of the acute setting identified by one commissioner

District nursing

- Reduce travel time through better route planning, less return to home base and better scheduling
- Reduce administration work to necessary minimum
- Reduce visits to non-homebound patients
- Reduce inappropriate referrals from nursing homes or develop into business opportunity
- Reduce inappropriate referrals from GPs

Health visiting

- Replace selected home visits in core and non-core service areas
- Reduce time spent waiting and travelling through consolidation of clinics
- Reduce administration work to necessary minimum
- Demand payment for vaccination services carried out for GPs (no need for pilot initiative, but hold conversation with GPs at right time)

Community hospitals

- Increase available bed days
- Reduce time spent on administration by clinical staff
- Reduce lost bed days due to delayed discharge for internal process reasons, self-funding patients, and external reasons
- Allow admissions and discharges out of hours

Physio-therapists/OT

- Reduce inappropriate referrals
- Avoid delays in equipment to reduce number of contacts required by patient
- Reduce 'did not attends' (DNAs) by setting up a reminder system (manned or automatic)

Source: Anonymised NHS commissioner example

Learning from published sources: UK and international

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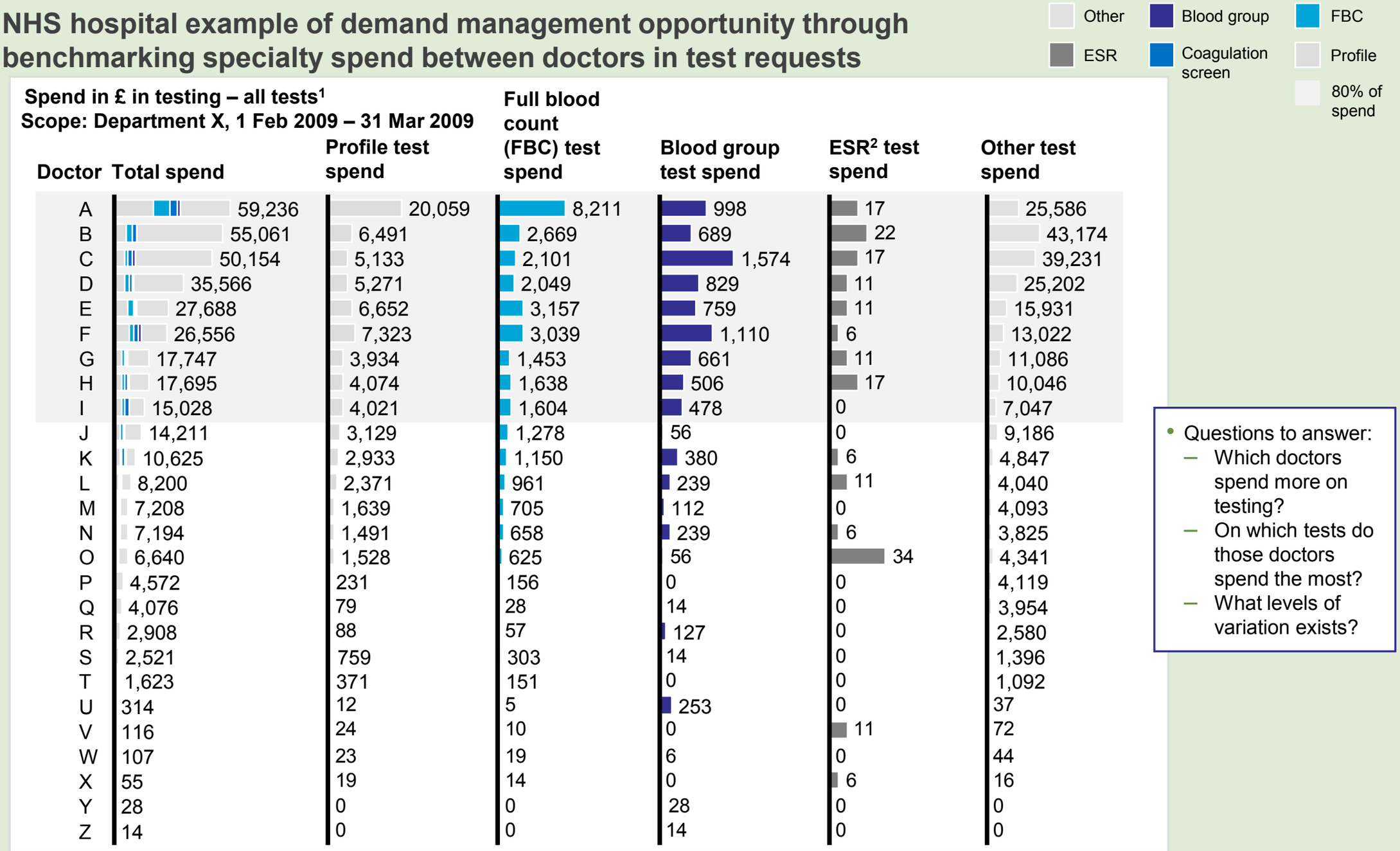
EXAMPLE

NHS hospital example of demand management opportunity through benchmarking specialty spend between doctors in test requests



Spend in £ in testing – all tests[1]
Scope: Department X, 1 Feb 2009 – 31 Mar 2009

Doctor	Total spend	Profile test spend	Full blood count (FBC) test spend	Blood group test spend	ESR[2] test spend	Other test spend
A	59,236	20,059	8,211	998	17	25,586
B	55,061	6,491	2,669	689	22	43,174
C	50,154	5,133	2,101	1,574	17	39,231
D	35,566	5,271	2,049	829	11	25,202
E	27,688	6,652	3,157	759	11	15,931
F	26,556	7,323	3,039	1,110	6	13,022
G	17,747	3,934	1,453	661	11	11,086
H	17,695	4,074	1,638	506	17	10,046
I	15,028	4,021	1,604	478	0	7,047
J	14,211	3,129	1,278	56	0	9,186
K	10,625	2,933	1,150	380	6	4,847
L	8,200	2,371	961	239	11	4,040
M	7,208	1,639	705	112	0	4,093
N	7,194	1,491	658	239	6	3,825
O	6,640	1,528	625	56	34	4,341
P	4,572	231	156	0	0	4,119
Q	4,076	79	28	14	0	3,954
R	2,908	88	57	127	0	2,580
S	2,521	759	303	14	0	1,396
T	1,623	371	151	0	0	1,092
U	314	12	5	253	0	37
V	116	24	10	0	11	72
W	107	23	19	6	0	44
X	55	19	14	0	6	16
Y	28	0	0	28	0	0
Z	14	0	0	14	0	0

- Questions to answer:
  - Which doctors spend more on testing?
  - On which tests do those doctors spend the most?
  - What levels of variation exists?

1 Need to normalise for patient base 2 Erythrocyte Sedimentation Rate

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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EXAMPLE

How an NHS hospital found procurement opportunities across all three levers of pharmacy spend

Lever category	Levers	Opportunity for improvement	Potential savings impact (%)
Purchasing power	• Competitive tenders and price negotiations • Purchasing consortia • Parallel imports	• Run tender exercises on drug classes with several therapeutic or generic alternatives • Leverage increased buying power of purchasing consortia • Capture the lowest possible prices from cross border drug trade while guaranteeing supply and quality	**3-5**
Demand changes	• Control of therapeutic creep • Therapeutic substitution • Generic substitution • Intravenous to oral switches • Enforcement of policies for TTA[1] and outpatient drugs	• Ensure that drugs are used within guidelines • Switch to most cost-effective product in drug classes with several therapeutic alternatives • Switch to most cost-effective generic alternative • Optimise intravenous vs oral delivery routes • Enforce compliance with policies for TTA[1] and outpatient prescriptions	**3-5**
Process changes	• Income control for drugs with special reimbursement • Waste reduction • Optimised distribution channels • Improve order-to-payment process	• Ensure full reimbursement for drugs that can be specifically charged for (eg improved coding) • Optimise patients' use of drugs and avoid waste • Optimise use of home delivery options and dispensing of drugs in community pharmacies • Ensure full contract compliance and avoid overpayment for drugs	**1-3** **7–13% savings achievable**

1 To take away

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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EXAMPLE

Levers considered by an acute trust to reduce fixed costs

Consolidate and increase efficiency of estates/assets

Levers	Actions to accelerate or consider
Close buildings	• Increase pace of decommissioning and exiting underutilised space • Sell land in order to release value to invest in capital projects
Cut operating costs of estates/ increase income	• Continue to negotiate energy efficiencies and drive for maintenance cost savings • Negotiate higher rents for tenants where possible
Re-purpose buildings	• Re-purpose for other medical uses (ie GP practices, private care)

Basis for the opportunity

- £600,000 in operational cost savings identified in recent estates plan by closing 10 buildings on the city campus
- Capture additional savings by closing larger portions of the site
  - Represents roughly 20% of the South site and leads to £160,000 in savings (15% of estimated utility bill)
- Least efficient buildings are closed first, therefore savings decrease as percent closed increases
- Closing
  - 30% of site could mean a 25% energy reduction (£250,000 savings)
  - 50% of the site could mean 40% reduction (£400,000)
- Land sales

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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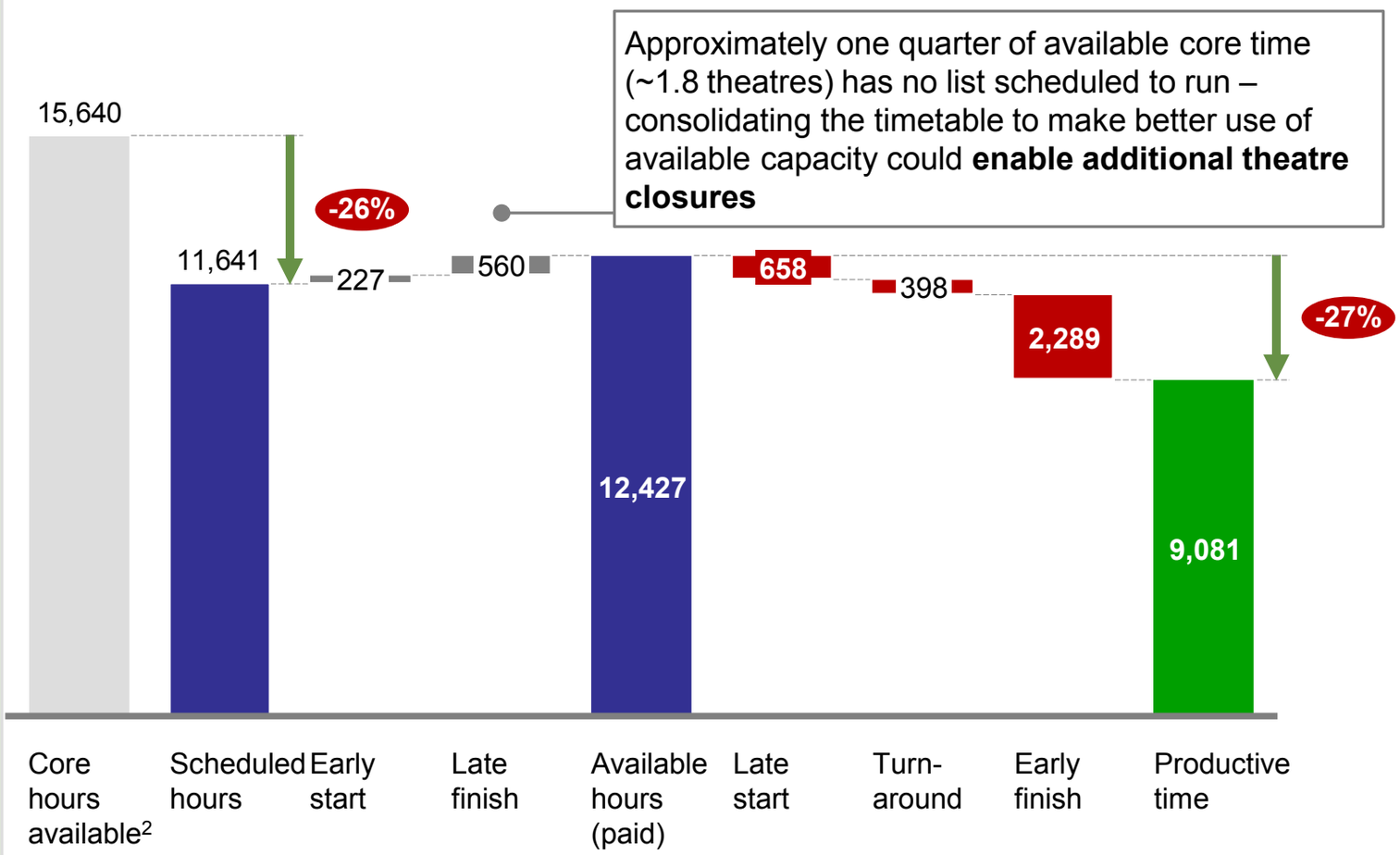
EXAMPLE

How an NHS provider reduced fixed costs by improving the use of fixed assets and its estate

Theatre usage and losses

Hours of theatre time[1]



Period of analysis from January – September 2013

Increasing 'core hours' represents running all theatres from 07:30 – 19:00, 5 days a week, every week → 15%

…would be worth…

Number of theatres

1

=

Number of WTEs[3]

10.5

=

Financial value

£0.6m

1 Period of analysis from January – September 2013
2 Core hours represents running all theatres from 07:30 – 19:00, 5 days a week, every week
3 Working time equivalent

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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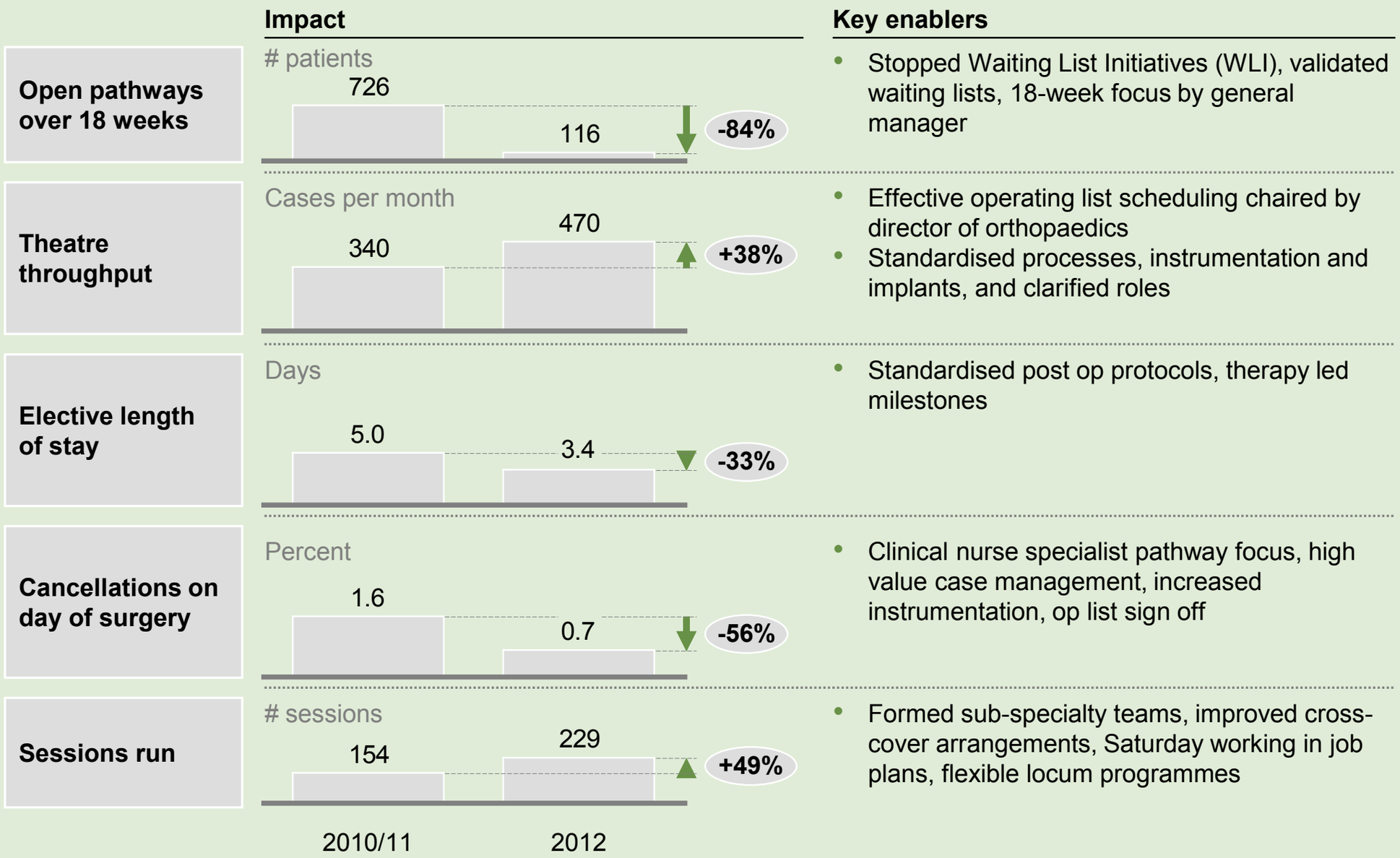
EXAMPLE

How a trust used a pilot to improve productivity and quality in one specialty



1 Average values in 2010/11 versus 2012 Jan-Dec

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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EXAMPLE

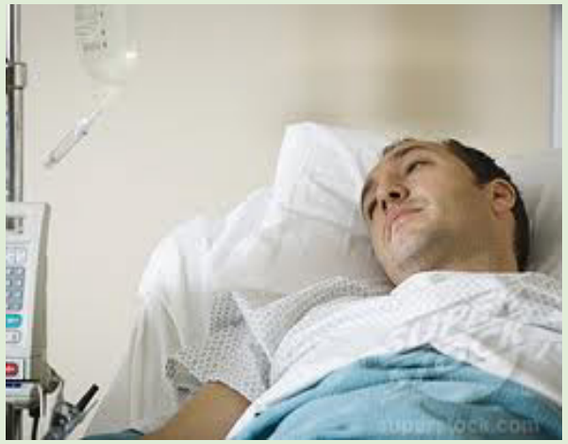
How self-care can play an important role: 63% of patients self-dialyse in Jonkoping, Sweden

Context

- Patients with kidney failure needing to come to hospital several times a week
- Little flexibility as to when the patients can come – leading to lower quality of life

How the solution works

- Patients manage entire dialysis process – have their own key card to the centre and can come/leave when they wish
- Encourage exercise and peer-to-peer support
- Convenience and greater sense of control
- Nursing staff role transformed



The impact

- 63% patients self-dialyse; target is 75%
- Reduction in side effects from self-dialysis
- Patients have dialysis more often
- Infection rates have declined
- 50–75% lower spend per patient

Video resource: www.youtube.com/watch?v=VEk-A3k98QA

Source: www.hpoe.org/resources/case-studies/1299

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EXAMPLE

How Narayana Health has standardised care pathways to improve quality and productivity at the same time

Context

- High quality tertiary and specialty care, including cardiac care and cancer treatment, are unaffordable for most of India's poor
- However, incidence of heart disease, cancer, and chronic conditions like diabetes, are projected to increase

The impact

- Low costs: surgeries at Narayana cost less than US$1,800 compared to US$5,000-US$7,000 on average in India; 30%-35% discount on medical supplies; brought down its prices by almost 35% since it started procurement; 22% of revenue spent on staff salaries vs. 60% in the West
- High quality: 1.27% mortality rate vs. 1% in US, 1% infection rate in Coronary Artery Bypass Graft (CABG) similar to the US
- Performed the second highest number of surgeries in a single facility in one day world wide

How the solution works

Narayana's process innovations include:

- **highly standardised** processes and protocols
- **assembly-line inspired surgery procedures**
- **right-skilling** of clinical workforce
- **telemedicine**

This enables Narayana to provide specialised care with quality outcomes that rival those of the UK and US at a fraction of the cost.

Foyer entrance on typical day

Telemedicine facility

Team during surgery

Video resources: www.youtube.com/watch?v=NfgrNCEN1RA; www.youtube.com/watch?v=is44fqWInsM

Sources: Khanna, Tarun, V. Kasturi Rangan, and Merlina Manocaran (2005; revised 2011) 'Narayana Hrudayalaya Heart Hospital: Cardiac Care for the Poor (A)'. Harvard Business School Case 505-078.
Prabakar Kothandaraman, P. & Mookerjee, S. (2007) *Healthcare for All: Narayana Hrudayalaya*. UNDP.
Cawston, T. (Undated) *High volume, specialist cardiac care in Bangalore, India*. Reform.

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EXAMPLE

How Kaiser Permanente's mobile health portfolio aspires to improve health and relationships between patients and their doctors

Electronic medical record

Messaging

Appointment scheduling

Location finder

Test result viewer

Source: Kaiser Permanente

Learning from published sources: UK and international

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EXAMPLE

How a managed care company uses telemonitoring to lower cost and improve care quality for long term conditions (LTCs)

Montefiore
Inspired Medicine

Context

- The Montefiore Health System is an integrated care delivery network with six hospitals, an extended care facility, cutting-edge primary and specialty care provided at more than 150 locations across the region, and a school of nursing.

The impact

- Telemonitoring saw a 50% participation rate and a 25% reduction in hospital utilisation of participating members
- Hospital in general highly ranked

How the solution works

- Telemonitoring program for heart failure patients and or/diabetes
- Designed to help patients monitor and manage their disease independently, reduce emergency room visits and avoid hospital readmissions
- The Telehealth device is a small machine, which connects to the patient's phone and allows them to monitor heart rate, blood pressure, weight, blood sugar, peak flow and oxygen levels on a daily basis. It will also ask 'yes' and 'no' questions related to symptoms
- Patients' daily health information is automatically and securely sent over the telephone line, and reaches the Telehealth nurse in less than 30 seconds
- The health data is reviewed and patients are contacted if there is an alert. Telehealth also alerts the patient's physician should they require a change in medication or treatment plan

Source: Litan. R, (2008) Vital signs via broadband: remote health monitoring transmits savings, enhances lives. Better Health Care Together.

Learning from published sources: UK and international

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EXAMPLE

Innovative technology to support the front line

Context

- Medical errors and incorrect diagnosis are a common feature in healthcare systems. The Institute for Health Improvement estimate that one in five diagnoses are incorrect or incomplete and nearly 1.5 million medication errors are made in the US every year
- Information is available to medical professionals to help improve decision-making
  - medical journals publish details of new treatments and discoveries every day
  - patient histories hold clues
  - electronic medical records contain vast amounts of data
  - this information could theoretically avert every improper diagnosis or erroneous treatment
  - Doctors do not have time to read every journal that could help them keep up to date with the latest advances.

How the solution works

- Watson is a computer that uses language recognition, hypothesis generation, and evidence-based learning to support medical professionals in making decisions
- Doctors use Watson to assist in diagnosing and treating patients
  - The doctor describes symptoms and other related factors; Watson begins by reviewing the input to identify the key pieces of information
  - The system supports medical terminology by design, extending Watson's natural language processing capabilities
  - Watson mines the patient data to find relevant facts about family history, current medications and other existing conditions.
  - It combines this information with findings from tests, examining all available data sources to form hypotheses and test them.
  - Watson can incorporate treatment guidelines, electronic medical record data, doctors' and nurses' notes, research, clinical studies, journal articles, and patient information into the data available for analysis.
- Watson will provide a list of potential diagnoses along with a score that indicates the level of confidence for each hypothesis.

Impact

- Can help doctors identify appropriate options tailored for individual patients
- Provides evidence-based insights to help researchers understand effects of therapies on certain patient cohorts
- Can help shorten time from research to practice

Sources: http://www-03.ibm.com/innovation/us/watson/pdf/MD_Anderson_Case_Study.pdf

http://www.ibm.com/smarterplanet/us/en/ibmwatson/implement-watson.html

Learning from published sources: UK and international

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EXAMPLE

10 productivity improvement ideas that had impact at a university hospital in Europe

How the solution works

1. Adjust staffing levels to fit actual work load by hour, day and week
2. Ensure all research is done on research funded time
3. Clean up physician schedules to focus on one task for at least 2 hours at a time
4. Fix the basics of patient flow; triage, rounds and discharge procedures
5. Visualise actual cost of diagnostics
6. Use nursing homes for long-stay low-complexity patients to free up time
7. Use drop-in for outpatient visits
8. Use all available time for production (7 am to 9 pm, Friday afternoons, weekends…)
9. Zone in on bottle necks to free resources – parallel processing, mobilising teams for fast clear-up, formalise responsibility for 'boring little tasks'
10. Implement simple, clear performance management visible to all staff at all times

Source: Anonymised European Provider Example; University hospital with two major sites in one city and over 1,500 patient beds

Learning from published sources: UK and international

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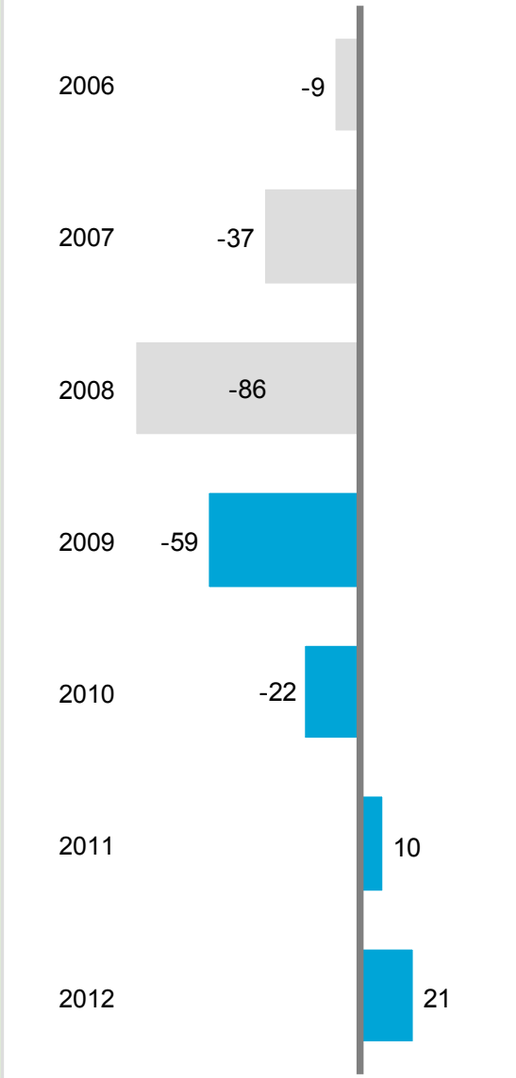
EXAMPLE

Productivity improvement programme: this European hospital experience shows that significant impact can be achieved within a relatively short timeframe

Significant impact on the bottom-line…
Net profit, € millions

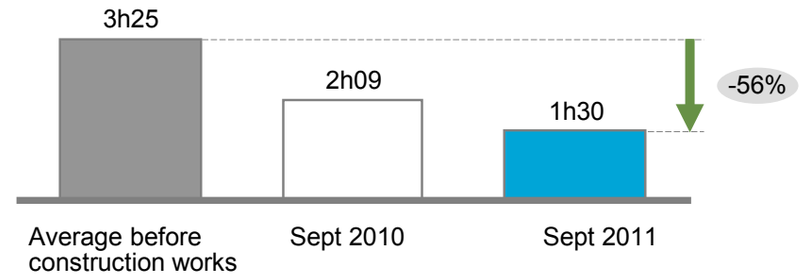


… through a holistic performance transformation…

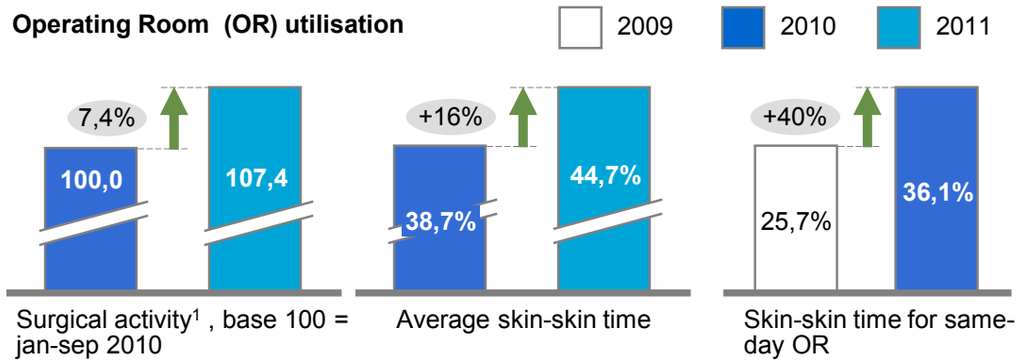
- Hospital construction works
  - A&E
  - Operating units
  - Laboratories
- Restructuration:
  - Surgical A&E
  - Care unit headcount
  - Medical salaries
- Medical project
  - Geriatrics and recovery
  - Digestive unit
  - Cardiology
  - Breast cancer
  - Ambulatory development
- Efficiency
  - Procurement
  - Central sterilisation
  - Central catering
- Other
  - Valuation of activities/coding
  - Invoicing and debt recovery
  - Valuation of real estate assets
  - Invoicing of private rooms
  - Marketing

… Which rapidly brought tangible results in operational performance

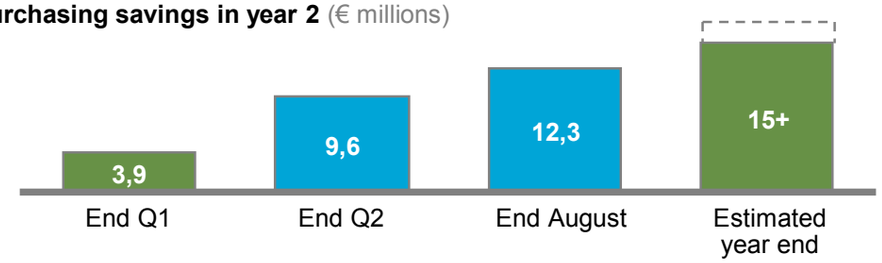
Paediatric Emergency Room throughput time



Operating Room (OR) utilisation



Purchasing savings in year 2 (€ millions)



1 Comparison Jan-Sept 2010 vs. Jan-Sept. 2011

Source: Anonymised European Provider Example; University hospital with five sites in one city and over 5,000 patient beds

Learning from published sources: UK and international

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Strategic theme 4 | Rebalancing your service portfolio through partnerships and mergers

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EXAMPLE

How an NHS provider debating the right portfolio of services considered five archetypes

	What	Services offered
1 **Major trauma centre**	• Specialised centres co-locating tertiary/complex services on a 24/7 basis • Serving population of at least 2 -3 million	• Neurosurgery, cardiothoracic surgery • Full range of emergency surgery and acute medicine • Full range of support services, ITU etc
2a **Major Emergency Centre (a)**	• Larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist hyper-acute services • Serving population of ~ 1-1.5 million	• Hyper-acute cardiac, stroke , vascular services • Trauma centre • Level 3 intensive care unit (ICU) • Moving towards 24/7 consultant delivered A&E, emergency surgery, acute medicine, inpatient paediatrics • Full obstetrics and level 3 neonatal ICU (NICU)
2b **Major emergency centre (b)**	• Larger units, capable of assessing and initiating treatment for the overwhelming majority of patients but without all hyper-acute services • Serving population of ~ 500-700K	• Moving towards 24/7 consultant-delivered A&E, emergency surgery, acute medicine • Level 3 ICU • Inpatient paediatrics • Full obstetrics with level 2/3 NICU
3 **Emergency Centre**	• Assessing and initiating treatment for most patients • Acute medical inpatient care with intensive care/high dependency unit (HDU) back-up • Serving population of ~ 250-300K	• Consultant-led A&E • Acute medicine and critical care/HDU • Access to surgical opinion via network • Possibly paediatric assessment unit and possibly obstetrics
4 **Integrated care hub with emergency care**	• Assessing and initiating treatment for large proportion of patients • Integrated outpatient, primary, community and social care hub • Serving population of ~ 100-250K	• GP and A&E consultant-led urgent care incorporating out-of-hours GP services • Step up/step down beds possibly with 48-hour assessment unit • Outpatients and diagnostics • Possibly obstetrics
5 **Urgent care centre**	• Immediate urgent care • Integrated outpatient, primary, community and social care hub • Serving population of ~ 50-100K	• As above but no beds

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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EXAMPLE

Another NHS provider considered what kind of elective centre it wanted to run

Type	Examples
1 **Independent, stand-alone regional elective hospital**	• Robert Jones and Agnes Hunt Orthopaedic Hospital • Royal National Orthopaedic Hospital
2 **Partnership elective centre**	• South West London Elective Orthopaedic Centre • Elective Orthopaedic Centre, Nottingham
3 **Cold site of a multi-site trust**	• Ashford and St Peter's Hospitals, Surrey • Calderdale and Huddersfield NHS Foundation Trust
4 **Elective centre co-located with a major acute**	• Lister Hospital, Stevenage • Nuffield Orthopaedic Centre and John Radcliffe Hospital, Oxford
5 **Independent sector treatment centre**	• Shepton Mallet Independent Sector Treatment Centre

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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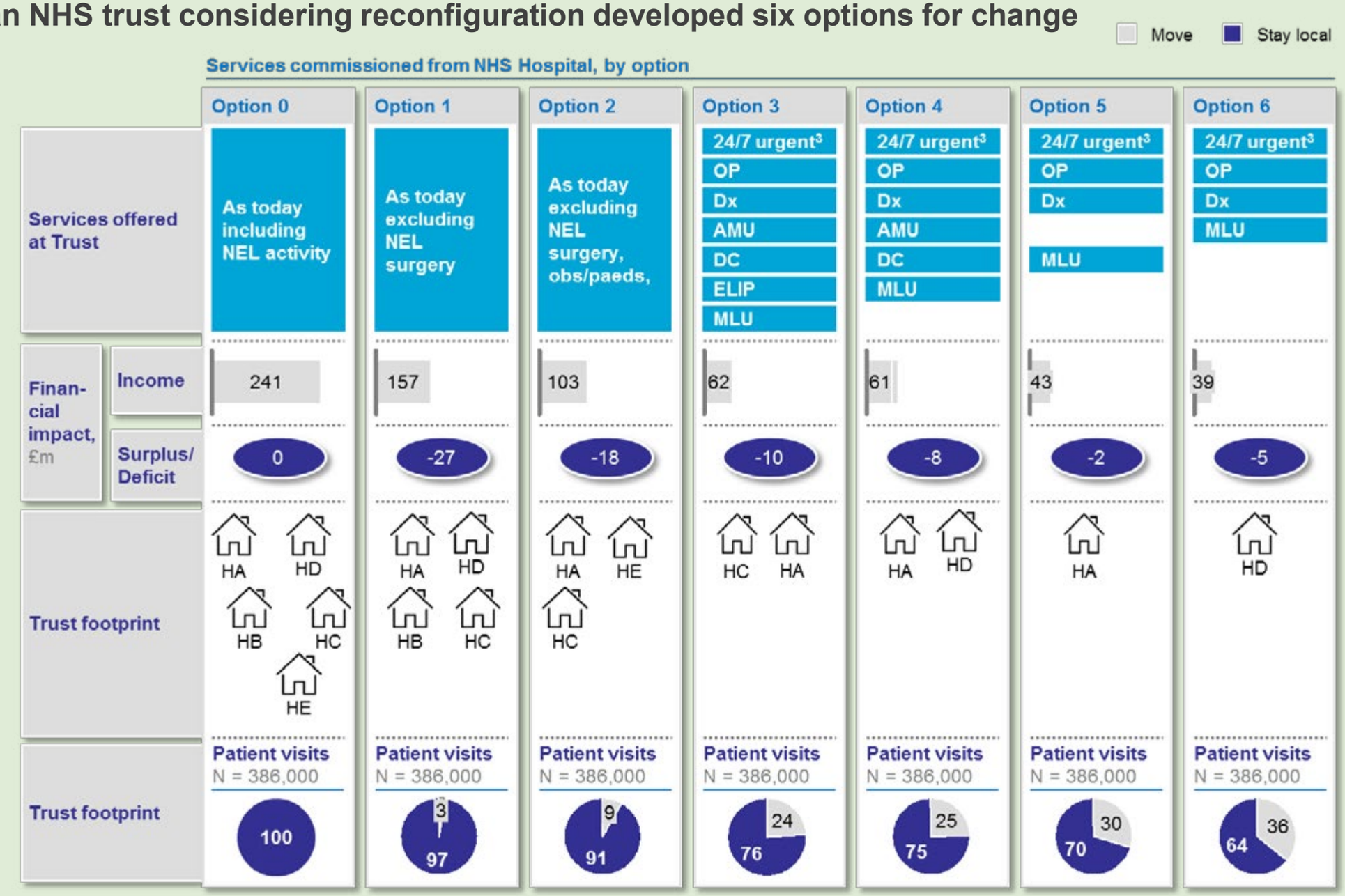
EXAMPLE

How an NHS trust considering reconfiguration developed six options for change



1 Excludes diagnostic activity 2 Would achieve a lower deficit under option 4b in which day case activity would be doubled
3 24x7 urgent care with 10x7 A&E consultant present

Source: Anonymised NHS provider example

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EXAMPLE

Benefits from vertically integrating services

Priority lever for trust

Levers		Benefits to hospital from integrated care
Re-venue	Change in activity	• Increased activity for community health service if trust chooses to develop such a service
	Revenue opportunities	• Capacity release in beds creates possibility to explore areas with higher margins and growth opportunities (eg, specialised care) • Positioning as 'lead providers' for selected services and receiving patients from other providers
Cost	Reduction of loss making activity	• Reduction above trim point in admissions (reimbursement at 30% tariff)[1] • Reduction in outpatient first to follow-up ratio and reduction in capacity
	Productivity improvement	• Reduction of length of stay for elderly people with long-term conditions due to earlier discharge, better support in the community, better co-ordination • Elimination of duplicated provider work (eg, single team into the home) • Stimulation of lower running cost mode (eg, click, call)
	Estate rationalisation	• Opportunity to decrease fixed costs by maximising use of selected estates and closing others where possible
	Corporate structure	• Simplification of reporting structures (eg, reduction of management overheads) • Eliminate duplicate functions

Trust plans to help commissioners in 2014/15 design a pathway to realise these benefits

1 Assumes that tariffs are levied in accordance with full Payment by Results guidance

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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EXAMPLE

How the RAID project in Birmingham reduced beds by 10%

What is RAID?

Highly visible multidisciplinary mental health team integrated into hospital

- 24/7 rapid assessment, interface and discharge service (RAID) providing single point of contact for all patients in hospital in A&E (1-hour response time) and ward (24-hour response time)
- Targeted interventions for adults of working age, substance misuse, older adult mental health
- Partnership working with third sector providers in and out of the hospital

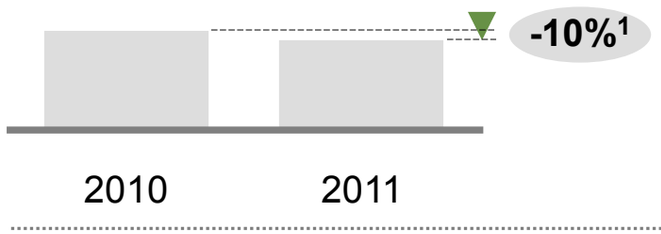
Key improvements

Five major improvements

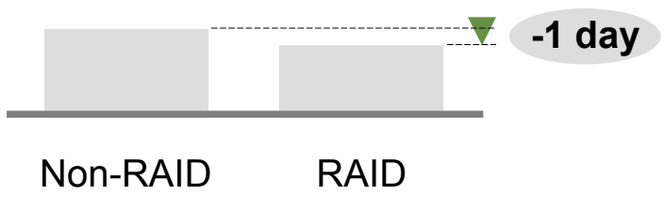
- Significantly increased patient referrals and assessments for in and out of hospital care
- Improved pathways to community teams and comprehensive clinical information now provided
- Earlier referral and identification of problems
- Improved clinical coding of inpatient episodes
- Formal & informal training to clinicians on mental health

Outcomes

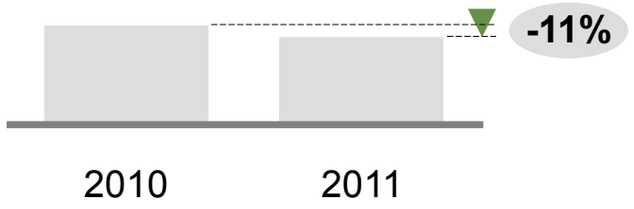
Bed-days



Average LOS



Emergency readmissions



Other indirect benefits

- Better clinician training
- Reduced average stay across hospital
- Reduced readmissions across hospital

1 Equivalent to two wards closed, assuming 30 beds per ward

Source: Birmingham and Solihull NHS Trust, HSJ 2010 Best Practice Report

Learning from published sources: UK and international

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EXAMPLE

Population-based model: international experiments with new reimbursement and risk-sharing models

		Selected examples
Full risk	‘Payer-led’ integrated network	Highmark Blue Shield; West Penn Allegheny Health System
	‘Provider-led’ integrated network	chenmed; ribera salud grupo; Kaiser Permanente; Geisinger Health System
Risk sharing	Accountable Care Organisation	CalPERS; CHW; Hill Physicians
	Episodes of care	Arkansas Health System Improvement
Gain sharing	Patient-centred medical home	CareFirst BlueCross BlueShield
	Pay for value	BlueCross BlueShield; Knappschaft

Learning from published sources: UK and international

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EXAMPLE

Fully integrated care: the Geisinger model

GEISINGER

Context

- Geisinger serves 2.6 million people in rural central and north east Pennsylvania; its patients are on average older, poorer and sicker than the national average, with high prevalence of chronic diseases
- Geisinger uses a patient-centred medical home (PCMH) model with Geisinger Health Plan (GHP) funded care co-ordinators and telemonitoring, shared information systems and best practice-defined episode-based payments for (some areas of) acute care

What was the scope of the care model?

- Geisinger Health Plan (GHP) is an open system: serving GHP enrollees (~33% of all patient care revenues), Medicare/Medicaid, Capitol Blue Cross, Coventry, Highmark
- PCMH aims to manage costs and quality for patients with chronic conditions, responsible for:
  - 80% of costs
  - 91% of prescriptions

What were the changes made?

- Enhanced PCMH model:
  - GHP-funded nursing care co-ordinator - navigator per PCMH practice
  - 24/7 phone access
  - telemonitoring
  - patient access to electronic health record (EHR)
  - Evidence-based pathways used to drive outcomes

How was the care model put in place?

- Shared information systems allow non-Geisinger providers (60% of provision) to view GHP patients' EHR
- Web portals facilitate data sharing between fragmented providers
- Regular practice-level performance reports and meetings to monitor results and drive improvement

How did payment reform support care model?

- GHP offers $1,800 per month to each physician to compensate for expanded scope of work; plus monthly stipends of $5,000 per 1,000 Medicare members to support extended hours
- Actual payments pro-rated based on percentage of targets met for 10 quality indicators

Impact

- 20% reduction in hospital admissions; 7% savings in medical costs
- ProvenCare episode-based best-practice payment system for coronary artery bypass grafts has led to a 67% reduction in mortality; 10% reduction in complication rate; 4% reduction in mean post-op length of stay

Sources: Geisinger Health System Annual Report, 2011 and website; Paula RA et al, Health Affairs, 2008

Learning from published sources: UK and international

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EXAMPLE

How Geisinger's medical home approach to chronic conditions reduced hospital admissions and medical costs

GEISINGER

Context

Region
Pennsylvania, US
Health system
Geisinger Health System (integrated system)
The challenge

- Geisinger's 2.6 million patients are, on average, poorer, older, and sicker than patients nationally
- Chronic care diseases are the leading cause of death and disability in Pennsylvania, accounting for
  - 80% of state healthcare costs and hospitalisations
  - 76% of physician visits
  - 91% of filled prescriptions
- Confronted with the challenge of using innovation to optimise health outcomes and reduce costs, Geisinger implemented the medical home approach

How does the solution work

Approach

- Geisinger used the medical home approach to improve outcomes and cost management for patients with chronic diseases
- The medical home organises primary care around the relationship between patient and personal clinician

Programme description

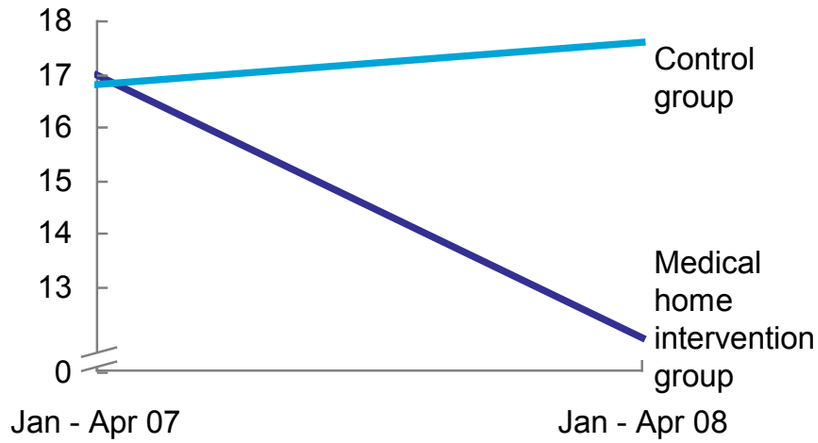
- The pilot programme from two sites included
  - 24-hour access to care services (enhanced by using nurse care co-ordinators, care management support, and home-based monitoring)
  - patient access to electronic health records (EHRs), allowing patients to view lab results, schedule appointments, receive reminders and e-mail providers
- Practice-based payments to compen-sate for extra work and additional staff
- Performance reports to monitor results

Impact

Productivity

- 20% reduction in hospital admissions
- 7% savings in medical costs
- Based on this success, Geisinger is expanding the initiative to 10 other practice sites and one non-Geisinger practice

Readmission rates in phase two of pilot



Time to impact
1-2 years

Key success factors

- Align incentives with physicians in care settings and from different health systems
- Apply EHR platform to ensure knowledge transfer throughout the system, and to those who know how to use and maintain it

Who could implement this initiative?

- A payer/system that pays for care, provider, or integrated system
- An organisation that has convening power and can leverage scale across providers

Sources: Geisinger Health System Annual Report, 2011 and website; Paula RA et al, Health Affairs, 2008

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EXAMPLE

Geisinger's ProvenHealth Navigator is an advanced medical home approach, ensuring round-the-clock access to a wide range of services

GEISINGER

a

Access to a set of basic services[1]

- Primary care
- Specialty care
- Geisinger-funded nurse care co-ordinator at each practice site

b

Predictive analytics to identify risk trends

c

A personal care navigator to respond to patients' inquiries

- Ensures application of evidence-based care
- Prevents further hospitalisations

d

Interactive voice response surveillance

e

Virtual care management support

f

Support for end-of-life decisions

1 Services are provided by Geisinger and vetted non-Geisinger referral providers

Sources: Geisinger Health System Annual Report, 2011 and website; Paula RA et al, Health Affairs, 2008

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EXAMPLE

ChenMed cares for patients with complex chronic care needs

- ChenMed is a family-owned primary care provider franchise based in Florida, but now operating from several states in the South East. It acts as a Medicare Advantage provider
- It was founded 25 years ago by a physician who saw an opportunity to provide better care at lower cost by focusing on proactive case management, barriers to adherence and incentives for clinicians to reduce avoidable hospital admissions

What was the scope of the care model?

- The programme is aimed at low to middle-income Medicare Advantage patients with complex chronic care needs:
  - 73% have ≥5 long term conditions
  - Average age 72 yrs
- ChenMed currently has 22 health centres

What are the differences with standard care models?

- Patients are offered high-frequency consultations (minimum 1 a month), enhanced services in a single location and free transport to appointments
- Doctors are offered small panel sizes (typically 1:400) and financial incentives to manage patient care out of hospital
- High staff-to-physician ratios support task-shifting

How was the care model put in place?

- The ChenMed model was developed over 20 years from a small base
- Clinician-led with strong organisational cultures and shared values
- Strong IT infrastructure supports care model
- Full capitation model with physicians taking on an increasing proportion of risk as they build experience with the system

What was the impact in terms of quality and costs?

- 38.2% fewer hospital bed days; 18% lower hospital admission rate and 17% lower readmissions rates compared to national averages for patient group; 73% medication adherence for people with diabetes, compared to 44% previously[1]
- Average Net Promoter Score of 92 in 2011 (30% of patients surveyed each day)

1 Medication possession ratio measured from 2009 to 2011 by University of Miami research team following introduction of new dispensing system

Sources: *Health Affairs*, 32, no.6 (2013):1078-1082; ChenMed website; Concierge medicine for the poorest, Forbes, 23/02/12

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Strategic theme 5 | Significant investment to support longer term aspirations

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EXAMPLE

A group of trusts considered the strategic options for the best organisational form to deliver their strategic goals through an academic health science centre… (1/2)

	Integration options	Description
Status quo	Continued collaboration (current state)	**Retain academic health science centre partnership, without further integration** • Trusts would keep all their own clinical services
Merger	1 Merger	**Merge NHS FTs into a single organisation** • Merge trusts into one organisation
Non-merger further integration options	2 Joint ventures in specific services	**Create joint ventures in specific services** • Create joint ventures in services displaying clinical and academic excellence • Trusts remain separate organisations
	3 Recast portfolios	**Change portfolio focus and assets of each trust** • Individual trusts take sole responsibility for delivering certain parts of the overall clinical, research and education portfolio • Trusts remain separate organisations
	4 Enhanced collaboration	**Create a joint venture organisation** with other partners

Sensitivities run on continued productivity improvement eg consolidate corporate functions and support services across trusts through insourcing or outsourcing solution

Source: Anonymised NHS providers

Learning from published sources: UK and international

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EXAMPLE

…and criteria to evaluate options for academic health science centres (2/2)

Criteria	Description	Potential sub-criteria
i **Clinical quality**	• What is the scale of the clinical quality benefit?	• Ability to deliver high-quality hospital and community-based clinical care responding to and meeting commissioner requirements • Ability to deliver integrated care across mental and physical pathways and improve population health
ii **Academic quality**	• What is the scale of the academic quality benefit?	• Ability to strengthen AHSC accreditation • Ability to deliver academic excellence in research and teaching • Ability to attract funding to support research and education • Ability to attract world-class researchers
iii **Financial impact**	• What is the scale of the net financial benefit?	• Financial sustainability of organisation(s) • Value for money (Net Present Value) • Transition costs • Capital costs } Affordability of the change
iv **Feasibility**	• Are there any legal or other barriers that make the option undeliverable?	• Ability of model to meet regulatory framework • Ability to staff roles • Effective, 'workable' governance • Internal capacity and capabilities to deliver change
v **Risk**	• How big are the practical challenges?	• Expected level of stakeholders' support • Requirement for external reviews • Level and duration of disruption and change
vi **Strategic fit**	• To what extent is the option consistent with other relevant strategies?	• Fit with commissioner strategies • Flexibility to form additional partnerships to develop strong academic health science network

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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EXAMPLE

How a group of trusts considering strategic options reviewed potential service change across all sites (1/7)

			Description by multi-site trust services on its sites			
			Site 1	**Site 2**	**Site 3**	**Green/Brownfield**
A	Standalone site: Status quo	Multi-site Trust: Status quo	As is	As is	As is	N/A
B	Standalone site: Increase in secondary acute services	Multi-site Trust: Low degree of service concentration3	As is	As is	As is	N/A
C		Medium degree of service concentration	Outpatients, diagnostics, UCC	Unplanned activity	Specialist elective & research activity	N/A
D			Unplanned activity	Outpatients, diagnostics, UCC	Specialist elective & research activity	N/A
E			Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	Specialist elective & research activity	Main acute activity
F			Unplanned activity	Specialist elective acute activity	Outpatients, diagnostics, UCC	N/A
G			Outpatients, diagnostics, UCC	Specialist elective acute activity	Outpatients, diagnostics, UCC	Main acute activity
H			Unplanned activity	Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	Main acute activity
I		High degree of service concentration	Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	Main acute activity	N/A
J			Outpatients, diagnostics, UCC	Main acute activity	Outpatients, diagnostics, UCC	N/A
K			Main acute activity	Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	N/A
L			Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	Main acute activity
M	Standalone site: Radical decrease in secondary acute services	Multi-site trust: low degree of service concentration	As is	As is	As is	N/A
		Multi-site trust: medium degree of service concentration	Outpatients, diagnostics, UCC	Unplanned activity	Specialist elective & research activity	N/A
			Unplanned activity	Outpatients, diagnostics, UCC	Specialist elective & research activity	N/A
			Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	Specialist elective & research activity	Main acute activity
			Unplanned activity	Specialist elective acute activity	Outpatients, diagnostics, UCC	N/A
			Outpatients, diagnostics, UCC	Specialist elective acute activity	Outpatients, diagnostics, UCC	Main acute activity
			Unplanned activity	Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	Main acute activity
		Multi-site trust: high degree of service concentration	Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	Main acute activity	N/A
			Outpatients, diagnostics, UCC	Main acute activity	Outpatients, diagnostics, UCC	N/A
			Main acute activity	Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	N/A
			Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	Outpatients, diagnostics, UCC	Main acute activity

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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EXAMPLE

Trust clinicians and managers developed evaluation criteria to assess these options (2/7)

Criteria	Question to consider
1 Do-able	• How easy is this option to implement? How much disruption will it create for patients and staff?
2a Quality of care	• Will this option support continued delivery of high-quality patient care?
2b Access to care	• What will be the impact on patient (and carer) access to care?
3 Clinical- teaching-research links	• Will there be better clinical-teaching-research links?
4a Affordable – capital expenditure & one-off costs	• Will this option require significant capital expenditure and transition funding?
4b Sustainable – income & expenditure	• Will this option be financially sustainable in the long term?
5 Actively supported	• Will this option be actively supported by staff, local public and political representatives?
6 Aligned with sector strategy	• How will this option tie to the sector's strategy and broader healthcare agenda, eg integrated care?
7 Platform for evolution	• Will this option create a platform for the AHSC vision and for the clinical vision?

Only considered in assessment of viable options (sift 3)

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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EXAMPLE

In the first filter process clinicians identified major feasibility and financial barriers to six options (3/7)

Lowest ranking options + Positive initial assessment - Negative initial assessment ⬭ Major barriers identified

	Option 1	1. Do-able	2. Impact on … A. Quality	2. Impact on … B. Access	3. Develop clinical-teaching - research	4. Financially … A. Capital/ one-offs	4. Financially … B. Annually sustainable	5. Have active support	6. Align with sector strategies
Status quo	A	++	-	+	-	++	- -	+(+)	- -
Limited concen-tration	B	+	+	+	-	+	- -	++	-
Slight concen-tration	C	+	+	-	+	-	+	+	-
	D	+	+	-	+	-	+	+	+
	E	- -	+	-	+	- -	+	+	-
	F	-	+	-	+	- -	+	+	+
	G	- -	+	-	+	- -	+	-	-
	H	- -	+	-	+	- -	+	-	+
High concentration	I	-	++	-	++	-	++	-	-
	J	- -	++	-	+	- -	++	-	-
	K	-	++	-	+	-	++	-	+
	L	-	++	-	+	- -	++	-	-
Radical decrease in secondary services	M	-	+	- -	-	- -	-	- -	- -

1 Greenfield refers to a separate location with the potential for redevelopment, not a location adjacent to an existing site; Option M can be used in addition to all dual and single-site options

Source: Anonymised NHS provider example

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EXAMPLE

Each option was evaluated and rated high, medium or low (4/7)

Criteria	Sub-criteria	Analysis
1 Do-able	• Disruption to clinical services • Ability to accommodate in available space • Compliance with planning guidelines	• % of combined bed base, • Planning guidelines assessment
2a Quality of care	• % current clinical issues identified that will be addressed • Clinical scale by site	• % top 20 clinical issues tackled • Average number of specialty spells per site
2b Access to care	• Average change in travel time • Trust A gain in activity	• Average and maximum travel time • % pop.<=5 min. blue light travel time • Travel time analysis
3 Clinical research and training	• Compatibility with trust existing investments • Clinical scale on each site	• All academic space remains co-located with Trust A • Total Finished Consultant Episodes per site
4a Affordable – capex and one-off costs	• Total capital expenditure • Stranded estate costs	• Capital expenditure required • m2 on Trust A sites used by other organisations
4b Sustainable – income and expenditure	• Accumulated losses • Likely financial position in future	• Accumulated losses by year 5 • Financial position in 5th year for Trust A; and 5th year for Trust B
5 Actively supported	• Staff support • Patient/political support	• Lost income • % new or refurbished estates • Number of hospitals retaining acute service
6 Aligned with sector strategy	• Re-consultation for stroke and trauma • Average activity/site, so that hospitals are sustainable	• Number of cases where re-consultation required for stroke and trauma • Change in the total cost base of the trust
7 Platform for evolution	• Compatible with Trust B moving to Trust C • Alignment with future service strategies	• Clinical space at Trust C • Objective assessment and rationale by clinical directors

All options will be scored on a relative high, medium, low scale

Source: Anonymised NHS provider example

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EXAMPLE

Summary of analysis for criterion 1: feasibility (5/7)

Options	Rating (H, M, L)	Rationale	Supporting Evidence: Cumulative increases in bed base on sites, #	Supporting Evidence: Planning guidance RAG rating	Supporting Evidence: New build, m2
1	H	• No new floorspace required, no patient disruption caused by service moves or building works	25	Green	-
2	H	• Limited new floorspace required to accommodate X Trust activity at Site 1 and minimal disruption to most patients	26	Green	-
3	M	• Moderate amount of new floorspace required at Site 2 and Site 3, some building work likely to cause significant disruption for some patients	402	Red	70,000
4	M	• Moderate amount of new floorspace required at Site 2 and Site 3, some building work likely to cause significant disruption for some patients	353	Amber	120,000
5	M	• Moderate amount of new floorspace required at Site 2 and Site 1, some building work likely to cause significant disruption for some patients	364	Amber	70,000
6	L	• Substantial amount of new floorspace required at Site 3, depending on greenfield development adjacent to Site 3 causing substantial patient disruption	705	Amber	130,000
7	L	• Substantial amount of new floorspace required at Site 1, depending on development of new clinical block and decant of office buildings causing substantial patient disruption	616	Red	130,000

Source: Anonymised NHS provider example

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EXAMPLE

Summary of analysis for criterion 2b: access to care (6/7)

Options	Rating 2 (H, M or L)	Rationale	Supporting Evidence Blue light travel time for trust patients (Minutes)
1	H	• >50% trust current catchment area has access to A&E within 5 minutes	Max: 8 Avg: 4
2	H	• >50% trust current catchment area has access to A&E within 5 minutes	Max: 8 Avg: 4
3	M	• 40-50% trust current catchment area has access to A&E within 5 minutes	Max: 8 Avg: 5
4	M	• 40-50% trust current catchment area has access to A&E within 5 minutes	Max: 8 Avg: 5
5	M	• 40-50% trust current catchment area has access to A&E within 5 minutes	Max: 10 Avg: 5
6	M	• 40-50% trust current catchment area has access to A&E within 5 minutes	Max: 8 Avg: 6
7	L	• <25% trust current catchment area has access to A&E within 5 minutes	Max: 10 Avg: 6

Source: Anonymised NHS provider example

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EXAMPLE

Summary of analysis for criterion: alignment with sector strategy (7/7)

Options	Rating
1	L
2	L
3	L
4	H
5	M
6	L
7	L

Rationale

The sector has identified priorities to help evaluate options

- Across Z Sector **A&Es need to be rationalised**
- Trust needs to provide a **specialist stroke centre at one of its hospitals**
- Future **services need to mirror the research** areas of local university and support the research agenda
- Another provider X needs to **fully utilise its current space**
- All options need to deliver a **financially sustainable future** for stand-alone provider X and trust

Source: Anonymised NHS provider example

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EXAMPLE

How one trust made its high-level assessment of organisational options for strategic initiatives

On balance, appears to be best option

	Advantages	Drawbacks
Stay as separate trusts	• Maximises focus on savings within each trust without regulatory or consultation distractions • Minimises distractions for managers and clinicians	• Clinical reconfigurations unlikely to happen without merger or commissioner funding agreement • Organisational loyalties and responsibilities make change difficult
Integration		
Merge early	• Enables service change operating under a single board and single set of priorities • Accelerates capture of benefits • Engage competition authorities early	• Risk to cost improvement programme while trusts are in a merger process
Merge while reconfiguring	• Reflects financial best case, if all service change and merger process can be completed simultaneously	• Extremely hard to do given conflicting guidance – service configuration requires open options while Monitor requires confirmed plans
Merge late	• Accelerate the urgent service reconfigurations as main priority • Avoids merger distractions (though competition authorities may engage on service change)	• As in 'stay as separate trusts' • Creates organisational anxiety and stress over personal futures • Risks to internal cost improvement programme during service reconfiguration

Source: Anonymised NHS provider example

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EXAMPLE

Different partnership models between healthcare providers and academic institutions: creating academic health science centres (AHSCs)

Type of partnership	Description	Operation of partnership
The Cleveland Clinic Lerner Research Institute Hospital owns academic centre	• Cleveland Clinic founded the Lerner Institute, its US$150m/ year research centre in 1978 and remains the sole shareholder • Teaching partnership with Case Western Reserve University	• Lerner Institute has own day-to-day governance with strategic direction set by the clinic board. Ultimately answerable to Cleveland Clinic for performance • Case Western relationship dates to 2002 and focuses mainly on teaching of medical students rather than research
Stanford Hospital & Clinics, Stanford University Medical Center University owns hospital	• Hospital moved to Stanford University's campus in 1959 • Stanford University purchased the hospital from the state government in 1968	• Hospital has own day-to-day governance with joint strategy setting process. Ultimately answerable to university for performance • Statute sets out which hospital decisions must be approved by university board of trustees
NewYork-Presbyterian, The University Hospital of Columbia and Cornell Equal partnership	• 'One hospital affiliated with two Ivy League Medical Schools' • NYP legally merged and run by a single board but two campuses retain individual relationships with their respective medical schools (Columbia and Cornell). No cross share-holdings	• Annual joint strategy meeting is prepared by series of lower level planning meetings as set down in formal terms of association • Boards of hospitals and medical school overlap – 'We all know each other' • Biannual retreat fosters open, trust-based relationship

The common thread is clear partnership agreements defining expectations and roles

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Strategic theme 6 | Strategic initiatives to strengthen the support structure for clinical services

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EXAMPLE

Strategic enablers agreed by one NHS provider to support its strategy

a **Board and quality governance**	• Programme for board development • Quality governance processes, including compliance with existing targets/national core standards
b **Clinical advisory group leadership**	• Programme to develop effective and inspiring leaders at all levels of the trust, starting with divisional leaders (medical, nursing, academic, operational)
c **Informatics and systems**	• IT systems to deliver relevant data in user-friendly formats (internal and external) – Collated across sites – Joined up quality, activity, finance, payroll
d **HR, organisational development and workforce**	• Effective human resources system • Culture of teamwork and partnership • Culture of improvement, innovation (through funding, empowerment, use of role models, appraisals)
e **Performance management**	• Annual planning/budgeting process with clear reporting lines and objectives/targets • Governance processes (eg schedule and focus of reviews, escalation, earned autonomy)
f **Estates optimisaiton**	• Estates strategy to support delivery of clinical excellence and financial sustainability

Source: Anonymised NHS provider example

Learning from published sources: UK and international

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Learning from other industries: non-healthcare examples

Radically different ways of doing things, adopted by organisations operating in very different contexts, can be a great source of learning and inspiration even if the examples do not translate to your FT's reality directly. Asking 'what if' is a very powerful technique for developing ideas which go beyond the obvious

You can look outside the healthcare field for inspiration, either formally – through case studies – or informally – through basic knowledge of how well-known businesses operate. Service industries, retail and any field that is significantly customer-facing will be tackling similar problems to those found in healthcare, and will be developing creative solutions. For example, hotels are innovating with self-service solutions for check in. High-street banks are using web-based and mobile interfaces for many customer transactions. Airlines and other industries have revolutionised operations through online booking, changes to workforce models and radical process redesign.

We have included four examples to show how learning from private sector companies could be applied to the NHS. These are intended only to illustrate the broader point that you can learn a lot by asking 'what could my FT learn from this successful business?'

- **Walt Disney World** adopted a strategy of 'customer first', with multiple actions to support it, and has become the world's most visited theme park as a result. Focusing on their employees – who they are, how they are motivated, what training they receive – has been the crux of their strategy. Many FTs strive to put the patient at the heart of their services and are thinking about how they can work with staff to make this vision a reality.

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- **Tesco** uses vast amounts of customer data collected through the ClubCard to develop its future strategies based on known current customer trends. Hospitals in the NHS and abroad are also starting to make significant investments in 'patient generated data' capture and use. US healthcare provider **Partners** has a dedicated Centre for Connected Health, where initiatives using patient generated data have led to significant quality and efficiency improvements for current patients, including a 50% reduction in heart failure-related readmission rates.
- **Toyota** is known for its dedication to Lean and 'just in time' working, ideas which many healthcare organisations have adapted for their needs. The talent management processes at Toyota can provide important insight into what factors need to be in place to truly have a culture of Lean. Multiple NHS providers have successfully adopted some aspects of Lean methodology.
- **Airlines** have continued to improve their safety records despite growing volumes and complexity: healthcare organisations can draw inspiration for their own safety improvement work from actions taken by the airlines.
- **Retail banks** have led a revolution in customer self-service for administrative tasks which do not require any specialist input and phone-based service for many other tasks. Primary care providers have adopted some aspects of this self-service approach – in some GP practices patients check in through an electronic board and outpatient departments in acute trusts are starting to use such systems. In Ireland, the MyMind social enterprise provides online booking and in-person or Skype-based mental health consultations.
- **Airlines such as EasyJet and SouthWest Airlines** have significantly changed staff roles in order to safely reduce workforce costs. Cabin crew now carry out a far wider set of tasks on and off flights than before. Healthcare providers have begun to adopt similar principles by reframing roles based on patient need, value added and skills required, rather than history or professional interests.

EXAMPLE

How focusing on the customer experience can generate significant impact

Walt Disney World

Situation

- Recreational resort in US
- Challenge was to become the world's most visited theme park

Actions

- Train entire organisation to put the customer at the centre by
  - recruiting caring people (eg interview three candidates at once to assess teamwork skills)
  - putting meaning into people's work (eg ensure employees' opinions are heard)
  - using experiential learning (eg offer training programs)
  - aligning organisation (eg align employee incentives to quality of guest interactions)
  - employing line-of-sight leaders (eg use of upward feedback)

Impact

- World's most visited theme park in 2010 (~47 mln visitors of which 70% are returning guests)
- Continued growth in number of visitors by 3.2% over 2003-10 vs. market growth of 1.4%

Getting customer ('guest') feedback at Disney

Quantitative

- Face-to-face surveys, eg guests entering and exiting are polled on their visit as well as on pertinent demographic information
- Telephone surveys, eg used as a follow-up tool for guests staying on property
- Utilisation studies, eg did more guests come through Pirates of the Caribbean before or after noon?

Qualitative

- Listening posts, eg a cast member on the steps of City Hall at the *Magic Kingdom* Park listening for feedback
- Focus groups, around questions like "What rides and attractions would you like to see in our parks?"
- Shoppers programme

Quantitative and qualitative

- Comment cards, guest letters, emails, which reveal comments like "…just writing a note to tell you that I was very impressed with Mary, who was our housekeeper"
- Social media is monitored to see what is being said by whom, about what, and when. This gives the ability to measure the real-time guest experience and react immediately

Source: www.iaapa.org and https://disneyworld.disney.go.com

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EXAMPLE

How customer-generated data can help organisations to understand customers and inform strategic decisions

Context

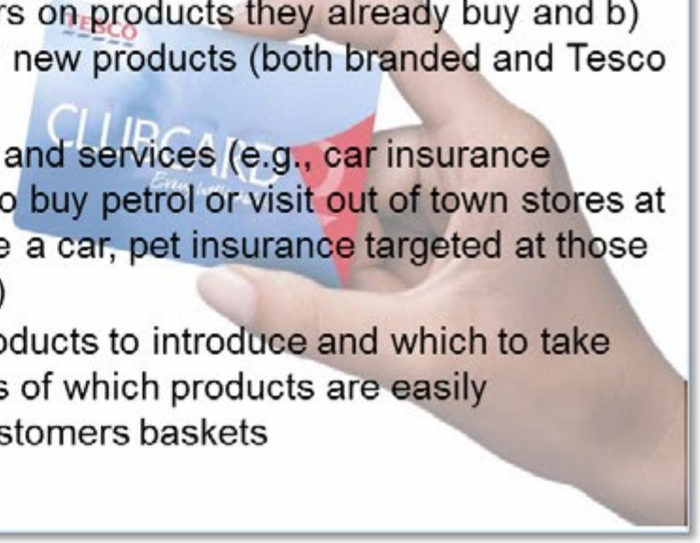
- Grow business and understand customer needs

The impact

- Grew market share by ~15% since 1994
  - Saved £300 million in promotion expense while increasing market share
  - Cost per redemption decreased by 50%
- Deliver strong performance results:
  - 75% decrease in customer complaints
  - 10 times increase in coupon redemption rates from pre-Clubcard rates (~3% to 20%-40%)

How the solution works

- Use big data in order to better understand customers allowing for better laid out stores and customized advertising
- Clubcard has ~ 15 million members and 80% penetration in terms of sales
  - Members have access to late availability and limited stock offers across categories including holidays, tickets and clothing
  - Insights collected through clubcards used to do things like:
    - Segment the customers into groups based on lifestyle, life stage and loyalty
    - TESCO send individually targeted coupons to shoppers to a) reward them with offers on products they already buy and b) encourage them to try new products (both branded and Tesco private label)
    - Launch new products and services (e.g., car insurance targeted to people who buy petrol or visit out of town stores at night so probably have a car, pet insurance targeted at those who buy pet food etc.)
    - Identify which new products to introduce and which to take out, based on analysis of which products are easily interchangeable in customers baskets



Source: Advanced Performance Institute Delivering success How Tesco is Managing, Measuring and Maximising its Performance

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EXAMPLE

How healthcare providers are beginning to make significant investments in patient generated data

Partners Centre for Connected Health (CCH)

- **Mandate:**
  - Create and validate technology-enabled solutions that empower patients and providers to transform health
- **Organisational model:**
  - CCH functions as the centralised body for programme development, working most closely with Partners Information Systems organisation
- **Focus areas**:
  - Chronic disease conditions; health and wellness; adherence, engagement, and clinical outcomes
- **Current initiative:**
  - Activity and wellness
    - Step Up: Virtual Coach
    - Partners Step It Up
    - Texting for Steps
  - Cardiac care
    - Connected Cardiac Care
    - Blood Pressure Connect
  - Dermatology
  - Diabetes
    - Diabetes Connect
  - Mental health
  - Remote consults and virtual visits

Differentiating factors

- **Recognised as a pioneering leader in the field:**
  - First to successfully integrate patient-collected data into its medical record system
- **Organisation emphasises interdisciplinary approach to development:**
  - Currently consists of nearly 60 clinicians, technologists, researchers and business strategists
- **Offering in the future will have lower concentration in mobile relative to other top systems:**
  - Research at CCH showed much lower mobile ownership in the target populations, which has influenced their strategy

Results and return on investment

- **"[Our aim]is to improve care, increase patient self-management and decrease cost**
- **Research:** The Centre has generated >100 scholarly publications
- **Results:**
  - **Heart Failure**
    - >1,200 enrolled patients
    - 50% reduction in heart failure related readmission rates
    - 44% percent reduction in non-heart failure readmission rates
    - Cost savings of more than $10 million since 2006
  - **Diabetes:** Self-reported HbA1c fell from 6.8% at the start of the study to 5.8% at the end

Source: http://www.partners.org/

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EXAMPLE

How Toyota's talent management underpins its success in sustaining a culture of 'Lean'

Culture and supporting elements	1. Establish clear measurements, targets, and accountability	2. Create realistic budgets and plans	3. Track performance effectively	4. Hold robust performance dialogues	5. Ensure rewards, consequences, and actions
• Consistency of approach – Homogeneous culture with emphasis on corporate wellbeing and respect for humanity – Common problem solving approach: 'the Toyota way' – Standardisation of all activities to smallest detail – 'Kaizen' (continuous improvement) mindset	• Targets are set top-down and cascaded down organisation: – Reliant on management's deep knowledge of the businesses • Challenging targets, conferring both respect and opportunity to achieve: – Facilitated by culture of mutual trust • Based on continuous improvement targets and business needs • Requirement that targets are under control of managers and linked to value creation	• Plans developed bottom-up: – Plan for achieving targets developed using proposals from the front line • Iterative process	• Strong focus on operational as well as financial measurements • Measurements cascade down organisation • Data on performance is freely available	• Discuss actual performance vs. plan • Where there are deviations from plan, managers have already prepared plans to solve problem • Follow a formal structure • Act like you would in coaching sessions: – Focus on collaborative problem solving – Emphasise mutual respect • Limited interventions for underperformance	• Clear link of performance to rewards

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EXAMPLE

How one global airline continues improving its safety record despite increased complexity and growing demand

Context

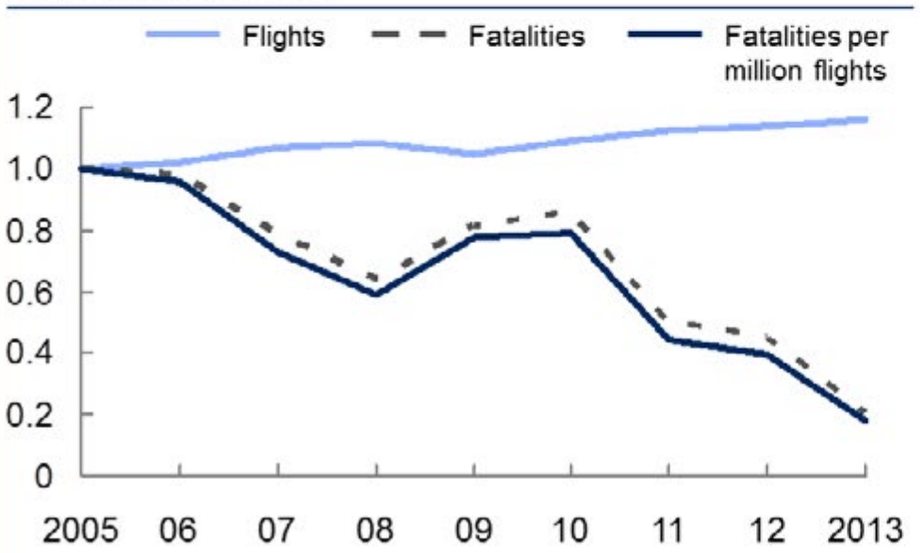
- The global aviation industry is built around a technologically complex system that has become so safe that air travel is routinely taken for granted

The impact

- Between 2005 and 2013, the number of global airline flights increased by 16%, from 27.3M to 31.6M
- Over the same period, the number of global aviation fatalities per year dropped by 79%, from 824 to 173
- In 2013, there were just 5 fatalities per million flights

Air travel fatality rate

Indexed to 2005 = 1.00



How the solution works

- Although extremely rare, airline accidents typically are the result of a sequence of relatively insignificant events that by themselves are not serious, but eventually result in dire consequences because pilots fail to recognize the true nature of the problem and to take the appropriate corrective measure(s)
- Like the medical profession, becoming a licensed airline pilot requires years of training, the acquisition of practical experience, successful completion of rigorous certification standards and mandatory recurrent training
- A successful outcome when things do go wrong is a function of: (1) prompt problem recognition, (2) coordinated problem solving, (3) selection of proper remedial action, and (4) strict adherence to checklists and standard operating procedures

Source: Disguised global airline example

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EXAMPLE

Some retail banks have explored new approaches to reduce the administrative tasks carried out by branches, and expect this trend to continue (1/2)

Next-generation ATMs

Functionality: ATMs with functionality for over 50 banking transactions including

- Cash deposits (instantly transferred to account)
- Bills payment directly at ATM
- Topping up of mobile pre-paid contracts for Turkcell, Avea and Vodafone

Automated branches

- **Futuristic design:** equipped with information stations, latest generation ATM5 and a private interactive room ensuring complete confidentiality (advisors available via video)
- **Interactive banking experience:** visitors browse products and services and apply instantly

Completely new digital and mobile bank

- **Fully mobile:** New account can be opened directly from mobile app, which includes mobile sales offers and replicates online banking
- **Additional features:** App includes advanced functions like ‘Easy transfer’ (P2P transfer function) and budgeting tool
- **Customer migration:** Existing BNP Paribas customers can easily migrate to ‘Hello bank!’

Source: Bank websites

Learning from published sources: UK and international

Examples from healthcare providers under each strategic theme

Learning from other industries: non-healthcare examples

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EXAMPLE

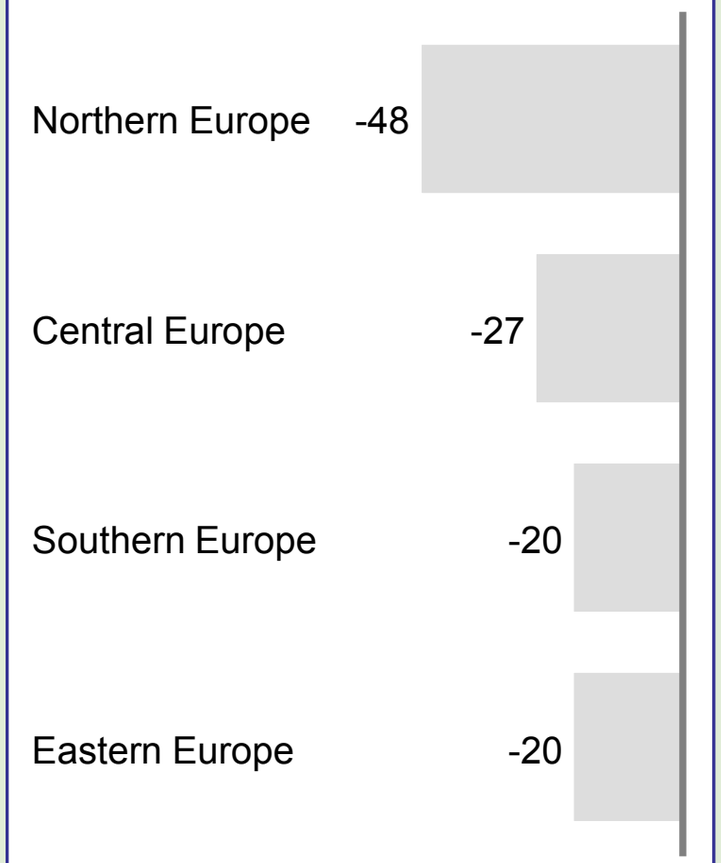
Some retail banks have explored new approaches to reduce the administrative tasks carried out by branches, and expect this trend to continue (2/2)

Sales activity
percent of sales

Activity in percent — Branch — Other channels

Today	Payment **transactions**	15	Role of the branch includes transactions, services, and advising
	Sale of **simple** services and products	50	
	Advising and sales for **complex** products	100	
5 years	Payment **transactions**	10	Significant shift into digital channels in line with market research
	Sale of **simple** services and products	30	
	Advising and sales for **complex** products	65	
10 years[1]	Payment **transactions**	<5	Exponential development in digitisation branch demand primarily for specialised advising
	Sale of **simple** services and products	<5	
	Advising and sales for **complex** products	30	

Expected decline in branch visits 2011-16
(percent)



1 Indicative

Source: ATM/cash desk reporting for digital branch business; European Financial Management Association (EFMA)

Learning from published sources: UK and international

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EXAMPLE

How a trust in London implemented a nearly fully automated outpatient reception

- This trust has redesigned its outpatient model based on an airport lounge
- Automated arrival and check in systems are used for the majority of patients with staff available for those who cannot use the technology
- A scheduling system 'pulls' patients to the correct room using electronic boards without prompt from staff in reception

"We could double our throughput and halve our footprint in outpatients and still deliver a much better experience"

Main benefits

- Puts the patient in control of the process and increases doctor–patient time and interaction
- Reduces staff costs in outpatients
- Creates a calmer environment

Potential barriers

- Puts more onus on doctors to be punctual and reliable
- Challenges the received wisdom that 'busy is good'
- Requires investment in IT and clinic space

Source: Anonymised NHS provider example

EXAMPLE

How MyMind increased access to mental health services in Ireland

Context

- Poor access to mental health professionals in Ireland:
  - Public system requires a GP referral, and waiting times often over 12 months
  - Self-pay (private) care is by self-referral, and waiting time is much shorter, but costs ~€80 per session with psychologist/counselor, €100+ with psychiatrist
  - Just as early access to support can quickly resolve a problem, waiting often exacerbates it
- Mental ill health costs the state an estimated 3% of GDP, mainly through loss of productivity
- MyMind is a mental health social enterprise established to address this need

Impact

- Clients seen within 72 hours
- Served 2,500 clients (average age between 25 to 45) in 2012, presenting with:
  - depression (31%)
  - anxiety (18%)
  - Relationship issues (12%)
  - stress and anger (8%)
  - other (30%)
- Patients have access to 80+ mental health professionals (psychologists, counsellors, psychotherapists, psychiatrists)

How it works

- Exploits simple modern technology to broaden service reach and make the patient journey easier:
  - Self-referral online
  - Clients browsing the website are invited to chat live with a counsellor, who can point them in the right direction
  - Book appointments online or by phone
  - Once booked, see a professional in person, or over Skype
- Uses profits from fee-paying clients to subsidise those less able to afford their services:
  - €50 full-price sessions
  - €20 benefit sessions for medical card holders and unemployed
  - Free sessions for clients in need
- Caters for cultural minorities – services offered in 15 languages

Video resource:

www.youtube.com/watch?v=zV3b7zniB1w

Source: http://mymind.org

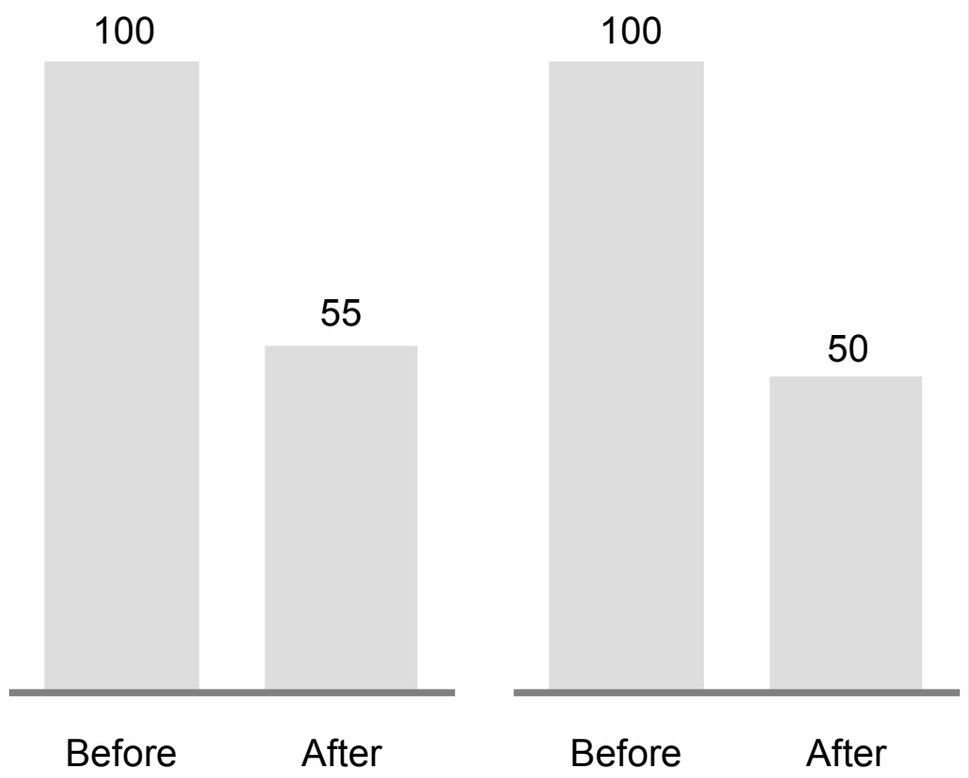
EXAMPLE

How two airlines changed traditional roles to reduce time on the ground

Cabin crew's role has changed in two ways …

	From	To
Cabin crew's role on the ground	• Responsible for their own section with no view of overall process progress	• Understands overall aim • Welcomes cleaning/catering into aircraft directly after last passenger disembarks • Steers cleaning/ catering – defines what needs to be done
Cabin crew's role on the flight	• Single area of concern was catering in the air, not clean up	• Selects trolleys for exchange • Moves trolleys to front galley if possible for easy cleaning • Pick up rubbish as landing

… reducing time needed to clean and cater on the ground



Impact: reducing turnaround times for cleaning and catering from 7 mins to 4 mins

easyJet

Both EasyJet and SouthWest have a 20 min turnaround against average of 40 min for the industry

SOUTHWEST AIRLINES

Learning from published sources: UK and international

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Monitor
Making the health sector
work for patients

Prioritise

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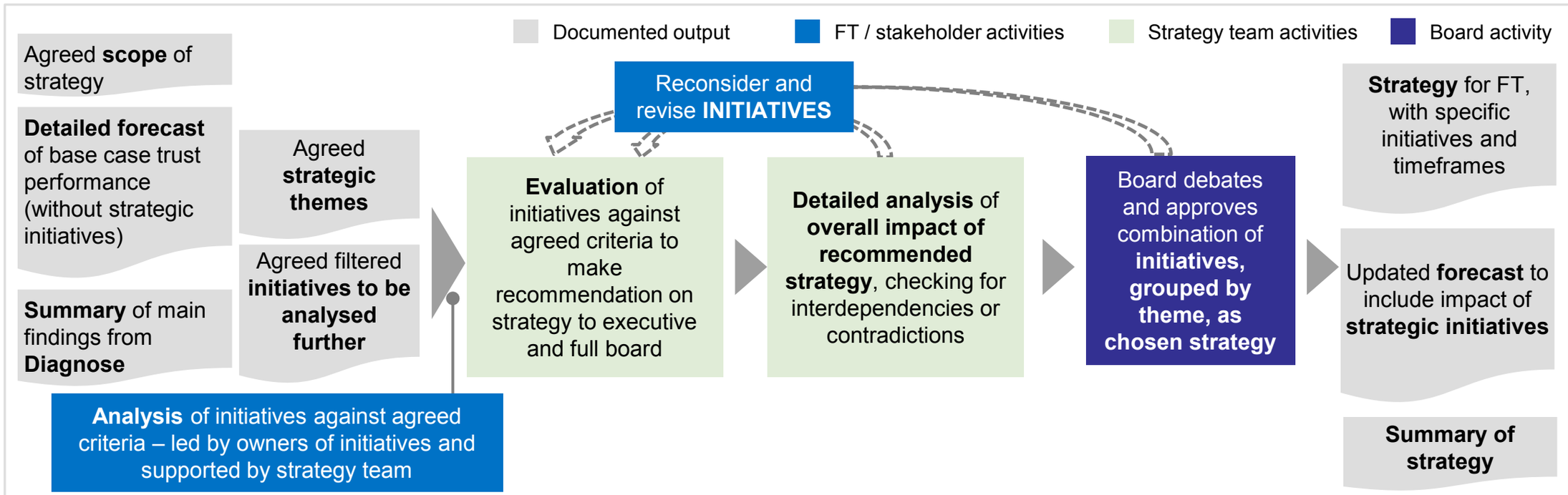
Introduction

The Prioritise stage involves deciding which strategic initiatives the FT will pursue to meet its goals by prioritising from a filtered list of initiatives that was produced during the Generate Options stage. To decide which of these initiatives to pursue, and therefore decide your strategy, you will do detailed analyses of the feasibility and impact of the initiatives and understand the interdependencies between them.

At a service line level, it is at this Prioritise stage that individual service's reviews and ideas for change would be compared against each other to ensure the consistency and coherence of FT's strategy overall. Work on understanding what strategic changes would be in the best interests of patients and best help meet the FT's overall goals will have been done within each service line during the Generate Options stage. Whereas in Prioritise the task is to make clear choices between the different options. A worked example of this overall process at service line level is included in this Prioritise part of the toolkit.

Following the choice of an overall draft strategy, you will need to calculate its impact on the FT's performance overall. The results of this analysis will either confirm that the strategy should be pursued or suggest additional work.

The process flow below shows the steps described and emphasises that the Prioritise stage is likely to be an iterative process.



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Modelling the impact of initiatives

At the Generate Options stage you produce a list of possible initiatives aligned to the selected strategic themes and filtered from your original longlist on the basis of high-level analyses, estimates or conversations. At the Prioritise stage you subject your initiatives to more intense scrutiny through detailed analyses against agreed criteria. This builds a detailed rationale for each initiative. Below are seven analyses you might conduct.

- **Estimate overall impact on quality outcomes.** Undertake a quality-impact assessment for each initiative. This could combine impact on a common set of priority measures (such as regulatory standards, mortality indicators, patient experience) with quality goals that are more specific to each initiative.
- **Assess the initiatives' financial impact as well as their costs, to develop a high-level business case.** The financial impact of all your initiatives should be assessed in terms of operating-income changes, operating-cost changes or capital investment required, and the net contribution to income and expenditure over future years. Include details of facilitating or transition costs. For major investments, calculate net present value.
- **Estimate the ease of implementation and the timescales.** Include factors such as the level of project management support needed, the internal and external resistance to change, the need to recruit new staff, alignment with contractual requirements, the level of clinical staff support, and the estimated timescale for achieving full implementation.
- **Evaluate against additional agreed criteria.** As well as analysing financial and quality impacts, you should also return to any other strategic decision criteria you set out in Frame and refined in Generate Options.

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- **Consider competition issues**. When developing strategic options that involve working with other providers, such as through mergers, acquisitions, joint ventures, service transfers, asset swaps, networks or management agreements, it is important that the proposed changes are based on a sound understanding of how they will benefit patients, particularly if they have the potential to raise any competition issues. It is important that the proposed changes are based on a sound understanding of why they are the best way of delivering improvements to services, particularly if they also have the potential to have adverse impacts on patients
- **Consider risk.** Your risk assessment will have two dimensions. The first is assessing the impact of each initiative against existing risks and the second is identifying new risks associated with each initiative and setting out thoughts on the degree to which these risks could be mitigated.
- **Carry out a sensitivity analysis.** A good strategy should be robust enough to succeed even if the external environment changes unpredictably. A recommended approach at this stage is to choose two or three of the most likely scenarios and examine the ways their effects would differ from the scenario that you are using for baseline assumptions. Test the sensitivity of your analysis for each initiative according to these other scenarios and assumptions.

The next page provides an example summary analysis template. It uses the same questions as for the longlist of initiatives but the answers need to be at a far greater level of detail. You would usually aim to collect information at this level for all initiatives you may decide to pursue fully. If you eliminate some initiatives early on as the result of an initial prioritisation exercise and without completing a template, you should still be able to articulate why they were eliminated. This is especially important for making sure that colleagues and patients who contribute ideas have a clear sense of how their ideas are then analysed and prioritised.

The following pages provide some sample analyses.

Example summary analysis template

Rationale	Evidence base
Which strategic theme is this initiative going to address?	How do you know that this will have the expected impact?
Description of initiative	
What is the idea? How will it work? What area of the FT does it impact?	
Potential impact	**Estimate of costs and timeframe required**
What do you expect the impact to be? 1. On quality 2. On finances 3. On other factors (eg workforce satisfaction) **For the filtered initiatives you will need to develop separate supporting analyses to explain how you made this assessment**	What will this cost to implement – one-off and ongoing running costs? How long will it take to fully implement this, and to achieve the results set out in impact section? **For the filtered initiatives you will need to develop separate supporting analyses to explain how you made this assessment**
Risks and feasibility for your FT	**Key stakeholders**
How easy will this idea be to implement? Describe barriers and mitigation. What could go wrong? Be explicit about new risks and score them. Which existing significant risks will it address?	Who has been involved (internal and external) in developing the initiative so far? Who should be consulted before we decide whether to go for this idea?

Further analysis would underlie these answers

The summary page for each initiative will need to have detailed supporting analyses to justify each answer

Impact assessment on quality, on financial performance dimensions based on supporting analyses

Other operational performance impacts summarised – based on more detailed supporting analysis

Output for each initiative: summary of impact

Description of initiative *What are you proposing to do differently?* *Which strategic theme does it support*	**Evidence base** *How do you know that this will have the expected impact?* *Is there independent evidence that this will work?*
Area affected *Description of initiative*	
Potential impact *What do you expect the impact to be?* *1. On quality* *2. On finances* *3. On other factors* *Provide summary analysis*	**High-level estimate of costs & time-frame required** *What will this cost to implement – one off and ongoing running costs?* *How long will it take to fully implement this and achieve the results set out in impact section?*
Risks & feasibility for your FT *How easy will this idea be to implement? Describe barriers and mitigation.* *What could go wrong? Be explicit about new risks and risk score them.* *Which existing significant risks will it address?*	**Key stakeholders** *Who has been involved)internal and external) in developing the initiative so far?* *Who should be consulted before we decide whether to go for this idea?*

Evidence-base for impact could include internal pilots, case studies, expert reports, or clinical research articles

Timescales for each initiative, taken from basic Gantt charts or other timeline estimates

Quantified risk and impact, with extent of mitigation possible, for each initiative. Feed score in from standard risk matrix

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A summary across all initiatives can help prioritise between different initiatives

Strategic theme	Name of initiative	Net Impact: Quality	Net Impact: Ongoing impact on income net of costs	Net Impact: Risk[1]	Feasibility: One-off implementation cost	Feasibility: Time	Feasibility: Capability
Theme One	Initiative One	Reduce pressure ulcers by 20%	↓ -2%	5	£250,000	3m	1-week training needed for nurses
	Initiative Two	Reduce in-patient mortality by 15%	↓ -1%	15	-	1y	Capability exists
	Initiative Three	Reduce HCAIs by 30%	→ 0%	10	£12,000	6m	New consultant needed
	Initiative Four	Improve Friends & Family by 20%	→ 0%	5	£170,000	7m	Capability exists
Theme Two	Initiative Two	Achieve CQC outcomes 4	↓ -1.5%	15	-	2y	Workshop needed
	Initiative Three	Achieve CQC outcomes 10 & 11	→ 0%	20	£190,000	18m	Analytical support required
Theme Three	Initiative One						
	Initiative Two						
	Initiative Three						
Theme Four	Initiative One	-	↑ 18%	10	£600,000	1y	New clinical skills required
	Initiative Two	-	↑ 7%	5	£270,000	6m	Experienced manager required
	Initiative Three	Reduce unnecessary admissions	→ 0%	10	£190,000	7m	Capability exists
Theme Five	Initiative One	Reduce unnecessary admissions	↓ -3%	25	£140,000	2y	Capability exists
	Initiative Two						
	Initiative Three						

Some initiatives / themes were filtered out at the end of the Generate Options stage

Further analysis would underlie this chart

1 Eg via New Zealand Risk Scores

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EXAMPLE

An assessment of how initiatives to increase collaboration between two trusts were expected to benefit patients and commissioners (1/2)

Aligning with national guidance

- Senior presence 24/7
- Reduced time to intervention and diagnostics
- 24/7 heart attack centre
- 7-days stroke/transient ischaemic attack (TIA) physician rota
- Sustainable acute surgery rotas

Creating centres of excellence

- Compete on a national level
- Enhanced and new/refurbished maternity services with level 3 neonatal intensive care unit
- Potential improvements (subject to consultation) to cancer centre, stroke centre, cardiac centre

Maximising patient care

- Higher quality and better evening and weekend care
- Maintaining two strong hospital sites
- Shifting scarce resources from duplicated overheads to patient care, eg haematology

Supporting commissioner intentions to improve health

- Support plans to shift care out of hospital
- Enable cost savings to manage lost hospital income
- Create consistent patient pathways

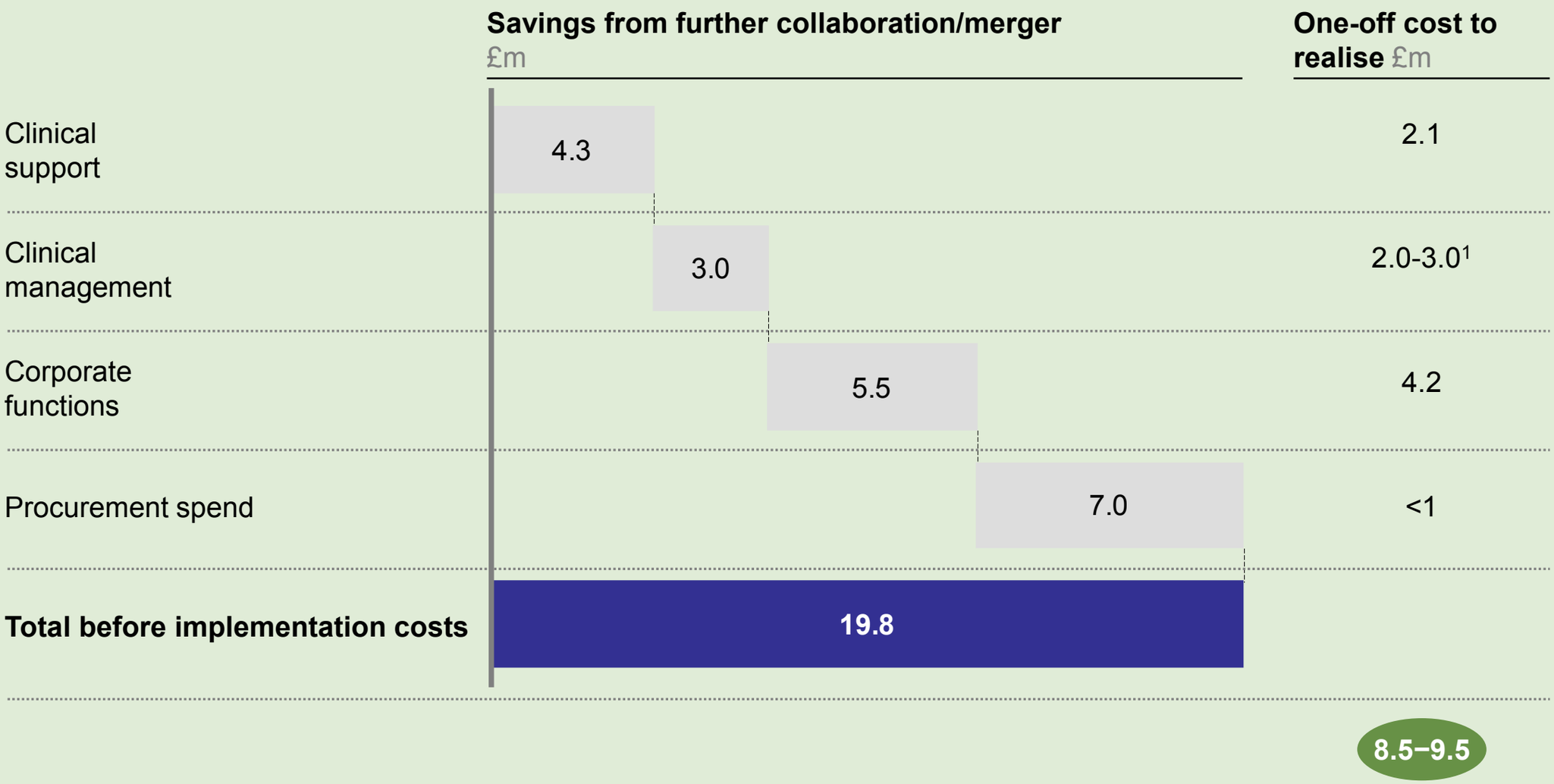
Improving joint working and integration

- Increased support to sustain services
- Increased potential to integrate with primary, community and social care
- Shared culture to innovate patient care

Source: Anonymised NHS provider example

EXAMPLE

An assessment of how initiatives to increase collaboration between two trusts were expected to benefit patients and commissioners (2/2)



1 Based on assuming one-off costs will be redundancy costs, and these will be on a similar scale to redundancy costs for clinical support and corporate functions. Includes capital costs of buildings and equipment

Source: Anonymised NHS provider example

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EXAMPLE

The operational (capacity) and financial impact on a trust of pursuing a range of service-change initiatives

Strategic grouping	Major strategies developed in phase 2	Anticipated impact: Capacity[1] Beds	Anticipated impact: Finance[2] £k
1 Unsched-uled care	• Single-site for stroke at FT; single site for fractured neck of femur and orthogeriatrics at FT; development of frailty pathway	37.3	-143
2 Elective	• All elective urology at FT; all routine and day-case ear, nose and throat at FT; off site in the community, expansion of lithotripsy, gynaecology, dermatology and ophthalmology	11.0	273
3 County wide	• Renal networked model and re-establishment of vascular network	2.0	460
4 Support services	• Development of advanced practice roles and early pathway involvement	0	-121
5 Cancer	• Family history service, satellite haematology-oncology at FT, plan for radiotherapy and cancer services	0	817
6 Obstetrics	• Two-site maternity services, with midwifery-led units at both sites; full range of risk at FT; ambulatory women's health centre, fetal medicine service	0.5	-343
7 Paediatrics	• Specialised service derogation compliance, paediatric trauma and orthopaedics expansion, market share growth	-14.9	4,183
8 Neuro-sciences	• Productivity improvements, neurosurgery repatriation, neurology strategy	-6.8	775
9 Trust-wide	• Remainder of overall 3% year-on-year length of stay improvement	84.0	3,832
Adjust-ments	• Re-invest 37 beds of LoS[3] benefit to move to 90% occupancy, at a cost of £1.7m • Reduce 30 beds of LoS reduction already in 2014/15 CIP plans, worth £1.4m • Remove clinical strategy schemes included in 2014/15 CIP plans, worth £1m	-67.7	-4,088
		45.4	**5,645**

1 Capacity impact refers to 'beds released', negative values being increases to the bed base
2 Financial impact measured as net contribution, negative values being costs to the organisation
3 Length of stay

Source: Anonymised NHS provider example

EXAMPLE

Summary assessment of strategic integration options against a range of criteria (1/2)

	Integration options	Clinical quality	Academic quality	Financial impact	Feasibility	Risk	Strategic fit
Status quo	Continued collaboration (current state)						
Merger	1 3-way merger	++	++	+	+	--	+
Non-merger further integration options	2 Joint ventures in specific services	+	+	-	-	-	-
	3 Recast portfolios	+	-	-	-	-	-
	4 Enhanced collaboration	+	-	-	+	+	-

++	Significantly better than the status quo
+	Better than the status quo
-	Worse than the status quo
--	Significantly worse than the status quo

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EXAMPLE

Summary assessment of strategic integration options against a range of criteria (2/2)

	Criteria	Description	Sub-criteria
i	**Clinical quality**	• What is the scale of the clinical quality benefit?	• Ability to deliver high quality hospital- and community-based clinical care responding to and meeting commissioner requirements • Ability to deliver integrated care across mental and physical pathways and improve population health
ii	**Academic quality**	• What is the scale of the academic quality benefit?	• Ability to strengthen academic health science centre accreditation • Ability to deliver academic excellence in research and teaching • Ability to attract funding to support research and education • Ability to attract world-class researchers
iii	**Financial impact**	• What is the scale of the net financial benefit?	• Financial sustainability of organisation(s) (including synergies) • Value for money (net present value) • Transition costs • Capital costs } Affordability of the change
iv	**Feasibility**	• Are there any legal or other barriers that make the option undeliverable?	• Ability of model to meet regulatory framework • Ability to staff roles • Effective governance • Internal capacity and capabilities to deliver change
v	**Risk**	• What are the scales of the practical delivery challenges?	• Expected level of stakeholder support • Requirement for external reviews (eg clinical commissioners) • Level and duration of disruption and change
vi	**Strategic fit**	• To what extent is the option consistent with other relevant strategies?	• Fit with commissioner strategies • Flexibility to develop additional partnerships and create a strong academic health science network

Making choices

Developing initiatives, carrying out initial impact assessments and prioritising a shortlist will involve many people and teams across the organisation but the final decision will rest with the board.

An effective decision-making process will:

- **feature thorough discussion and challenge** – the decisions result from discussion as a board (and in any supporting bodies) where there is real opportunity for debate and challenge, not through separate, individual off-line communications or the simple ratification of the strategy team's recommendations

- **be based on criteria** – the decisions are made with reference to the criteria you set out at the Frame stage and confirmed or updated during Diagnose and Forecast. Common pitfalls include failing to determine criteria at the Frame stage or subsequently ignoring them and creating new ones

- **be supported by detailed analysis** – the decision-makers have access to and understand high quality detailed analyses of the expected impact of each initiative

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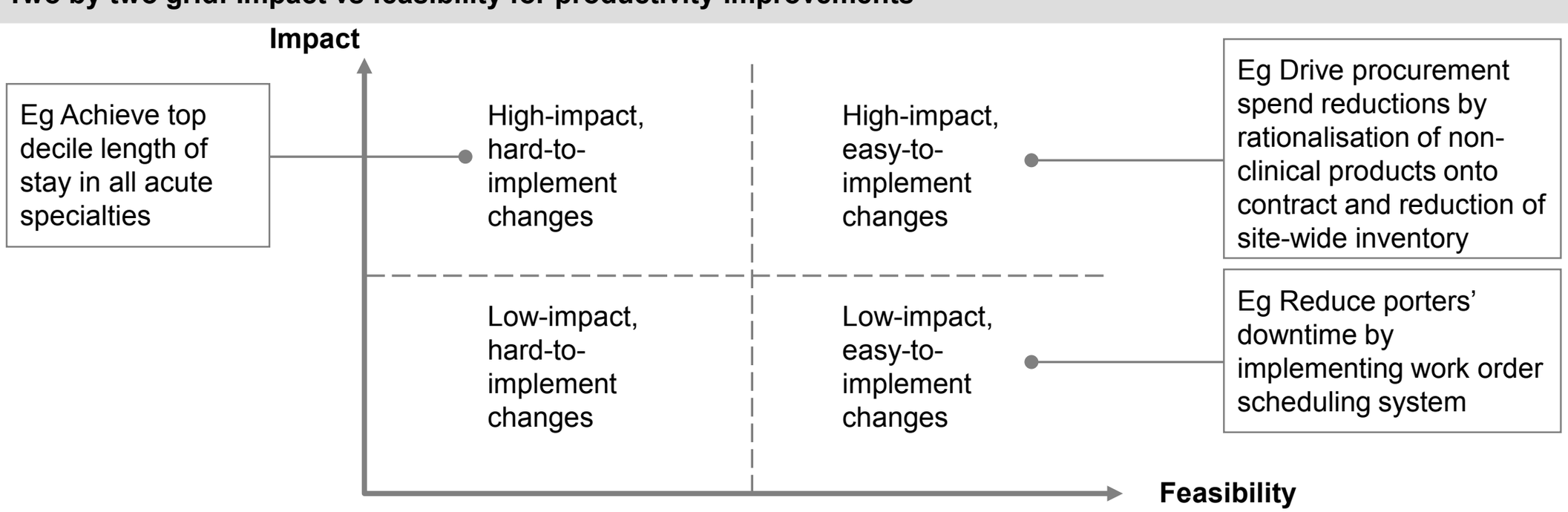
Filter the outputs in this stage to create a shortlist of proposed strategic initiatives for each theme

A prioritisation framework supports the decision-making process by using the impact analyses to sort the relative priority of initiatives. Presenting choices in this way will enable you to synthesise often complex conclusions and understand the relative impact of initiatives in a single view.

In the example below, the simple 'two by two' matrix compares impact versus feasibility. 'Feasibility' should be defined; it will normally combine considerations such as speed of delivery, likely resistance, the transitional costs of implementation, and available implementation skills. The impact axis could either be a single factor (such as quality or finance) or a composite index weighted for several areas of impact.

You may have used this matrix for the initial filtering of initiatives but you will now prioritise again, based on a far richer understanding of each initiative.

Two by two grid: Impact vs feasibility for productivity improvements



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Prioritisation

In a two-by-two matrix you can compare whichever issues are most important to your FT. In this case, the positive impact is judged on a composite index by scoring on a range of criteria.

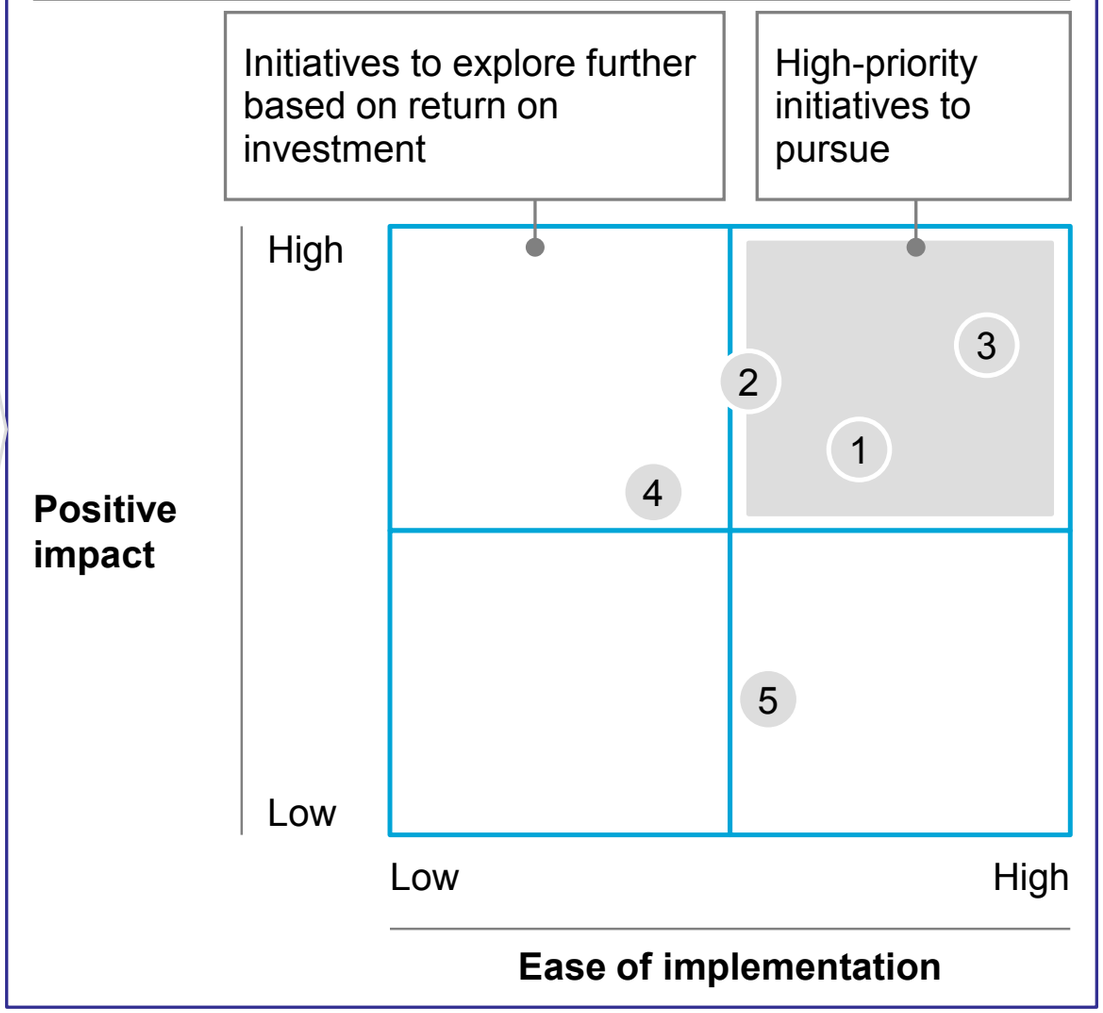
Positive impact

Composite index based on relative scoring of:

- evidence of delivery of patient outcome improvement
- evidence of impact on measured patient experience
- forecast physical capacity released
- financial benefit at EBITDA (earnings before interest, taxes, depreciation and amortisation) level

Prioritisation

Prioritisation matrix



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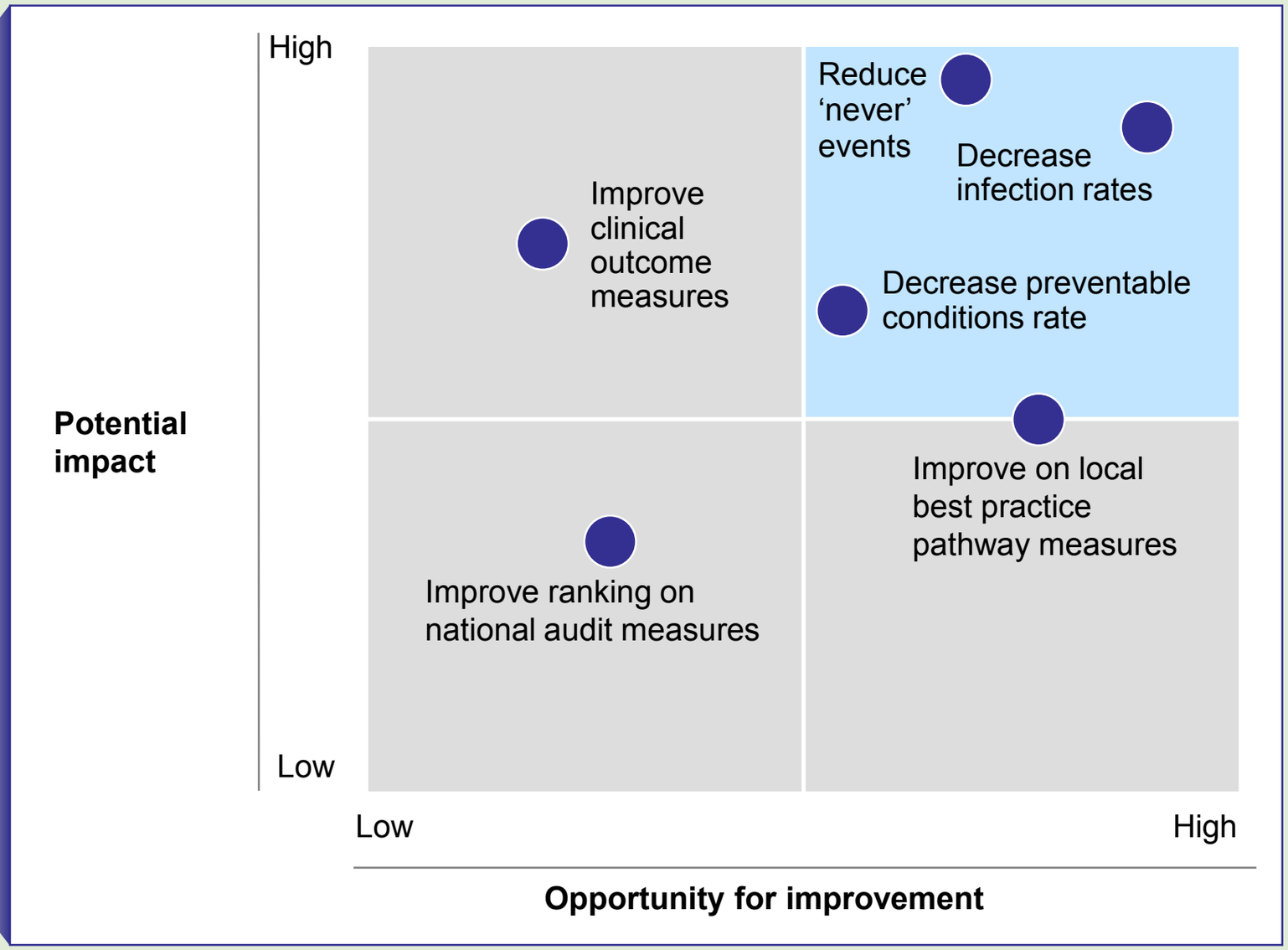
EXAMPLE

Analysis providing focus areas for clinical quality improvement priorities

Methodology for prioritisation

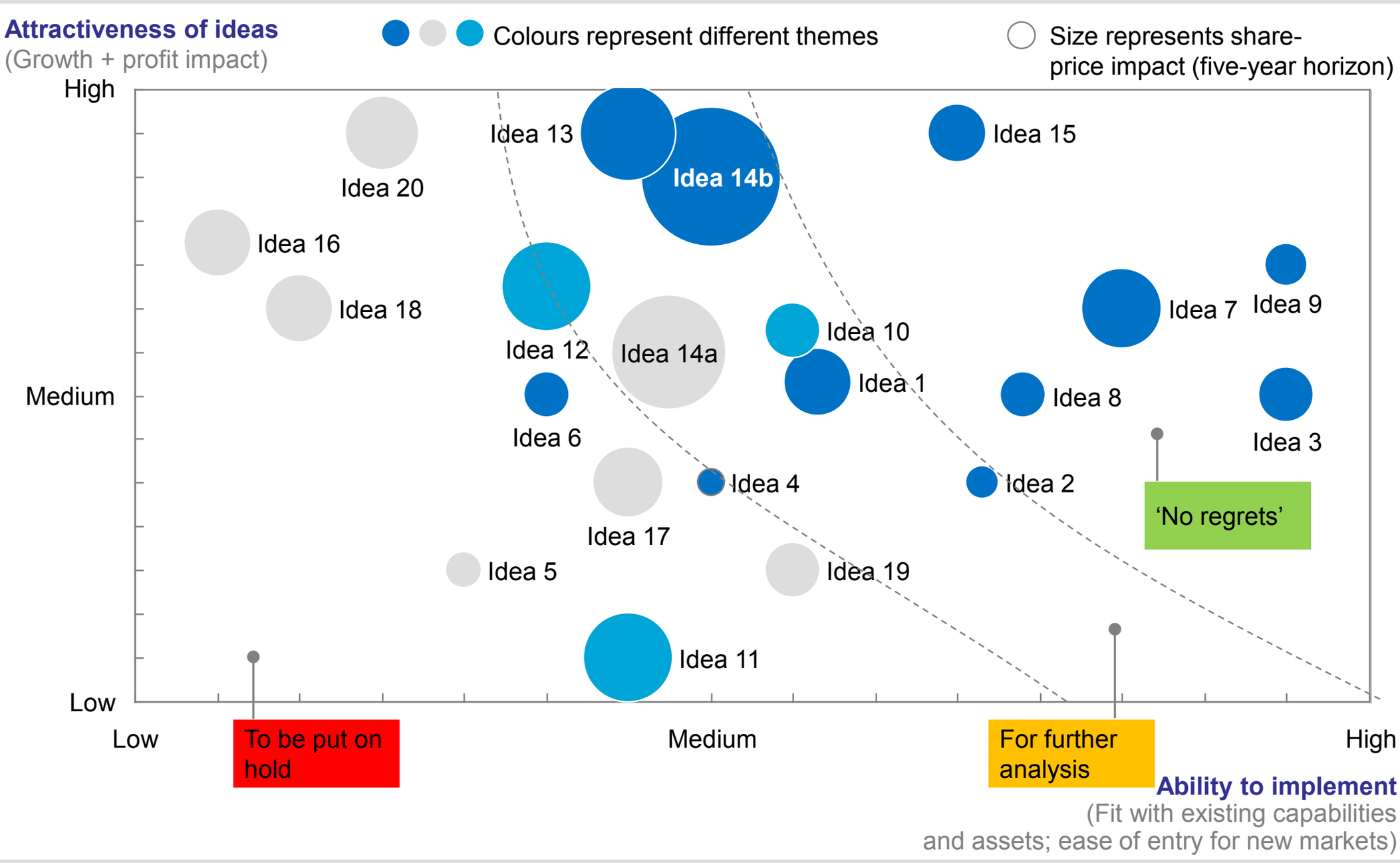
- Analysed data requests and survey results to determine opportunity for improvement
- Worked with clinical quality staff, leadership, and frontline clinical leaders to identify priorities and determine relative importance
- Surveyed medical and nursing frontline staff for additional input



Source: Anonymised NHS provider example

EXAMPLE

Making choices: private sector example of prioritising strategic ideas for change



Source: Anonymised business example

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EXAMPLE

Making choices: This is a summarised output of a decision-making process to select six proposed initiatives

Achieving a successful strategy will require both performance transformation and strategically partnering to increase scale

Areas of opportunity from impact assessment

"What should our strategy be given significant challenges we are facing?"

"How can we maintain or maximise income?"

Frame strategic options

Performance transformation

1 Purchasing and supply chain	2 Workforce excel-lence/productivity	3 Clinical operations improvement
5 Estates and other asset utilisation	Benefits and pay reform	Corporate centre
Third party operation - services	4 Ambulatory clinic utilisation	Coding and capture
Non-tariff pricing/ contracting	Working capital management	

Growth/innovation/scale

Referral increases , organic growth
6 Increase scale via partner or merger
Innovative care and payment models

Medical staff alignment and operations

"How can we remove waste from our cost base?"

"How can we build a medical leadership community around the strategy, and ensure they are engaged with our goals?"

Source: Anonymised US healthcare provider example

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Illustrative example of a service strategic review

The work of understanding what strategic changes would be in the best interests of patients and best help meet the FT's overall goals will often be done at service-line level during the Generate Options stage.

This section includes examples of the questions and analyses that could be relevant for a service-line-level strategic review. Bariatric surgery has been used because it provides a good illustration of the need to answer a wide range of questions before reaching a strategic decision. Answering these questions well involves looking at a wide range of data sources (such as trust performance, other provider performance, national guidance, local commissioners' guidance, original research) and taking into account the views of a wide range of stakeholders (specifically staff, patients and commissioners).

The bariatric surgery example runs from Frame through to the Prioritise stage.

Illustrative example of a service strategic review: bariatric surgery (1/4)

Stage	Questions	
1 Frame	For a hypothetical small, well-performing teaching trust, one of the questions for the strategy development work agreed in Frame stage is **'Should the trust expand their bariatric surgery service?'**	National Institute for Health and Care Excellence (NICE) guidance on bariatric surgery updated[1] in 2014
		FT currently provides laparoscopic adjustable gastric band (LAGB) and gastric bypass surgery at low volumes
2 Diagnose	What is the quality of bariatric surgery at this FT?	The trust operates within UK benchmarks for LoS, mortality and readmissions rates but their volumes are lower than recommended. The trust does not achieve 24/7 bariatric surgeon and anaesthetist cover (as in BOMSS guidelines).[2] There is high variation in complications rates for trust's surgeons (1/80 vs. 1/100, benchmark is 1/100). Results are on a par with similar sized units but below large-volume units
	What do patients think of their bariatric service?	Family & Friends score for GI surgery is 73/100; no complaints in last year (small sample size); patient experience score of 78/100 overall, but 60/100 for waiting for access
	What do commissioners currently think of their bariatric service?	Clinical commissioning group (CCG) guidelines suggest LAGB and bypasses should be done at scale to improve quality and cost, ie more than 50 per surgeon annually – the service is subscale at 41 and 38 annually per surgeon respectively (with two surgeons), totalling 123 LAGB and 76 gastric bypasses annually
	Are there relevant operational measurements the trust should consider for bariatric surgery?	
	What is the trust's financial performance on bariatric surgery currently?	SLR analysis of GI surgery shows positive margins. Their equipped operating theatre has high utilisation as it's not solely used for bariatric surgery. Procurement costs are largely handled centrally by the FT but gastric bands specifically are handled by GI surgery and not purchased at scale. Staff sickness rates do not differ from the FT overall
	Who else offers bariatric surgery?	'Healthier Weight' is the main private provider in the local health economy (LHE), and run a high quality operation which attracted 5% of those the trust placed on waiting lists last year

1 www.nice.org.uk/media/default/about%5Cwhat-we-do%5Cnice-guidance/obesity-update-guideline-draft.pdf

2 www.bomss.org.uk/wp-content/uploads/2014/04/Service_std-2012.pdf

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Illustrative example of a service strategic review: bariatric surgery (2/4)

Stage	Questions	
3 Forecast[3]	**Population (projected changes for the next 5 years)**	
	What is the projected growth for LHE population?	
	If current prevalence continues, how many people will be eligible for surgery?	The Association of Upper Gastrointestinal Surgeons predicts a change of 40,000 additional surgeries annually based on the US precedent[1]
	If trends of the last five years continue, ie prevalence of obesity continues to increase, how many people will be eligible for surgery?	
	If the NICE guidelines change, how many people will be eligible for surgery?	NICE is currently considering lowering the threshold for bariatric surgery to a BMI of over 30 kg/m^2 for those with type 2 diabetes
	What is the current % of the population in the LHE with body mass index (BMI) in the 25-29, 30-34, 35-40, 40-50, >50 kg/m^2	
	National commissioners	
	What are their ideas/intentions for the future of GI, and bariatric surgery specifically ?	Overall CCG intentions are heavily weighted towards out-of-hospital care. Specifically, the commissioning strategy is to shift the obesity pathway to earlier intervention and increase emphasis on prevention.
	Local commissioners	
	What volumes of bariatric surgery will other healthcare providers expect?	
	What work is being done by commissioners to review this service?	
	What do local pathways for weight reduction/obesity treatment look like?	
	Can commissioners afford more bariatric surgery?	Local CCG is not currently running a deficit.
	What are local GPs' views?	
	How big is the impact of obesity on demand for healthcare locally?	
	What are other commissioner priorities and is obesity one of them?	Medical costs are 30%[2] higher for those with a BMI over 30 kg/m^2
	What are cost effectiveness arguments/analysis for bariatric surgery?	
	How does this compare to other local priorities?	
	Patient attitudes	
	Of those eligible for surgery, how many have historically chosen it?	Bariatric surgery requires a multi-disciplinary team (MDT) with surgeon, anaesthetist, dietician, psychologist, gastroenterologist, and specialist weight loss surgical nurse
	Has there been a reaction from patients to the NICE consultation?	
	Do clinicians feel that there is unmet demand?	
	Clinical interdependencies and cost implications	
	What are the clinical interdependencies for this service?	
	How would expanding provision of this service affect other clinical plans?	
	What impact will changing from a major emergency centre to an emergency centre, as the Urgent & Emergency Care Review, have on the quality/cost of bariatric surgery?	The trust will continue to be able to assess and initiate emergency care for all patients, but will not have as wide range of specialist services. The emergency surgery unit will close, impacting the scale of overall volume of surgery in the FT

1 The Provision of Services for Upper Gastrointestinal Surgery, November 2011
2 Withrow, D. and Alter, D.A. (2011) The economic burden of obesity worldwide: A systematic review of the direct costs of obesity, *Obesity Reviews*, Feb 12, 131-141
3 These are questions on activity – parallel forecasts would be created for income and costs, to understand projected financial sustainability of the service

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Illustrative example of a service strategic review: bariatric surgery (3/4)

Stage 4 — Generate Options

Questions

Clinical quality

How can the trust improve the quality of bariatric surgery?

How can the trust improve patient experience?

→ Increase scale of bariatric surgery to minimum recommended volumes, 125 overall and 50 per surgeon annually, as in 'Clinical Commissioning Policy: Complex and Specialised Obesity Surgery[2]

Financial margins

How can the trust improve margins on bariatric surgery?

What providers of equipment does the trust use and how could the trust improve negotiations with them?

→ Currently the trust uses an adjustable band only available from a single supplier[3]

Could the trust change the way they charge commissioners to share the risk and reward?

→ Bariatric surgery is expensive but is cost-effective in the long term due to the comorbidities associated with obesity

Operational efficiency

How can the trust improve its operational efficiency?

How can the trust create a step-change in productivity: for staff, procurement and estate?

→ Given reduction in specialties due to Urgent Care review, overall scale of surgery at the FT is changing, reducing numbers of anaesthetists

Should the trust set up as a dedicated elective centre for bariatric surgery work?

→ Shortage of dieticians; could the trust work with a neighbouring FT?

Would this work better as a stand-alone service?

Could the trust be the stand-out provider in this field in the city / county / country?

How can the trust think more broadly about the need for obesity treatment?

Are there any strategic partnerships the trust should consider?

→ Partnering with Weight Watchers has been successful, with 1/3 of participants losing > 5% of their bodyweight[1]

What does leading-edge global treatment look like?

→ US providers have improved morbidity and mortality[4] by centralising in high-volume centres and introducing accreditation [5]

What have other UK providers done?

→ Other FTs have implemented gym referrals

1 Weight Watchers on prescription, Ahern et al. BMC Public Health 2011, 11:434 2 Clinical Commissioning Policy: Complex and Specialised Obesity Surgery, NHS Commissioning Board, April 2013, Reference : NHSCB/A05/P/a 3 http://gb.ethicon.com/healthcare-professionals/specialties/bariatric/gastric-banding

4 http://www.ncbi.nlm.nih.gov/pubmed/23943121 5 http://www.mbsaqip.org/wp-content/uploads/2014/03/Resources-for-Optimal-Care-of-the-MBS-Patient.pdf

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Illustrative example of a service strategic review: bariatric surgery (4/4)

Stage 5: Prioritise

Questions

How does the trust now decide if this is a priority in comparison with all the other strategic ideas?

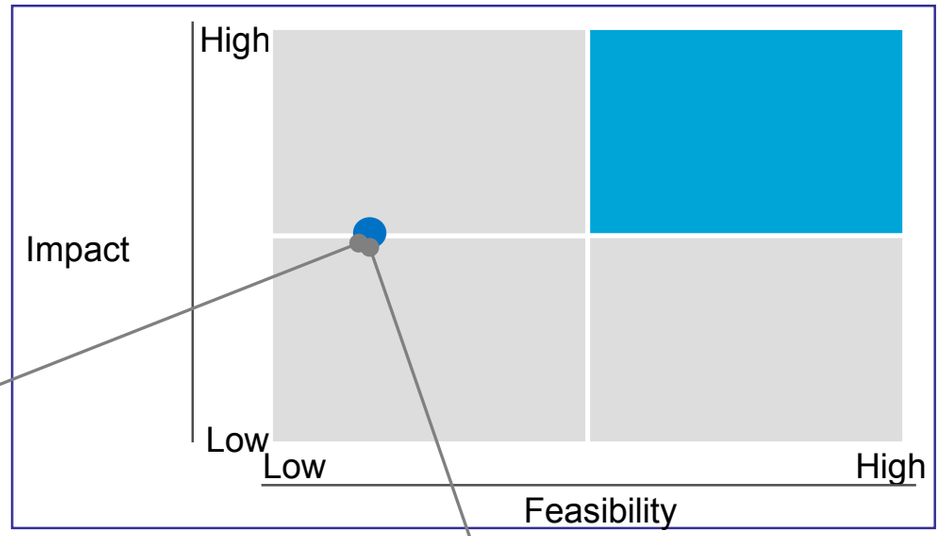
- What will the quality effects of expansion be?
- How likely is an increase in demand for LAGB/gastric bypasses?
- What will the operational effects of expansion be?
- What effect will expansion have on the rest of GI surgery, and other surgery areas?
- What will the long-term costs of this be?
- What will the effects on margins be?
- What is the initial investment required?
- Can the trust afford the initial investment?

Commissioner priorities are moving towards prevention, particularly early intervention to prevent obesity in childhood

Increase in local demand made less likely by commissioners' initiatives to prevention

Two more consultants required on an ongoing basis and four specialist weight-loss surgical nurses

Set-up and equipping another operating theatre designed for morbidly obese patients



Feasibility is low as commissioners aim to emphasise prevention and manage obesity prevalence

The overall judgement is not to invest in expanding the bariatric surgery service. While obesity rates are rising and there are possible NICE guideline changes, local commissioners intend to manage obesity through early intervention. This means that an expanded bariatric surgery service is unlikely to be financially sustainable for this trust.

Overall impact is an aggregate of the net improvement of quality of patient care (which would be moderate) and the net improvement of trust finances (which would probably be neutral or even negative over five years)

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Developing a coherent strategy

Having chosen your strategic initiatives, you will want to consider how they fit together to create a coherent strategy so that you have a balanced portfolio of initiatives within each of the themes identified in Generate Options.

A balanced portfolio will mean that your strategy is coherent: the initiatives work together to help and reinforce each other rather than contradicting each other. Being balanced also means that you can achieve your objectives while balancing risks against benefits over the expected timeframe. In other words, you will be confident that most of your strategy will be successful, while accepting small risks that could potentially yield large rewards.

To achieve this coherence, you first need to ensure that your initiatives are complementary. For example, there would be a clash between an initiative that aimed to increase care of the elderly work and an initiative that aimed to reduce activity in the trauma and orthopaedics service. You will also want to understand the interdependencies between initiatives: is there one that can only be implemented when another is complete or under way? For example, you only increase the utilisation of your theatres once the working patterns of on-call consultants have been amended to ensure weekend coverage.

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Creating a balanced portfolio of initiatives

You can assess balance in several ways including reference back to the concept of ‘three horizons’ introduced in Generate Options.

In the example below the axes of the assessment are the balance between risk (judged by degree of change and scope) and the timescale for achieving the benefits. The size and colour of the bubbles add other dimensions of information.

Risks

Low: current service improvement

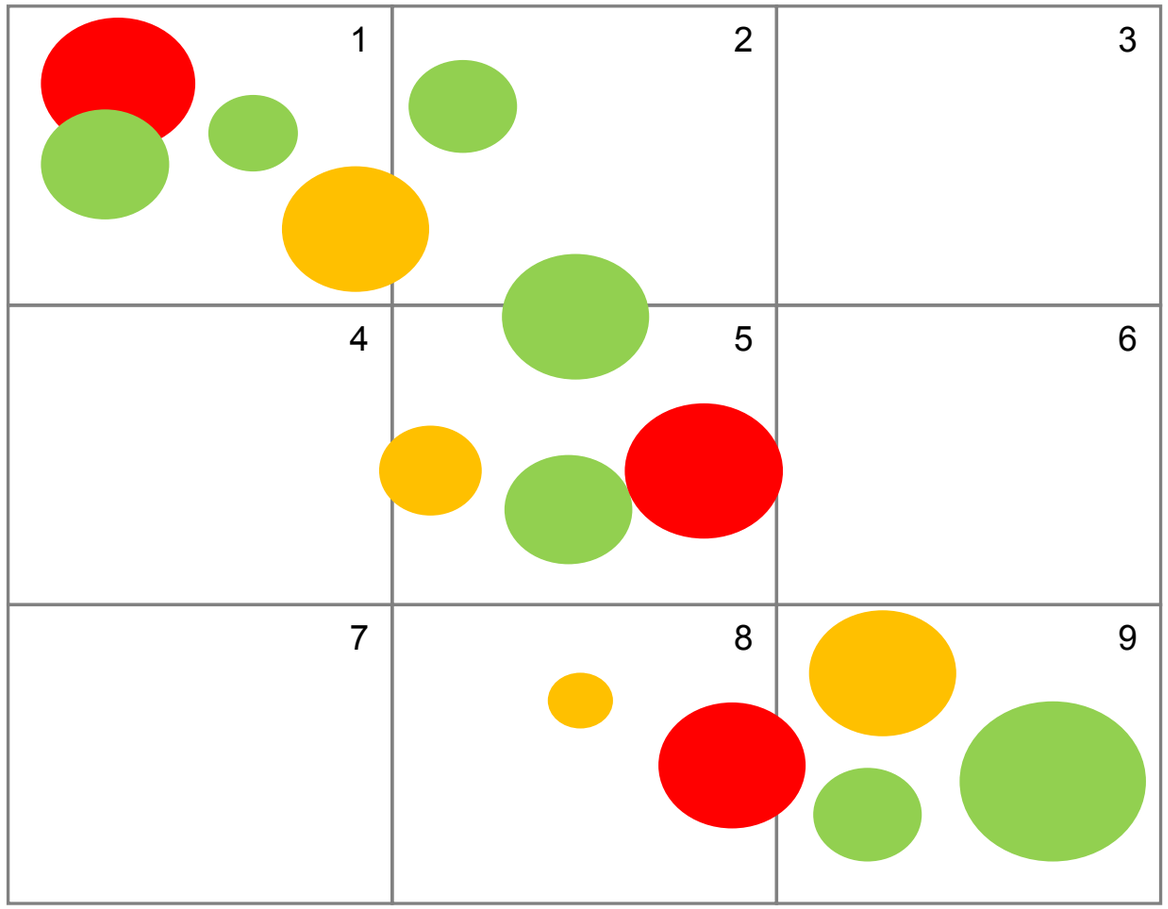
- Builds on work your FT is currently doing
- Involves some implementation risk

Medium: smaller changes

- You have less direct experience of this work or way of working

Large: big changes to particular services

- Possibility of success difficult to estimate at the onset



Horizon 1: 1 year

- Meet current expectations
- Extend and defend core activities

Horizon 2: 2-3 years

- Create medium-term opportunities

Horizon 3: 3+ years **Time**

- Generate portfolio of high-impact options
- Create long-term strength

Colour of bubble reflects relative capacity intensity of initiative

- Requires high capacity
- Requires medium capacity
- Requires low capacity

Size of bubble reflects relative attractiveness of initiative

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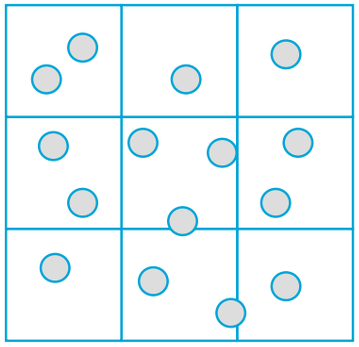
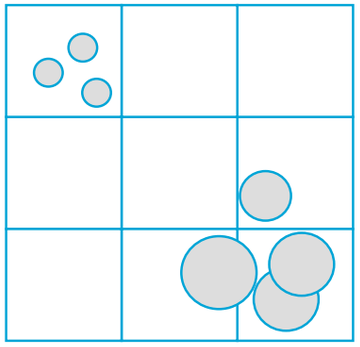
Creating a balanced portfolio of initiatives

By mapping initiatives against a grid, as illustrated on the previous page, you can work out whether your strategy lacks focus, is too risky/risk-adverse, or lacks definition. The patterns shown below are those that would give cause for concern if they represented your choice of initiatives mapped in this way.



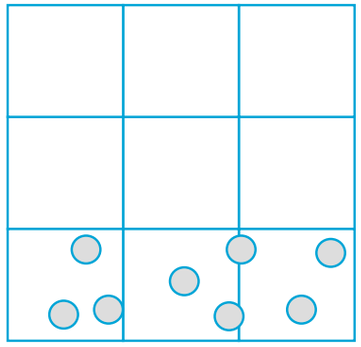
Lack of focus

If your strategy is scattered around long-term, short-term, high and low risk, it would signal a lack of focus



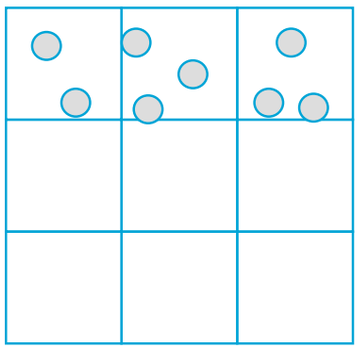
Big investments, big risks

If your strategy requires a lot of investment for risky, long-term initiatives, you are not spreading your risk



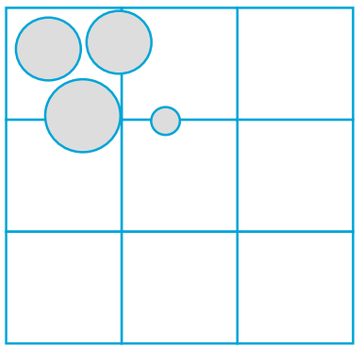
Risky

If your strategy is focused solely on high-risk initiatives, it is a sign of being too risky



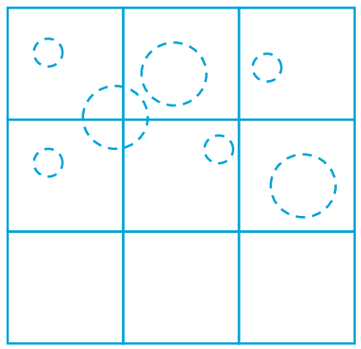
Risk averse

If your strategy shows just low-risk initiatives, it is a signal of not being risky enough



Poor innovation

If your strategy requires a lot of investment for short-term, low-risk initiatives, it is a sign that it could be more innovative



Poor definition

If it is proving difficult to map your initiatives against the grid, they are likely to be poorly defined

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Summarising the strategy

Once you have chosen your strategic initiatives it is important to create a simple and effective way of communicating the essential elements. This will help the decision-makers see the full picture of the chosen direction. It will also support the wide communication that will be an essential part of confirming agreement and commitment across the FT and among external stakeholders.

The following pages contain a sample template that you could use to prompt discussion about what could be included and examples of healthcare providers' strategies summarised on a single page. Whichever form you choose for the summary, you should be clear about exactly what is the focus of your strategy and – equally importantly – what it is not. The one-page summary will help you check that your strategy is not too wide-ranging and unfocused.

You can use these one-page strategy summaries, and the other details decided in this stage, to create the organisational goals in the next stage, Deliver. Although your goals will be specific and measurable they will change with time but your one-page summary strategy should apply for the full period that your strategy describes.

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Generic template for a one-page strategy summary including the important elements

Strategy on a page

Why?	What is the challenge facing you and the case for change?
What?	What are you trying to achieve through this strategy?
Where?	Which patients, geographies, specialties, sectors (primary care, secondary and tertiary, mental health, etc) will you focus on?
How?	What future delivery model and capabilities are required and how will this be different from now?
When?	How will the strategy be delivered over time – what should happen when? When are the big changes you need to make likely to happen?
£	How will we look financially in the future at a headline level (income, costs, surplus, cash and overall viability)?

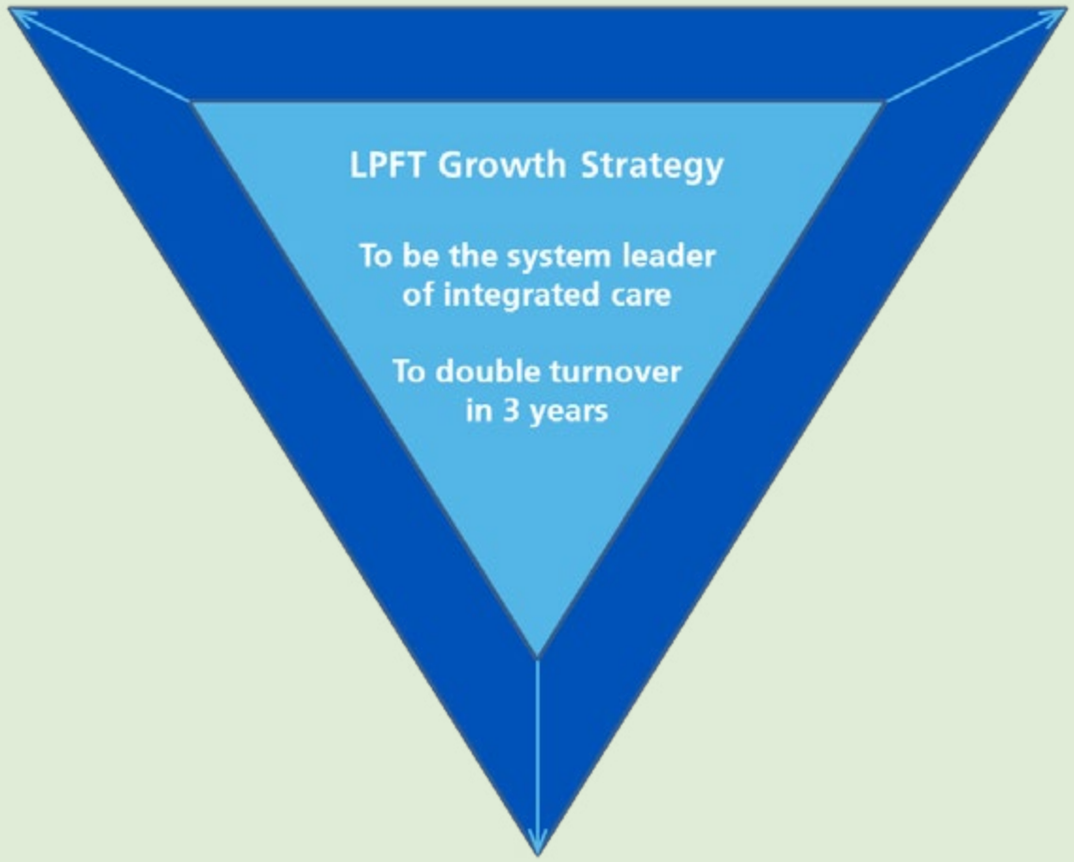
What have we decided NOT to do?

EXAMPLE

A high-level description of the strategic themes for a mental health trust

Targeted growth: competing within markets

System integration: competing for markets

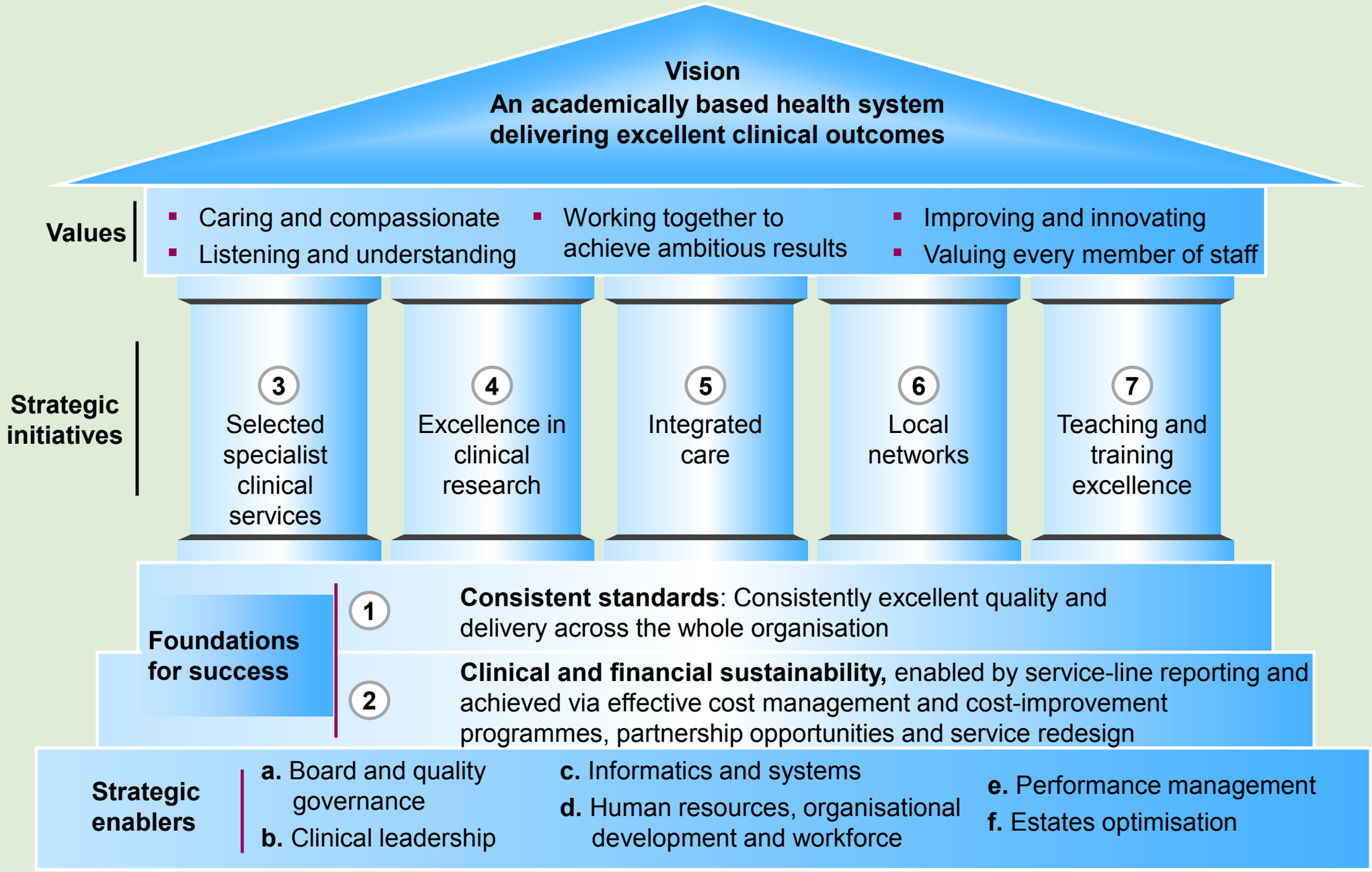


Retention of existing portfolio: keeping the base safe

Source: Lincolnshire Partnerships NHS Foundation Trust

EXAMPLE

Summarising strategy: explaining the overarching vision and values for the trust



Source: Anonymised NHS provider example

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EXAMPLE

An integrated health economy solution with an emphasis on the themes and underlying philosophy of the strategy

Aspirations for a new integrated approach, supported by four pillars of care

The empowered person	Community-provided care	Local specialist care	Regional specialised care
Proactive empowerment of individuals to take responsibility for their own health	Fully integrated and co-ordinated community care provided by a multi-professional team	High quality specialised care delivered within a reasonable distance of people's homes	Highly trained specialists delivering world-class care on a regional level

New strategy shifts care away from a reactive acute setting

Source: Anonymised NHS provider example

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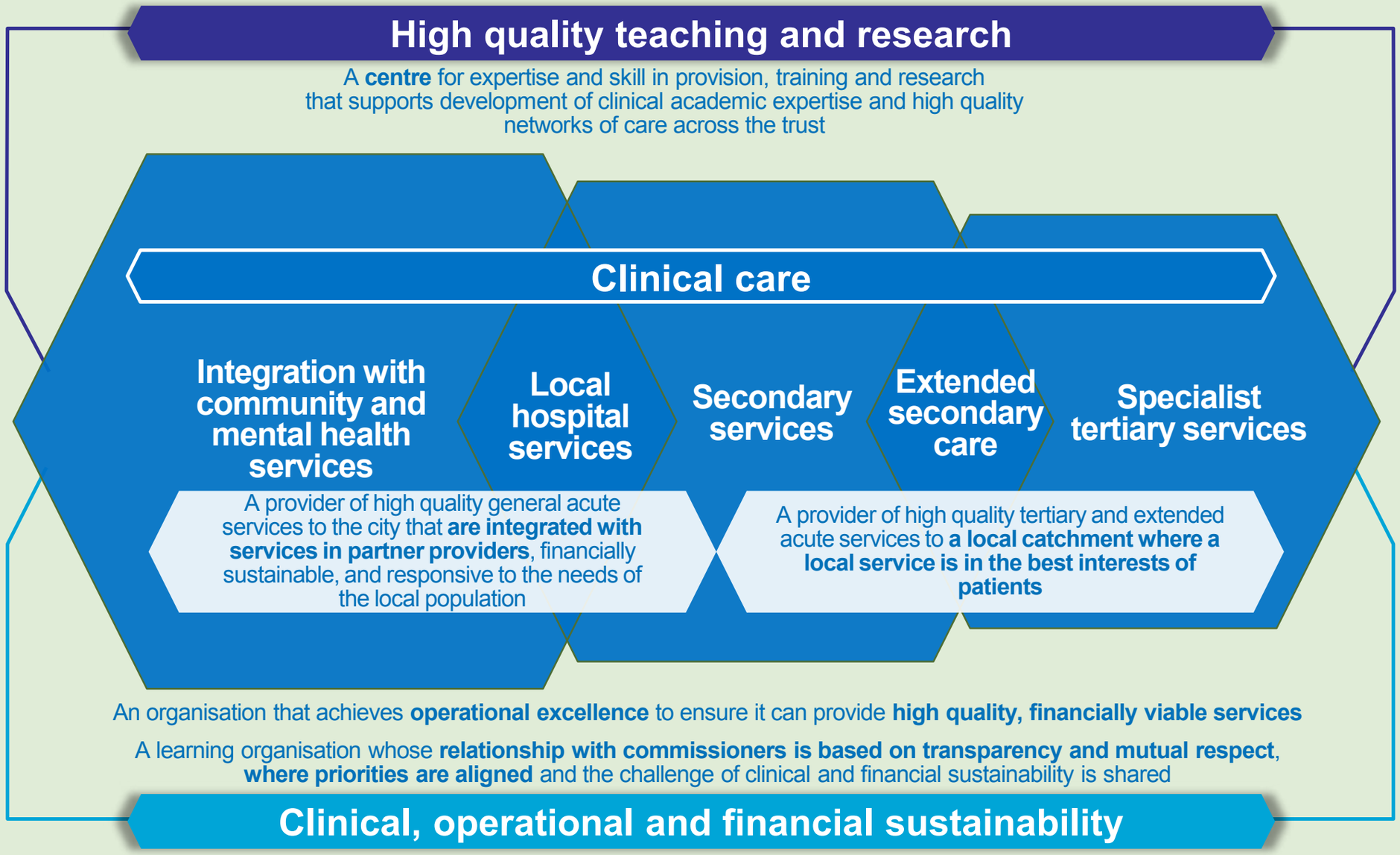
EXAMPLE

Adapted from a teaching trust, this describes the significance of themes in teaching and research, and shows the enabling strategies that are important for delivery of core services



Source: Anonymised NHS provider example

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EXAMPLE

A one-page summary describing strategic initiatives and the steps to achieve them

Strategic initiative	Long term goals	Description
1 Increasing efficiency requirements	A. Deliver current target in 14/15 and 15/16	• Deliver £36m total savings for 14/15 and the incremental £8.2m in 15/16 (total recurrent savings in CIP plan of £44.2m as of 15/16)
	B. Further improve productivity and control cost inflation (further push FEP)	• Close the remaining gaps to productivity benchmarks by improving internal operations • Implement the forward improvements that leading hospitals will make, ie – match skills to task in corporate and clinical functions so that costly staff are not over-utilised – continue to fight cost inflation by increasing negotiating leverage with suppliers – improve operations in outpatients (i.e. reduce DNA's, optimise staff scheduling)
2 Insufficient system reconfi-guration	Implement a financially-sustainable emergency pathway	• Joint review of the emergency pathway and continued implementation of the health economy strategy to introduce a 'Transfer to Assess' programme • Ensure additional external facilities are commissioned to enable the trust to reduce the cost base • Potentially commission a community care ward in order to improve patient flow and earn the appropriate tariff
3 Lack of step-changing successes	A. Redesign specialist/ tertiary services	• Accelerate the development of provider networks and centres of excellence • Continue to collaborate more with neighbouring trusts to optimise the flow of specialty activity in the region and improve trust's ability to absorb other activity in the region
	B. Consolidate and increase efficiency of estates	• Rationalise the estate footprint of the South site • Continue to negotiate energy- and facilities-savings wherever possible • Match estate footprint to utilisation level as care moves out of hospital
	C. Identify commercial opportunities	• Outsource support and/or clinical services (or become the outsourced provider in areas of excellence) • Explore opportunities to deliver specialist services in other hospitals
	D. Expand scope of technology and self-service	• Implement patient-facing technology to increase self-care, compliance with treatment, and reduce missed appointments • Standardise and automate administrative and clinical functions in order to reduce corporate overhead and improve quality of outputs • Use technology to enhance staff productivity, eg electronic intensive care unit, wireless bed monitoring, telemedicine
4 Governance and pace	Improve accountability and capability to increase pace	• Strengthen performance framework to increase transparency of performance and help motivate staff to action, and effective from 'ward to board' • Improve in-year monitoring of financial information in order to speed up decision-making and improve decision quality • Train and support speciality teams (including clinicians and managers) in identification and delivery of CIPs

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Supporting resources

Stage	Monitor resources	Other resources
Prioritise	• Annual plan guidance (issued each year) • Director-Governor Interaction in NHS FTs: a best practice guide for Boards of Directors	• The Green Book: appraisal and evaluation in central government

Monitor
Making the health sector
work for patients

Deliver

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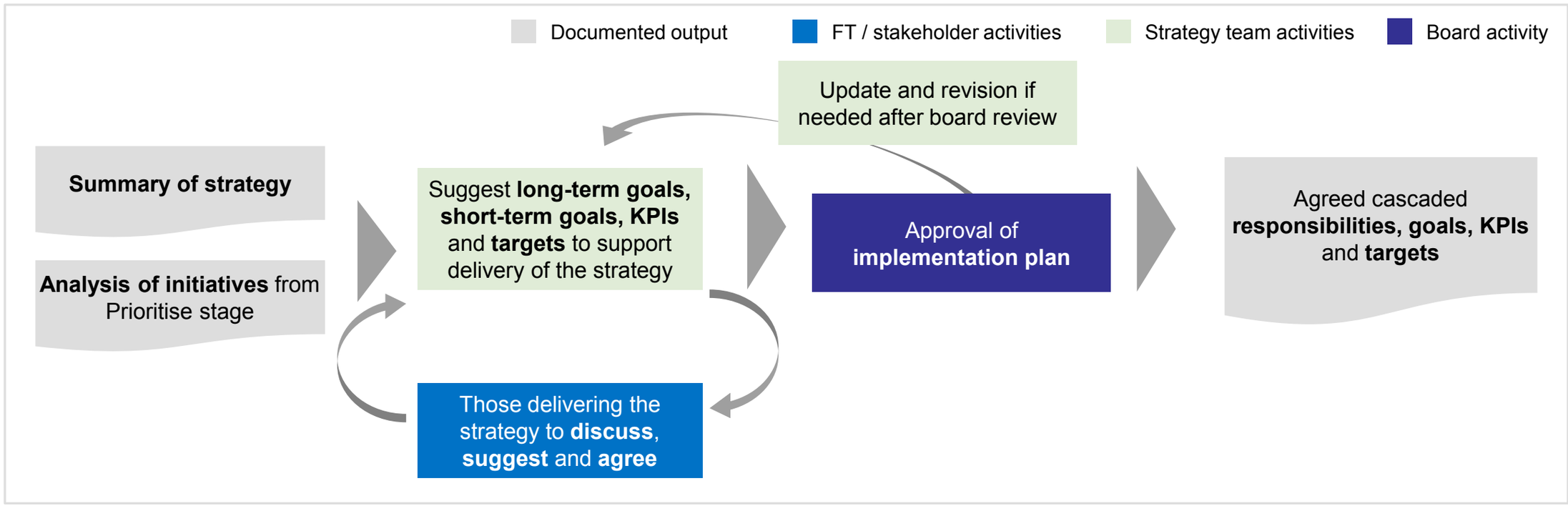
Introduction

The Deliver stage involves implementing your strategy. The diagram below summarises the steps you will need to take and how they work together.

There are three parts to this stage:

- supporting the delivery of your strategy
- reallocating resources and skills in line with your strategy
- communicating the strategy

In this stage, the chances of success will be greatest if you have been co-creating the strategy with staff across the organisation and with your stakeholders. More detailed guidance on this can be found in the How to Get This Done stage in **Involving the whole organisation in strategy development**.

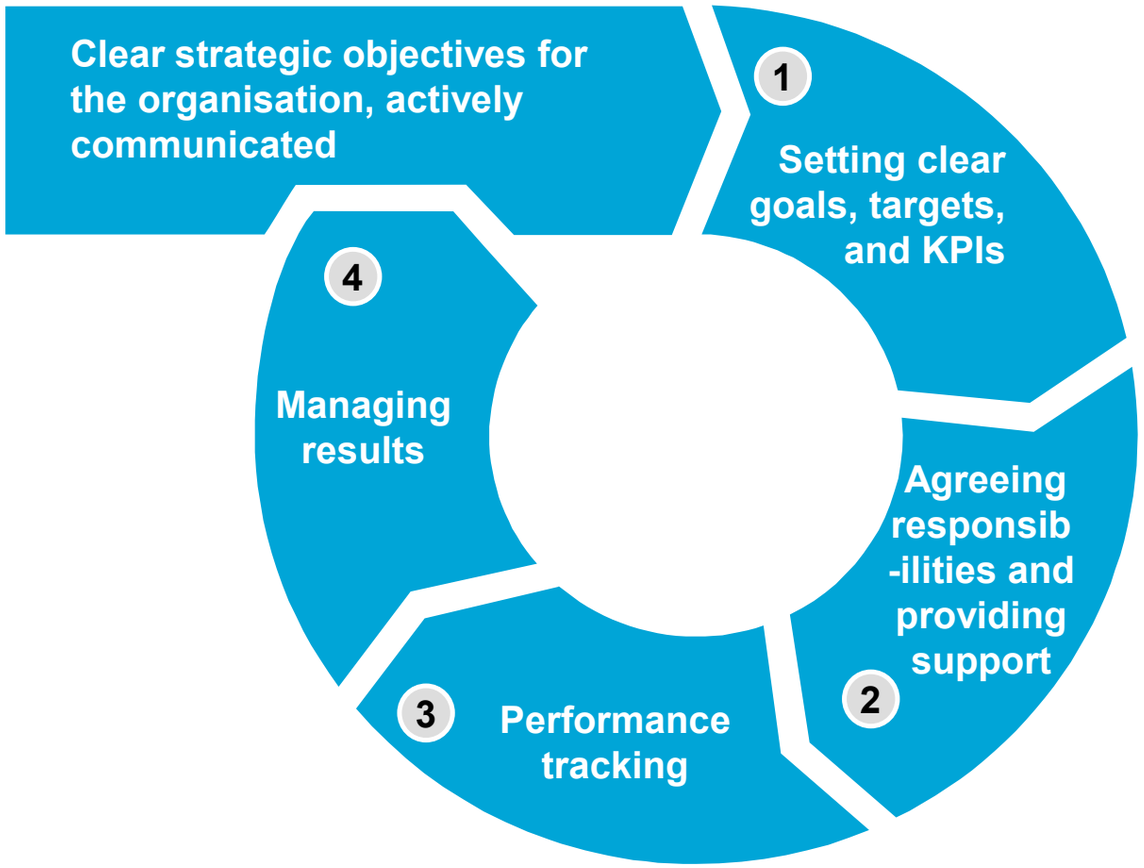


Supporting the delivery of your strategy

Summary of the steps necessary to support delivery of your strategy

To implement your FT's strategy, your strategic initiatives need to be translated into individual goals with associated key performance indicators (KPIs). These goals are agreed with individuals, so that they can see how their work contributes to strategic objectives. To monitor the goals and achieve results, you need to use performance-tracking mechanisms and effective performance management.

This diagram summarises the four steps to supporting the delivery of your strategy:



1. Translating strategic initiatives into goals, targets and KPIs by year, so that they are reflected in the operating plan from year one onwards
2. Agreeing responsibility for delivery and providing individuals with the support they need
3. Effective performance tracking
4. Open recognition of good performance and clear actions to address poor performance at individual, team and trust level

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Step 1: Set clear goals, targets and KPIs

The first step in delivering your strategy is to set specific goals for each theme and for the initiatives that will achieve them.

An initiative may have more than one goal. When you specify the goals for each initiative, you should think about including all the relevant aspects of quality, financial, workforce and operational goals that the initiative can help with. This continues to apply when an initiative has just one objective. For example, if you want to achieve a 10% cost-base reduction, your goal should still explicitly make reference to maintaining quality and safety standards.

Long-term goals need to be translated into goals for the next year and for following years. Actions and targets for agreed strategic initiatives will be a part of the current year's annual plan, even if some initiatives will take full effect only in later years.

The goals you set should be SMART – Specific, Measurable, Actionable, Results-oriented and Timely.

Work with operational leaders (and project support colleagues where these exist) to break long-term strategy goals down into short-term goals. It is important that everyone understands how their own work and the short-term goals contribute to the long-term goals.

Goals can be translated into KPIs with agreed target levels of achievement; KPIs should be selected in collaboration with the people who will be responsible for delivering them. These initiative owners will have valuable insights about what the most effective KPIs will be, and their involvement will lead to better results.

Specific	• Is the outcome of the goal clearly defined? • Is it easy to understand?
Measurable	• Is the goal easy to measure? • Do we have or can we collect the data required? • Can it be benchmarked against other teams or outside data?
Actionable	• Can the team responsible for the goal help to achieve it? • Do we understand what action will lead to the goal? • Can we take steps that will affect the measure?
Results-oriented	• Is the goal relevant to the organisation as a whole? • Does it support next level of KPIs and help the organisation to achieve overall strategy?
Timely	• Can the goal be measured at a frequency that will allow us to solve problems and track success? • When will the result be achieved?

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The SMART principles of goals apply equally to choosing KPIs. In addition, the following five principles are also relevant:

- **Measure what you want to achieve, not just what you can easily measure.** A common pitfall is using only those indicators that are easy to measure. Ease of data collection is a criterion to use when selecting KPIs, but not be at the expense of a measurement that will accurately reflect the desired outcome.
- **Align KPIs across the organisation.** Make sure that the measures do not conflict or create unintended priorities. If various departments use different measures, they may end up with different motivations and solutions. Aligning KPIs will also help you to benchmark internally.
- **Use common KPIs.** Wherever possible (but not at the expense of the other principles), it is beneficial to adopt measures with similar formats/definitions to those in other parts of the FT and other organisations, so that performance can be compared internally and externally.

Measure things that staff can control. If KPIs are not influenced by the efforts of staff, the incentives will not be aligned with strategic goals. People should be given targets only where they can directly influence achieving them.

- **Use both process and outcome measures.** Process measures are used to ensure that you have put in place the changes needed for the initiative to succeed. For example, in pursuing a strategic initiative on quality turnaround in mortality, the process measures might be:
  - that an early-warning score system has been implemented
  - that ward staff have been trained
  - that an outreach team has been appointed.

  The outcome measure is the resulting level of in-hospital mortality on which the FT was previously underperforming.
  Using both process and outcome measures for each initiative will give a comprehensive view of progress, with early indications of success.

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EXAMPLE

How one trust translated a strategic theme into overall objectives, divisional goals, streams of work and team or individual targets

One strategic priority theme

Improving care and services through integration and collaboration

Four FT-wide strategic objectives for this theme

Deliver the Integrated Care Programme for Older People

Integration and Collaboration within the North West Sector

Collaborate within Greater Manchester and beyond

Service developments/ Redesign

Three divisional goals to achieve first objective

1. Integrate pathways and assessment processes between Emergency Assessment Unit and community-based multi-disciplinary groups

2. Integrate FT services into the multi-agency contact centre

3. Care home medical practice involvement

Workstream to achieve divisional goal

2. Integrate FT services into the multi-agency contact centre

Ten streams of work support the second goal, each with a KPI owned by one individual. eg Work-stream 2 – 'Integrate services into the multi-agency contact centre' and has these targets:

- **co-locate first round of FT services by January**
- **co-locate second round of services by June**
- **integrate processes and develop joint roles with partner organisations by December**

Source: Salford Royal NHS Foundation Trust

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EXAMPLE

How a strategic initiative was translated into KPIs

Strategic initiative: Improve use of theatre
Long-term goal: Increase theatre use to 80% while maintaining quality

Targets	From	To
Maintain three anaesthetists for every two theatres	• Frustrating waits between patients • 50% of operating time	• Quick transition between one patient to the next in the theatre • 70-80% of operating time
Move to run-through list for a full day	• Mostly two-session theatre day • One-hour break in the middle of the day to allow for overruns	• Mostly run-through theatre days • Smooth running across the day
Improve relationship with anaesthetists	• No coherent team	• Single, high-performing team that works smoothly and appreciates each other's needs and expectations
Effective management of theatre scheduling	• Theatre lists cancelled during holiday periods • Theatre cancellations due to maintenance • Overruns	• Theatre maintenance takes place with minimum cancellations and impact on productivity • Highly-effective theatre list enables treating optimum number of patients

Outcome measure to track (KPI):

- Patients per theatre per day (by subspecialty)
- Procedures per list (run-through)

Process measure to track (KPI):

- By consultant measures
  - late starts
  - early finishes
  - knife-to-skin time
  - needle-to-skin time
- By anaesthetist measures
  - late starts
  - early finishes
  - anaesthetic time
- % of run through lists

Source: Based on an anonymised NHS provider example

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EXAMPLE

How a trust translated outcomes into measurable benefits

Outcomes	Top prioritised measurable benefits
Patient experience and care outcomes	Falls
	48-hour access to primary care
	Family and friends test
Staff experience	Staff turnover and sickness/absence rates
	Staff satisfaction
Service utilisation	Share of high-risk service users under case management
	Average length of stay per emergency admission
	Residential admissions rate per 1,000 population served
	Acute admissions rate per 1,000 population served
	Bed days per 1,000 population served
	A&E admissions rate per 1,000 population served
Financial resources	Total cost per capita and growth rate
	Social care cost per capita and growth rate
	Non-elective inpatient cost per capita and growth rate
	Elective inpatient cost per capita and growth rate
	Outpatient cost per capital and growth rate
	A&E cost per capita and growth rate
	Community Health Services cost per capita and growth rate
	Mental Health cost per capita and growth rate
	Commissioner and providers deliver financial statutory duties

Source: Based on an anonymised NHS provider example

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Step 2: Agreeing responsibilities and providing support

Consider the leadership approach, including the active involvement of clinical leaders. Strong clinical leadership within healthcare providers results in better performance. The effectiveness of clinical leadership can be enhanced using the principles of devolved responsibility and clear decision-making responsibilities outlined in Monitor guidance on Service Line Management (SLM). A strategy cannot be implemented by the strategy team alone: a clear system of delegation of strategic initiatives is required. To benefit from effective decentralised leadership by clinicians, you are likely to need to provide individuals with organisational development support.

Be clear about how responsibility cascades from board to divisions to teams and individuals. Delivering a strategy is a joint effort and achieving the goals is a shared responsibility. This can be emphasised by articulating the roles everybody can play in achieving the strategy. For example, a strategic initiative to reduce harm to patients cared for by community teams can be expressed as a board-level goal, as a target for locality teams, and a goal for individual community nurses.

Assign owners for all KPIs. When selecting a measure to track an initiative, ask 'Who is responsible for achieving this? Do they know the measure, and have they been involved in agreeing it?' Each initiative should have a carefully chosen and clearly designated owner. Make clear the change that you expect them to achieve, and what this means for them as individuals. You may want to include performance on agreed measures in your appraisal process, to demonstrate that this is an organisational priority.

Align with existing organisational systems. The governance structure for strategy delivery should be closely aligned with existing FT governance, while also making clear the additional responsibilities that have been agreed. For example, the divisional head of General Medicine might agree to lead a cross-divisional initiative to improve length-of-stay performance.

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Step 3: Performance tracking

You will need to monitor the KPIs you have agreed for your strategy to check whether the expected results are being achieved.

You will probably want to integrate the monitoring of strategy implementation with existing performance-management systems much as possible. This ensures that strategy delivery is not seen as something separate from ordinary activity or as 'someone else's job'

You may want to include measuring progress of strategic initiatives in:

- individual performance objectives
- a department's team-based objectives and performance reviews
- clinical directorate/divisional objectives, annual operating plans and performance reviews
- integrated executive team and full board reports

The following features are recommended for effective performance review processes at each of these levels:

- face-to-face performance conversations, with action taken as a result
- inclusion of a balanced range of measures (relevant aspects of quality, finance, operations, and workforce)
- no measures on scorecards used for reviews that are not relevant to the objectives of the individual or team being reviewed
- measures to be prioritised and/or weighted if needed
- measures are agreed and understood by all those accountable for them
- data is up to date

It is important to set clear written expectations for a performance management review process; an example follows.

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EXAMPLE

A trust's explicit standards for KPIs and how they should be used in performance management

	Criteria	Description
KPIs	Relevant	All KPIs provide useful information on care group performance
	Right level	KPIs can be broken down to identify the root causes of problems
	Mutually agreed targets	Those responsible for meeting a target are involved in setting it
	Prioritised	The most important KPIs are clearly highlighted and restricted to a number than can be addressed with the necessary rigour
	Balanced	All important aspects of care group performance are covered
KPI management	Accountable	Held to account either by a more senior member of staff or by someone else referring to a written statement of performance expectations
	Responsible	Able to influence a performance indicator directly (rather than indirectly by asking someone else to do something)
Links	Dedicated contact	A named individual
	Mutually agreed roles and responsibilities	Both sides have agreed what can be expected of them
	Regular performance meetings	A schedule of meetings on defined dates at which operational matters are discussed and concerns about the functioning of the relationship can be raised

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EXAMPLE

Measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making actually lead to improvement. The Institute for Healthcare Improvement considers three types of measures as outlined below

Process measures

Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system?

For diabetes: Percentage of patients whose haemoglobin A1c level was measured twice in the past year

For access: Average daily clinician hours available for appointments

For critical care: Percent of patients with intentional rounding completed on schedule

Outcome measures

How does the system impact the values of patients, their health and wellbeing? What are impacts on other stakeholders such as payers, employees, or the community?

For diabetes: eg. Average haemoglobin A1c level for population of patients with diabetes

For access: eg 18 weeks performance

For critical care: Intensive Care Unit (ICU) percent unadjusted mortality

For medication systems: Adverse drug events per 1,000 doses

Balanced measures

Are changes designed to improve one part of the system causing new problems in other parts of the system?

For reducing time patients spend on a ventilator after surgery: Make sure reintubation rates are not increasing

For reducing patients' length of stay in the hospital: Make sure readmission rates are not increasing

Source: Institute for Healthcare Improvement

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EXAMPLE

This tracking of service line performance integrates ongoing operational measures with an initiative on theatre performance

Goals	KPI	April	May	June	July	August	YTD	Trend target	Trust target	National target
18 weeks	Admitted patient care – % patient clock stops <18weeks	90.00	90.19	89.34	92.02	90.47	90.45	↓	92	90
	Non-patient care – % patient clock stops <18weeks	97.40	97.98	97.59	97.18	96.85	96.18	↑	97	96
	Open pathways – % patient clock stops <18weeks	92.37	93.36	92.56	92.07	92.49	92.57	↑	92	92
	Number of falling specialties	8	5	7	3	7		↓	0	0
	Number of incomplete pathways (size of WL)	27216	28332	28252	27828	28070	28070	↓		
Infection control	<6 p/a MRSA bacteremia cases, post 48 hours (BLT)	2	0	2	2	0	6	↑	0	
	<59 p/a C. difficile cases, post 72 hours (BLT)	3	3	4	5	9	24	↓	5	
A&E targets	% of patients discharged within four hours in A&E (Type 1)	95.92	95.47	94.5	94.47	94.74	95.03	↑	98	96
	% of patients discharged within four hours in A&E (All types)	96.09	95.6	94.66	94.65	94.9	95.19	↑	98	96
	Left without being seen – % (LWBS)	2.26	2.74	2.47	2.51	2.62	2.52	↓	5	5
	Time to treatment – median (mins)	29	35	34	31	30	31	↑	60	60
	Unplanned re-attendance rate – Expert opinion suggest levels should be below 5% but levels less than 1% may reflect a risk averse approach to care	1.43	1.14	1.41	1.01	1.01	1.2	↑	1-5	1-5
Cancelled operations	Patients not re-admitted and treated within 28 days of a cancelled operation	0	2	2	0	0	4	→		
	% cancellations not re-admitted within 28 days	0	4.35	0.85	0	0	0.93	↓	4	5
Cancer access	14 days breast symptoms	83.61	93.22	87.69	92.16	96.23	90.31	↑	95	93
	14 day GP	93.1	94.86	94.17	97.5	95.72	95.17	↓	95	93
	31 day 1st treatment	98.46	96.32	96.09	95.32	96.88	96.53	↑	98	96
	62 day GP	71.96	87	87.01	85.59	74.36	81.16	↓	87	85
	62 day screening	81.82	83.33	100	82.35	84.62	85.71	↑	92	90
	Subsequent 31 day drug treatment	100	100	100	100	100	100	→	99	98
	Subsequent 31 day radiotherapy treatment	94.79	96.08	98.98	96.43	95.24	96.34	↓	96	94
	Subsequent 31 day surgery treatment	100	97	96.3	94.12	96.67	96.48	↑	96	94
Strategic initiative: Theatres	Patients per theatre per day	3	4	5	3	3	5	→	6	
	Procedures per list (run-through)	10	8	6	6	7	8	↓	4	
	Average knife to skin time	90.05	91.10	89.50	89.00	86.00	85.95	↑	80.00	
	Average needle to skin time	15.09	15.00	15.10	15.15	15.05	15.10	→	10.00	
	Average anesthetic time	20.00	21.10	20.05	19.95	19.50	19.02	↑	15.00	
	% of run through lists	80.10	81.00	80.30	79.00	78.00	80.00	↓	90.00	

Source: Anonymised NHS provider example

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You may want to develop periodic reports that track progress against intended strategy outcomes, and which are separate from your ongoing reporting processes. This will allow you to decide whether any interventions to the strategy are necessary. The critical difference with periodic reporting on strategy is that the reports cover not only the process and outcomes of initiatives but also updates on the critical assumptions used to determine the strategy. These assumptions might include performance of the FT against forecasts, performance of other healthcare providers, commissioners' positions, patients' feedback, and regulatory assumptions.

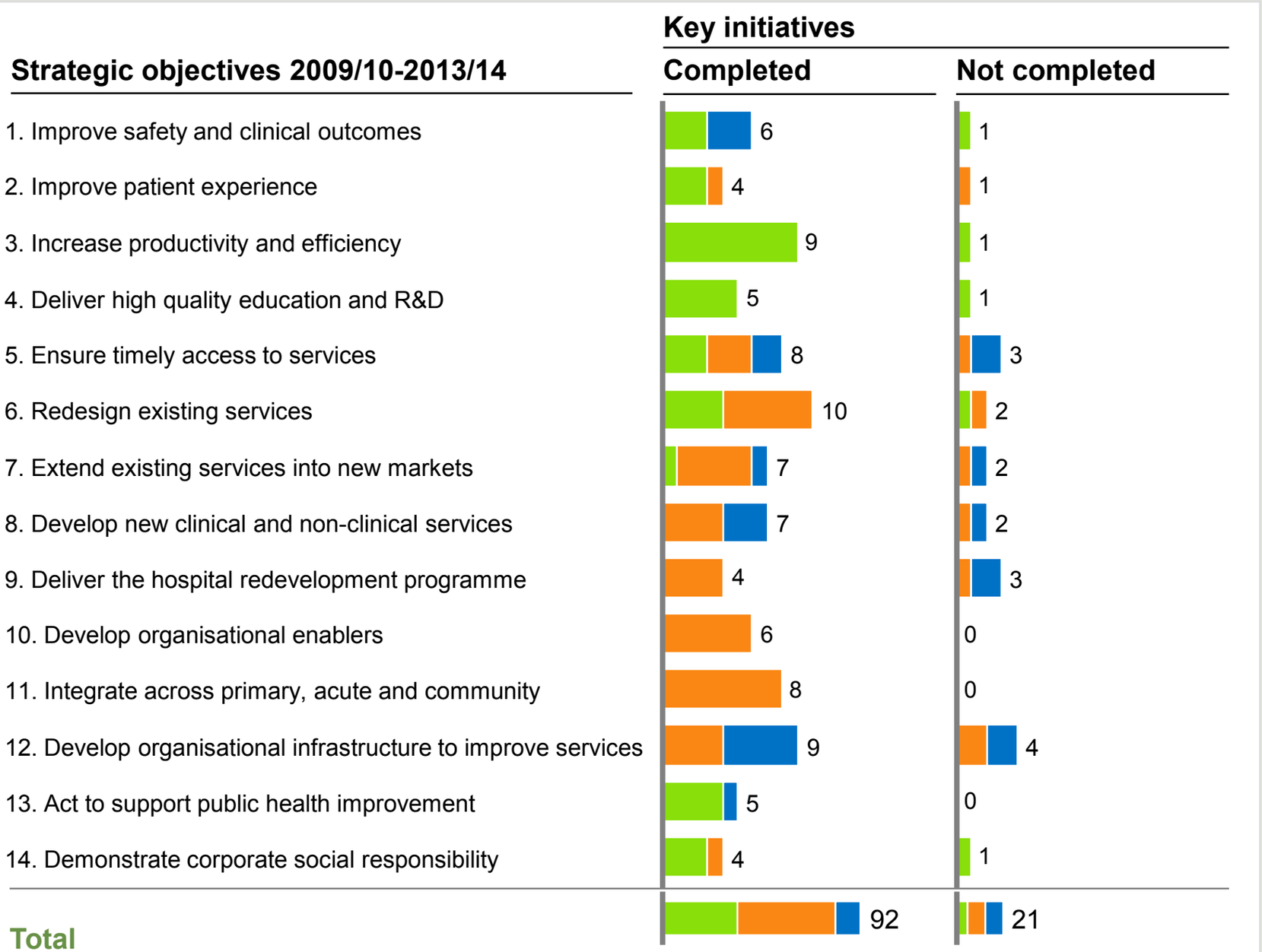
Typically, dedicated periodic reporting on strategy would happen every 6 to 12 months; the frequency will depend on the speed of change in the external environment and the urgency of your initiatives. This kind of reporting should take place at executive team and full board level, and involve governors.

In the following example, a trust has reported separately on the progress of initiatives that specifically support the strategy.

EXAMPLE

This report looks specifically at the progress of strategic initiatives

Clearly tracking the successful completion of strategic initiatives increases overall chances of success.



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Step 4: Managing results

A relatively devolved, clinically led organisation can effectively deliver strategic initiatives if the balance between autonomy and accountability is maintained. Some features of this balance are shown in the diagram below.

Greater devolved autonomy can lead to improved performance but needs to be matched by heightened accountability

Benefits of autonomy

- Speed of decisions
- Decisions closer to the patient
- Greater feeling of control
- Sense of shared purpose in teams
- Flexibility in deployment of financial resources
- Job satisfaction and motivation

Consequences of accountability

- Expecting to have to account personally for performance
- Personal and team consequences
- Being prepared to take corrective action personally
- Finding solutions within your area of control

A systematic process of face-to-face, performance reviews are an important method of ensuring accountabilities are met. Including individuals' results in their performance appraisals is an effective way to demonstrate that these initiatives are real priorities for your FT.

The examples in the following pages show how one NHS provider set out responsibility for decisions for accountable leaders (varied according to the risk profile of the services), and a framework for thinking about reward and recognition.

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EXAMPLE

An NHS provider's framework for responsibility for decision-makers that defines the recognition or consequences for clinical directors

	Low-risk service line	Medium-risk service line	High-risk service line
Decision-making rights	• Greater decision-making autonomy (to maximum defined under Service Line Management) including greater budgetary control	• Some increased decision-making autonomy (eg in lower-level HR decisions and/or clinical decisions) depending on which area is causing service line to be rated amber	• Limited/no additional decision-making rights beyond current authority
Service line incentives and consequences	• Increased service line incentives (eg quicker sign-off of business cases, ability to reinvest proportion of surplus, opportunity to reinvest private patient income)	• Some increased service line incentives (eg access to some capital funds)	• Limited/no additional service line incentives and at worst some service line consequences (eg increased consultation required before sign-off of business cases)
Personal incentives and consequences	• Increased individual incentives (eg 'star performer' development schemes, access to research funding/resources, excellence awards)	• Limited/no incremental individual incentives	• Removal of some personal incentives or introduction of consequences (eg removal from clinical director role)

Source: Anonymised NHS provider example

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EXAMPLE

A possible range of incentives and consequences to be used to support effective performance, based on experience in four trusts

	Examples of potential incentives based on feedback in four trusts	
Individual	1. Empowerment: the chance to make a difference 2. 'Thank yous' and other recognition for good performance (eg staff awards) 3. Additional annual leave 4. Opportunity for career development, growth and training (eg mentoring, coaching, exchanges) 5. Support for research initiatives eg sabbatical opportunities, learning trips 6. Removal of disincentivising irritants	1. Performance-related remuneration and/or career fast-tracking 2. Financial incentives (for all team members), linked to attainment of individual and team goals 3. Excellence awards (may be linked to clinical, financial or operational performance)
Service line	1. Opportunity to earn autonomy 2. Faster decision-making 3. Communication and consultation prior to change 4. Performance transparency across directorates, (eg anonymised league tables where directorates would know their own score) 5. Clarity of accountability 6. Access to managers/leaders and sight of them 'out on the wards' 7. Team/service recognition and awards (eg team dinners) 8. Improve working environment	1. Control over budgets and P&L (including Private Patient home) 2. Opportunity to retain profit, even if not for immediate use 3. Greater access to capital
	Non-financial	**Financial**

Source: Executive director interviews in four NHS FTs

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Reallocating resources in line with your strategy

Real change to support new strategic initiatives is unlikely without the visible reallocation of resources in line with your decisions. This applies to all kinds of resources: operating budgets, clinical leadership time, capital allocations, project management support, senior management and board time, and the interest and attention of governors.

Shifting resources to support your agreed strategic initiatives will often mean taking them away from de-prioritised initiatives. These shifts may need to be step changes rather than merely small, incremental changes in year-on-year allocations. In addition to reallocating resources, specific support should be provided to those who manage change; resources for this should be allocated at the start of your implementation period.

Organisations that reallocate resources effectively will be able to see a real difference from one year to the next. Making these changes visible and communicating the reasons for them will reinforce organisational priorities.

Communicating the strategy

Clearly and convincingly explain to leaders and staff at all levels the need for change, the new strategy, and the action necessary to succeed

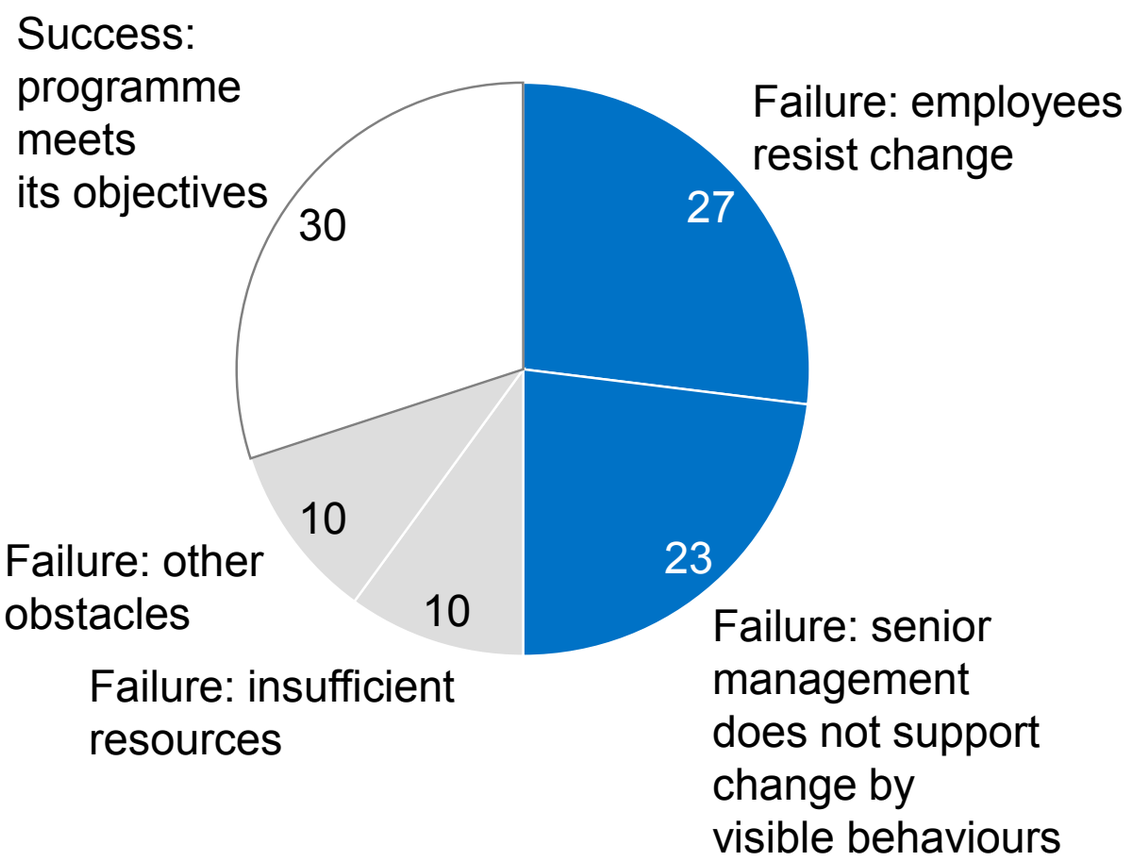
Using the summary of the strategy that you developed in the Prioritise stage, think about how to make this relevant and engaging for the various individuals and teams in the organisation. Find out what information they need in order to support change, and think through what will engage, guide and motivate them most effectively. Bear in mind that people usually prefer to hear about change in face-to-face meetings with their direct managers and leaders.

Staff can be invited to workshops, webinars, networking events or training exercises as appropriate. Consider providing events that will support staff on a continuous basis, such as gatherings where they can discuss with their peers their new approaches and ways to achieve their goals, along with regular check-ins with managers, and chances to celebrate interim successes.

By being clear and motivating in your communication, with consistent key messages for all audiences, you can inspire others to champion the changes needed to deliver the strategy.

Culture change is not easy

Research suggests 70% of change programmes fail, most because of cultural elements



Why is it so hard?

1. Cultural interventions are often not clearly linked to performance, so become low priority in the eyes of leaders and others
2. Such initiatives frequently fail to go beneath the organisation's surface, to explicitly address hidden mindsets and attitudes driving daily behaviours
3. Dysfunctional cultures are tough to change – especially as this involves influencing behavioural change and ways of working of thousands of staff

Source: Beer, M. and Nohria, N. (2000) Breaking the Code of Change. Boston: Harvard Business Press.

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Different forms of communication will be appropriate for different audiences but the overall message should remain consistent

Audience	Objectives of the communication	Features of the communication
CCG	• Align CCG and FT expectations • Build FT credibility • Keep sensitive information confidential	• Articulate a compelling strategy story • Link distinctive competencies to strategy • Set measurable goals • Demonstrate willingness to co-operate
Board	• Obtain the approval of the strategy and its implications • Provide a clear sense of milestones and financial outcomes	• Articulate the rationale underpinning strategy choices • What the choices are and their implications • What to expect, and by when • What are the risks and how are they being dealt with
Clinical directors	• Reinforce conviction around the strategy (this should have been built during the strategy development) • Align the leadership team on the proximate goals for each	• Remind them of the reality of the starting point • Articulate the rationale underpinning behind the strategy choices
Frontline clinical staff	• Motivate around a shared vision for the FT • Define a common measure of success • Convince staff to change their mindsets and behaviours	• Focus on the changes in their behaviour which are needed
Broader support staff	• Motivate around a shared vision for the FT • Define a common measure of success • Convince staff to change their mindsets and behaviours	• Very few themes • Focus on the one or two behaviour changes needed

One FT identified a longlist of broadcast channels and face-to-face opportunities for communicating with staff and other stakeholders

Internal channels

- Intranet
- Social media
- Texting
- Digital, including apps and games
- Storytelling microsite
- Photography, films and podcasts
- Weekly e-bulletin
- Monthly newsletter
- Quarterly newspaper
- Team briefing
- Quarterly open meetings
- Cascaded briefings
- Email briefings
- Leaders' blogs
- Posters and leaflets
- Payslip communications
- Raising concerns hotline, confidential email and post-boxes
- Staff awards events and dinner
- Team showcases
- Electronic notice boards; ambient media

External channels

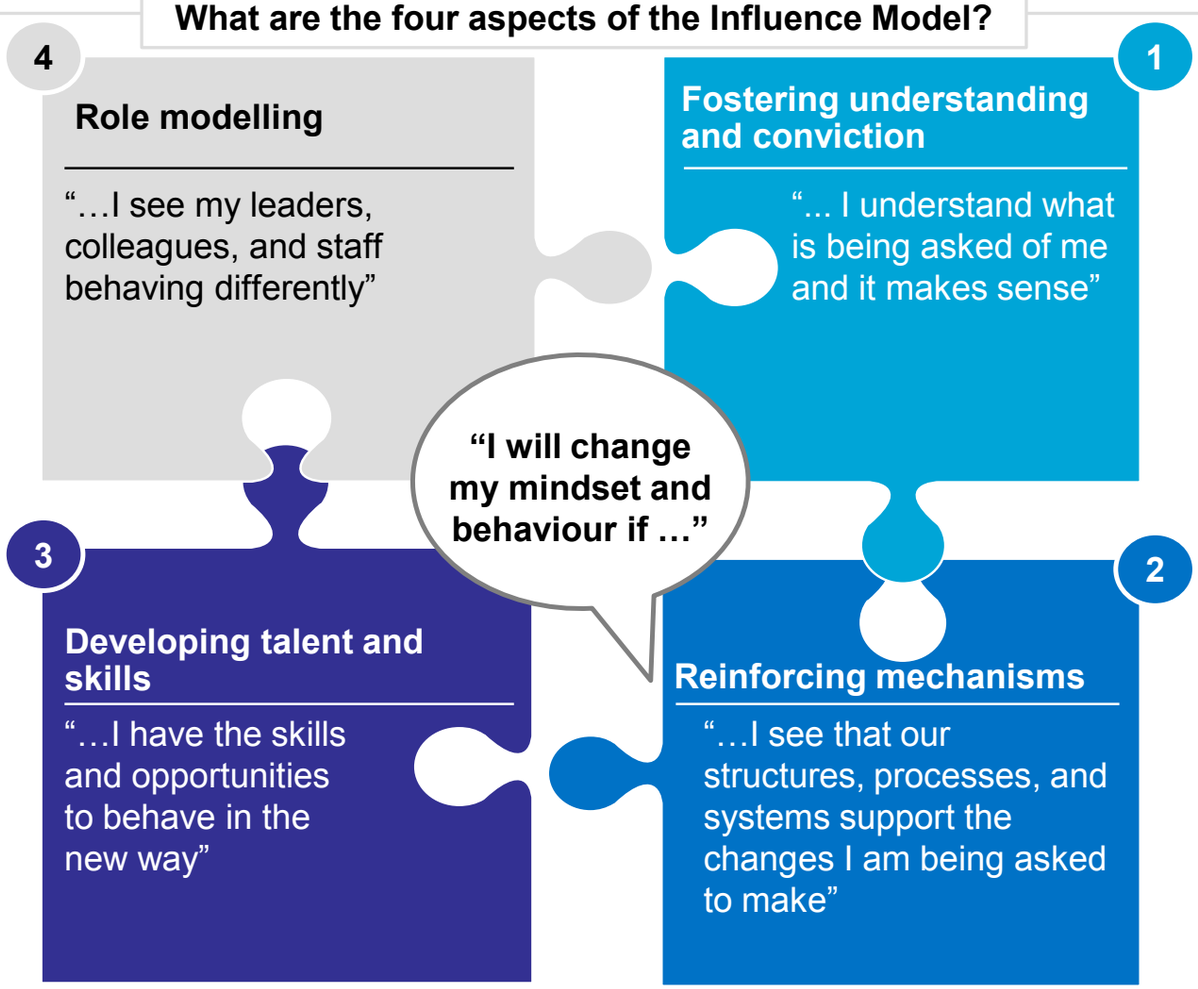
- Website
- Facebook, Twitter and YouTube
- Texting
- Digital, including apps and games
- Storytelling microsite
- Photography, films and podcasts
- Media relations including TV documentaries and media partnerships
- Annual report
- Public events
- Bespoke posters and publications
- Internet and web-based feedback (eg NHS Choices)
- Business development collateral (eg GP newsletters and bespoke brochures; events; trade shows)
- Electronic noticeboards, and use of design and technology in the new hospital
- Tactical advertising
- Charity campaign activity
- Consultation exercises
- Roadshows

Source: Anonymised NHS provider example

Achieving behaviour change: the Influence Model identifies four aspects which must be addressed for people's behaviour to change

This model is based on research and evidence from many different types of organisation. It emphasises that achieving behavioural change in a workforce requires four elements: communication to foster understanding and conviction, formal reinforcing mechanisms, the development of talent and skills, and role modelling. This model could help you to identify the actions you need to take to support behavioural change necessary to implement strategic initiatives.

What are the four aspects of the Influence Model?



How do I implement the four aspects?

1

- Strategy is communicated with relevant goals and rationale at every level
- Simplified, visual strategy is shown throughout organisation

2

- Team and individual performance reviews focus on strategic goals
- Resources are allocated to strategic priorities

3

- Leadership programmes develop ability to deliver strategic goals
- Specific training is given for those whose roles change

4

- Executive directors reference strategy in day-to-day conversations and team meetings
- Leaders dedicate time to strategic initiatives

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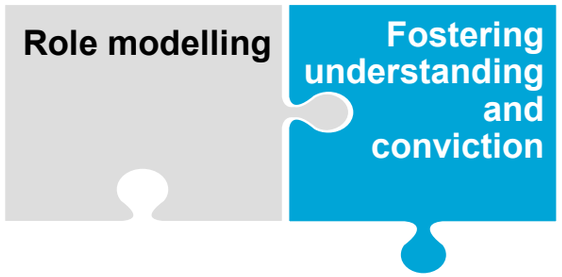
Change stories

Using change stories to communicate the strategy can foster understanding and conviction and demonstrate role modelling. Change stories are personal descriptions of the change needed in an organisation, and describe why it is needed, the solution proposed and why, and how the listener can support the changes alongside the teller. A cascade of change stories from board to divisional leaders, from divisional leaders to departments and so on can be effective.

To help achieve change, identify pivotal people throughout your trust who can become ambassadors. People who can influence change are not always those in identified line management positions. Individuals can have influence because of their knowledge, expertise, their respect from others, or their strong internal networks. Techniques exist for mapping such pivotal relationships within an organisation. Identify people who have influence and who can champion the changes you are making; they can particularly help to change the behaviour of others by becoming role models.

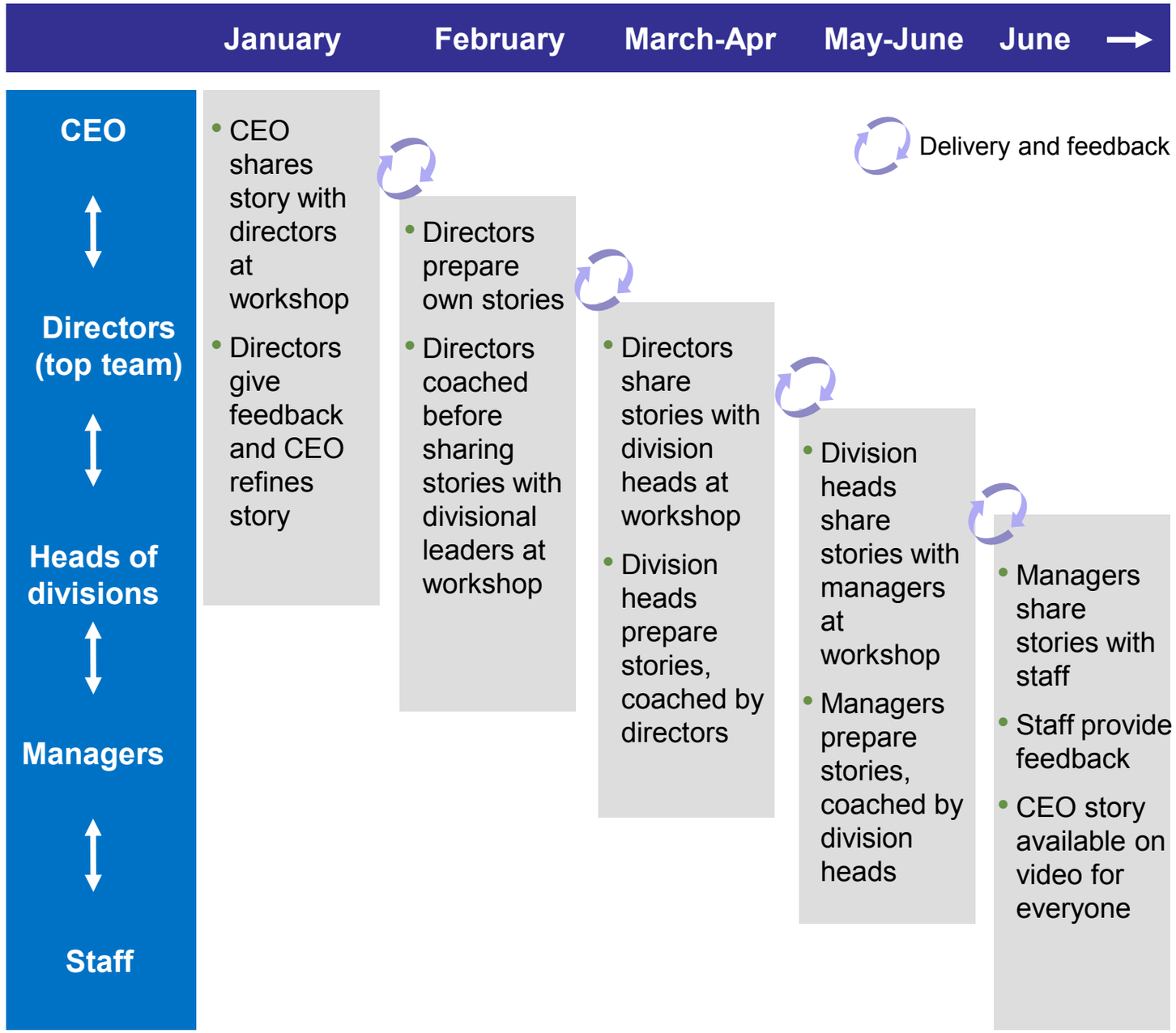
Using change stories to communicate the strategy can foster understanding and conviction and demonstrate role modelling (1/2)



Change stories are a personal description of the change needed in an organisation, incorporating answers to the following questions:

- What is the goal?
- What is the problem?
- What is the solution?
- Why is this the right solution?
- Can we do this?
- Who thinks we should do this?
- What will be done differently?
- Can the listener do it?
- Why should the listener do it?

Change stories show that others in the organisation support the change, and help people to understand the reasons for the change.



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Using change stories to communicate the strategy can foster understanding and conviction and demonstrate role modelling (2/2)

Nine tips for change stories	What it means in practice
1 Convey your own personal energy, excitement, and conviction	• Use phrases like: “I feel…”, “I’m doing this because…”, “I want to go for this…”, “I know we can do this”
2 Tell stories to make it real to people…	• Tell stories that mean something to you as well as to your audience
3 …but don’t leave out the high-level context-setting	• For example, use the macro perspective to really raise people’s ambitions about the scale of the opportunity
4 Be honest	• When you don’t know something, tell people that you don’t know, and when they can expect to hear more
5 Be clear on your rationale for change, and build it into your story	• Be clear whether you are arguing ‘we have to change’ versus ‘we are changing because we can’. The second alone is probably not compelling
6 Be clear on what we are changing toward – what will be different…	• Try to be really specific – what will be different in your audience’s day-to-day lives?
7 …while acknowledging the strengths and achievements of the past	• For example, talk about how organisational values like integrity are not going to change
8 Use rhetorical techniques, to the extent you can build them into your own style	• For example, “I believe we can do this, I believe we have the skills to do this, I believe we need to do this”
9 Use clear language, relevant to your audience	• For example, translate terms like: ‘patient value’ into what they actually experience and deliver

Supporting resources

Stage	Monitor resources
Deliver	• **Well-led framework for governance reviews: guidance for NHS foundation trusts**

Monitor

Making the health sector
work for patients

Evolve

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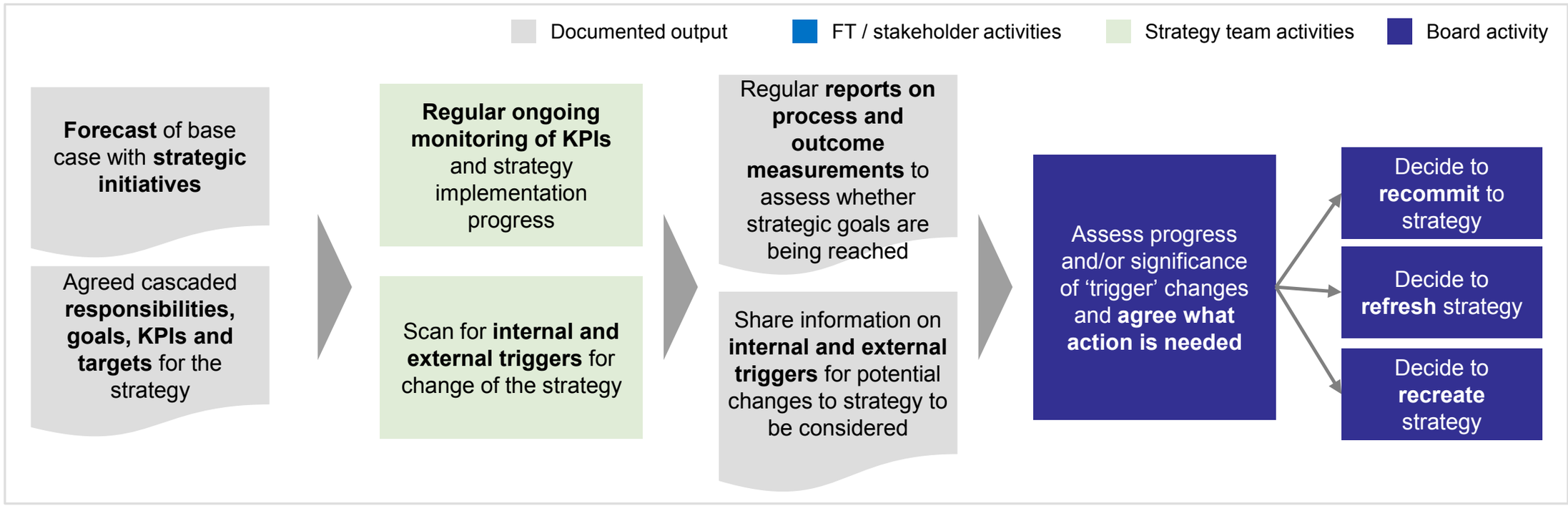
To remain relevant for your trust, the strategy needs to evolve to take account of the challenges that will be faced in implementation and any unexpected new external factors. You will need to monitor progress against the short- and long-term goals, and the relevant measures set out in the Deliver stage. You will also need to agree triggers – specific changes in your performance or the external environment – that would automatically require a review of part or all of the strategy. Finally, you should set out plans for periodic reviews. How this could work is set out below.

Following either type of review, you might want to recommit to the current strategy, refresh it (having taken into account relatively small changes) or recreate it entirely. A guide to these options is included in the How to Get This Done stage.



Reviewing your strategy: triggers and periodic reviews

Triggers for strategy review and contingent decisions

Strategy development and planning is a dynamic process. Changes are not always gradual or evolutionary; the assumptions and analyses underpinning your strategy can quickly become out of date. Hence it is good practice both to define triggers that would prompt a full or partial review and to develop a view on contingent decisions. There is a difference between these. Contingent decisions are pre-agreed responses to changes whose occurrence has been anticipated, enabling the FT to act quickly to mitigate the impact. A trigger leads to a review of strategy without a pre-agreed response.

Changes that could trigger a strategic review

Changes that could trigger a review include:

- Significant variation in performance on strategic goals or in the progress of strategic initiatives.
- Changes in overall performance of the FT, such as a predefined deterioration in financial performance in a specific service, or significant missed access targets
- Significant changes in the external environment, such as an unexpected merger of other healthcare providers, deteriorating financial stability at the commissioning organisation, or the collapse of a local provider or a part of the primary care system.
- Significant changes in government or regulatory policy, such as post-election shifts in policy on access targets, tariff levels and structure, or organisational restructuring or changes in regulatory standards.

The key is to be specific about the level of deterioration or change and the specific circumstances that would prompt a review. You should monitor these triggering changes and report on them in strategy updates so that any necessary reviews take place promptly.

You would usually identify just a few triggers, defined according to what would affect your trust's most important initiatives. In some cases, a combination of triggers may indicate that a specific, pre-defined scenario is unfolding.

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Individual contingent decisions

From your work in Prioritise on scenario development and sensitivity-analysis, you will already know which scenarios and critical assumptions have the most impact on your strategy. You may want to develop contingent decisions on that basis. Usually you would identify that a change in a single assumption, external factor or aspect of your trust's performance could have such a significant impact on your strategy that you would make different choices and pursue different initiatives. You will then need to discuss and agree with the board what actions will be taken in the event that such a factor changes.

The slides that follow illustrate:

- one approach to identifying critical uncertain assumptions, changes in which would have a significant impact on your FT
- an example of how an FT tracks movement in service line economics, a specific factor on which decisions about future strategy are dependent
- an example of a scenario approach that groups several factors together

If there are several high-impact scenarios and single triggers that are important, then you might lay out your anticipated responses in a contingent road map. This can create a common understanding at a senior level in the event that a specific scenarios arises and people will be primed to react quickly when these events occur. This is a systematic way of dealing with uncertainty in the plan. Examples of best practice in developing contingent road maps and an illustration of one for a mental health FT are set out in the following pages.

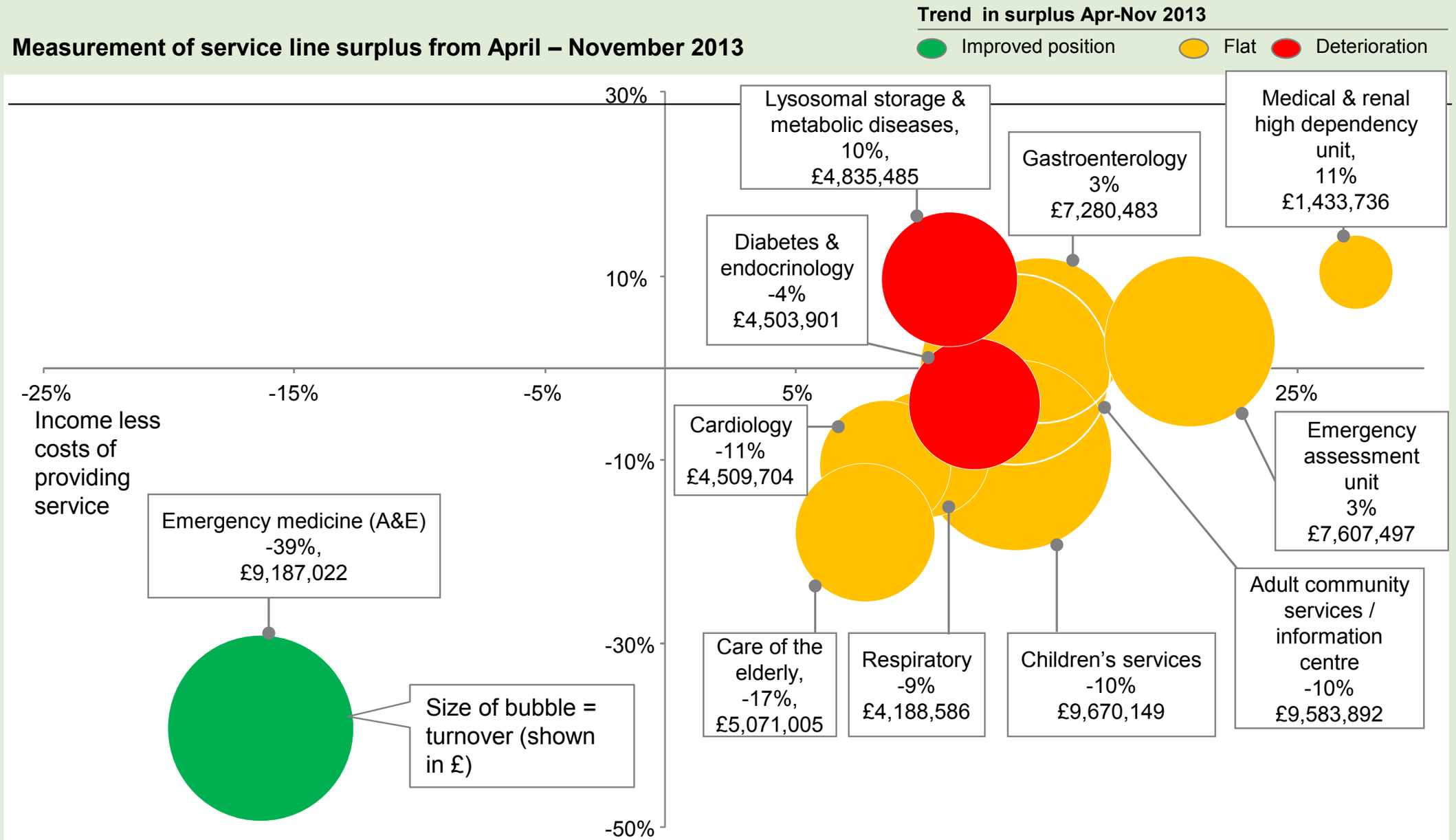
Identifying sources of uncertainty that would trigger contingent decisions

Uncertainty comes from many sources: macroeconomic, regulatory, competitor, technology, customer-related and internal capability. To understand which are relevant, you need to model the impact of a change in each. Then list the specific uncertainties that would have most impact on drivers of performance and create the highest risk to your strategy. You can input these factors into your contingency road map. In this example an FT has identified the factors that would have most impact on strategy, described the possible impacts and then incorporated this into a contingent road map.

Factors that would have critical impact on FT strategy		Sample impact
Additional cost to deliver required quality	Staffing	New requirement demands significant staff increase
	Infrastructure	Technology change requires major capital investment
Activity (demand for care)	Impact on supply	Another local provider exits a service causing sudden demand shift
	New treatments	
	Demographic change	
Income assumptions	Commissioner-driven	Commissioner decision to tender a core service
	Payment type	Mandatory capitation payment for all emergency medical and elderly services
	Level of payment	Additional 1% on tariff deflator

EXAMPLE

Tracking service-profitability over time: changes to profitability could be used as a trigger



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EXAMPLE

Combinations of factors coming together to create specific scenarios that may require you to undertake a strategic review or turn to contingent decisions

	What has to happen before given scenario comes true?	Potential early and leading indicator of scenario
Scenario 1 Increased financial position for trust	• Tariffs increase or deflator removal • Demand increase, eg through demographic growth / case-mix shift/ reduced services in local other hospital funded by commissioners • Commissioning for Quality and Innovation (CQUIN) funding increases	• National economy recovers and / or government announces no further spending-cuts to the NHS • Local hospitals issue consultations on closure plans
Scenario 2 Decreased income for trust	• CIP targets increase • Tariffs decrease or deflator increases • CQUIN funding decreases • Demand decrease, eg through case-mix shift / increased services in local competitor hospital	• Trust commissioners register increasingly large deficits • National economy worsens and / or government announces larger spending-cuts to the NHS • Local hospitals' strategic plans include increasing services in particular areas

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Developing a contingent road map with decisions made in advance about probable actions: six features of best practice

Built around contingencies that really matter	• The local health economy (LHE) may present dozens of uncertainties, but only a few will have a material impact on your strategy. Focus on those priority issues in the roadmap.
Based on a thorough understanding of the range of possible outcomes for each source of income	• Contingent road maps are grounded in fact and follow an exhaustive study of possible future outcomes. This distinguishes them from contingency plans, which focus on how to respond to a worst-case scenario in one key source of income (eg demand, tariff, Commissioning for Quality and Innovation).
Key signals or trigger-events are identified for each contingency	• The contingent road map on the KPI dashboard should closely track the latest developments in government funding, CCG financial status and services offered by local hospitals.
Strategic actions are specified for each contingency	• Some contingencies may demand a revised strategy, while others may call for maintaining the status quo.
The road maps are continuously revised, based on revised information about the LHE	• Contingent road maps should be regarded as living documents, not merely scripts for future action.
The plans don't just recommend changes in strategy	• They create changes because they are linked directly to strategic capital-allocation and decision-making processes.

Source: Road Maps Through Uncertainty by Hugh Courtney

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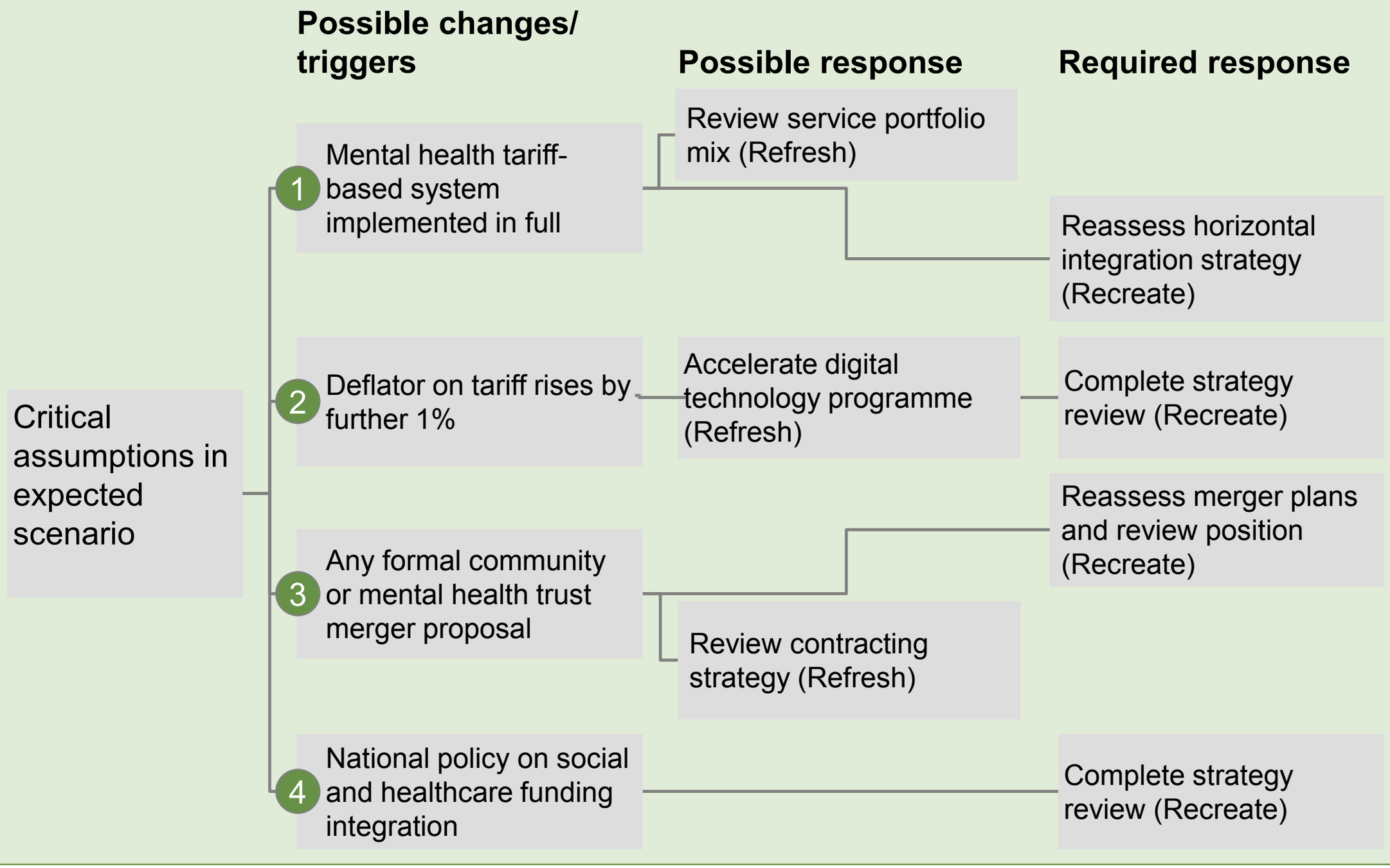
EXAMPLE

A contingent road map for a mental health trust



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Periodic review timelines

In addition to thinking about specific triggers for a review of your strategy, it is important to set predetermined periodic reviews of your strategy to check whether it is still relevant. You don't need to repeat all seven strategy development stages every year. The processes set out in the Deliver and Evolve stages describe the activities that would be repeated in an annual cycle. The other stages would be totally reworked only every few years, or when trigger events occur. It is expected that you will need to recreate a strategy only every 3 to 5 years, and refresh it in the interim.

Supporting resources

Stage	Monitor resources	Other resources
Evolve	• Quality Governance: How does a board know that its organisation is working effectively to improve patient care? • FT Annual Reporting Manual • Code of Governance	• Intelligent Board 2006, Dr Foster Intelligence

Monitor
Making the health sector work for patients

Testing the Strategy

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Introduction

It is important to review your strategy during its development and when it is complete.

The ultimate test of an FT strategy is that it sets out a realistic path to achieving or maintaining clinical, financial and operational sustainability of services.

The three fundamental review questions set out below underpin this. If you have been through each of the stages of the strategy development model thoroughly, you will have no difficulty in responding 'yes' to each question.

- Question 1 tests the quality of your analysis in the opening stages.
- Question 2 makes certain your FT has considered a number of strategic options and chosen one effective coherent strategy.
- Question 3 ensures that there is regular monitoring and assessment of the capacity and capability needed to deliver, using the guidance in the Deliver and Evolve stages.

The following pages suggest critical questions that the board can ask to make sure that each stage has been carried out effectively. In addition, we also offer a tool called 'The Ten Timeless Tests of strategy' which organisations in the commercial sector have used to compare their strategy development against best practice.

Testing your strategy process

Questions the board can ask to test the strategy development process (1/3)

Frame	1	Clarity and breadth of strategic decisions	Have we expressed the scope clearly, as questions to be answered, and do we have an agreed view of what our strategy must achieve?
	2	Criteria	Do we have clear, measurable criteria written down and agreed to make the decisions about the best strategy for us?
	3	Participation	Have board members and the wider leadership of the FT been personally involved in conversations and decisions about Frame?
	4	Senior review	Has the board agreed a systematic process and set aside enough dedicated time to involve itself in ongoing review of the strategy?
Diagnose	1	Balanced assessment	Does our analysis cover a balanced set of measures, including quality and safety of care, operational, workforce measurements and financial performance? Does the analysis show us underlying causes of performance issues?
	2	Patients and customer focus	Have we kept a focus on understanding what lies behind the patients' experience, and the needs of our patients and commissioners?
	3	Aiming high	Have we challenged ourselves through detailed comparisons against high-performing organisations in healthcare here and internationally and other sectors?
	4	Health economy alignment	Are we confident that the analysis has involved close working with commissioners and the rest of our health economy, resulting in agreed baselines and priorities?

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Questions the board can ask to test the strategy development process (2/3)

Forecast	1	Balanced assessment	Have we forecast trends across all important measures, including clinical quality trends and not just activity and finance?
	2	Understanding causes	Do we truly understand the causes of change in the forecasts we have created and not just the numbers? Is this explicit in our Forecast outputs?
	3	Whole-trust view	Can we see a comprehensive picture of how the trust will look in the future?
	4	Health economy alignment	Are we confident that the forecasts result from close work with commissioners and the rest of our health economy, resulting in a shared view?
	5	Scenarios and sensitivities	Rather than having just one view of the future, do the forecasts look at different scenarios, including at least an upside and downside case?
Generate Options	1	Themes that link to analysis	Do our proposed strategic themes have a rationale rooted in the prior analysis and do they tackle the strategic questions we identified in Frame?
	2	Challenging perspectives	Have we sought inspiration from as wide a range as possible of external sources in healthcare and other industries to identify ideas?
	3	Participation	Has our search for initiatives involved a large number of people across the whole organisation and external partners?
	4	Narrowing the options	By the end of this process, is the potential list of options derived from meaningful discussions among the board, informed by robust information and against agreed criteria?

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Questions the board can ask to test the strategy development process (3/3)

Prioritise	1	Truly understanding impact	Do we know enough about the impact of shortlisted initiatives to make robust choices?
	2	Clear choices through discussion	As a board, have we made choices through discussion, with challenge, and are we all clear on what the choices are?
	3	Coherent strategy	Do the chosen initiatives work together with an appropriate balance of risk, and is the board confident that the strategy will deliver clinical, financial and operational sustainability?
	4	Communication of the strategy	Is there a clear illustration and a description of the chosen strategy that we can use to communicate across the organisation and with stakeholders?
Deliver	1	Clear, measurable goals	Are there long-term goals for the strategy and short-term goals for initiatives that will be measured?
	2	Shared responsibility and ownership	Can leaders and teams at all levels explain the link between what they have to do and delivery of the strategy? Do they feel responsible for achieving it?
	3	Visible reallocation of resources	Have clear decisions been taken to reallocate people, skills, time and money in pursuit of the strategic initiatives and does everyone know this?
	4	Monitoring	How will we know whether the delivery of strategy is successful? How will the board be kept informed, and how will they know if it is successful?
Evolve	1	Linked measures	Are we measuring the right things – do we have a good balance of measures and do they actually reflect what we are trying to achieve?
	2	Triggers	Have we decided what would trigger a review of the strategy and what would trigger specific contingent choices already set out in the strategy?

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Testing your completed strategy

Common pitfalls to avoid

Frame

- Focusing on analyses rather than decisions
- Focusing on too many decisions rather than the few that matter
- Limiting yourself to an insufficient scope
- Ignoring the human context in the decision-making process

Diagnose

- Over-averaging & superficiality in scope definition and analysis
- Forgetting the patients' and customers' perspectives
- Confusing performance with capabilities

Forecast

- Trying to predict the future
- Not seeing the impact of big problems ahead
- Simple extrapolation
- Standard best, base and worst case scenarios

Generate options

- Picking one dominant idea
- Developing generic alternatives
- Brain-storming rather than structuring creative idea-generation
- Copying 'best practice' without context
- Overlooking responses of other provider and com-missioning organisations

Prioritise

- Insufficient focus on the handful of real choices that require genuine commitment
- Vagueness
- Under-investment in your critical strategic choices

Deliver

- Insufficient time and effort to build social conviction, identify the required changes and set up the infrastructure
- Disconnect between budget, capital, and people process
- Insufficient piloting
- Not addressing how to influence those who are resistant to change

Evolve

- Not revisiting critical assumptions over time
- Not incorporating new information
- Insufficient experimen-tation and learning
- Monitoring the wrong parameters

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Step back and review the result of strategy development

In the commercial sector, many organisations develop strategies that fail. The Ten Timeless Tests of strategy help organisations compare how well their strategy development compares with best practice. Meeting all ten is a hard task: one study showed that only 35% of executives felt that their company met more than three of the tests[1]. But gauging how well your strategy compares can inspire your organisation to improve it.

1	Will your strategy beat the market?	…or are you just playing along?
2	Does the strategy tap the true source of advantage?	…or is it based on a misplaced diagnosis of why you earn returns?
3	Is the strategy granular about where to compete?	…or are markets defined generically, failing to allocate resources to match opportunities?
4	Does it put the enterprise ahead of trends and discontinuities?	…or does it assume continuation of the status quo, not reacting to change until it's too late?
5	Does the strategy embed privileged insight and foresight?	…or does it rely on common analysis of common data to yield common wisdom?
6	Is uncertainty properly defined and accounted for?	…or is uncertainty either being ignored or inducing paralysis?
7	Does it balance commitment-rich choices with flexibility and learning?	…or is there too much planning and too little focus on choices that can unfold over time?
8	Have alternatives been evaluated without bias or false inference?	…or does the strategy fall victim to biases and faulty logic in the way decisions are made?
9	Is there true conviction to act?	…or are the old beliefs behind the new strategy left unchanged?
10	Is the strategy translated into clear actions and reallocation of resources?	…or is it a vague statement of intent that doesn't connect to new actions?

Source: 1 Bradley, C., Hirt, M., and Smit., S., (2011) Have you tested your strategy recently: Ten Timeless Tests. McKinsey Quarterly, Jan 2011

EXAMPLE

Step back and review the result of strategy development

Many of the principles of the Ten Tests apply equally well in the NHS context. Others do not, but can be adjusted to reflect the goal of maximising benefits for patients, across the whole health system. The example below is an adjusted version of the Ten Tests used by one FT to facilitate a board discussion of how their strategy could be improved.

Ten Timeless Tests of Strategy adjusted by one trust for use with its board

1	Does the strategy create more value than peers, while collaborating within the health system?	…or are you aiming for the middle and acting alone?
2	Does your strategy tap the true source of advantage?	…or is it based on a misplaced diagnosis of your strengths?
3	Is your strategy granular about where to compete, at least down to specialty level?	…or are markets defined generically, failing to allocate resources to match opportunities?
4	Does it use innovation to put the *organisation* ahead of trends and discontinuities?	…or does it assume continuation of the status quo, not reacting to change until it's too late?
5	Does your strategy embed privileged insight and foresight, including from patients and commissioners?	…or does it rely on common analysis data to yield common conclusions and miss sources of insight?
6	Is uncertainty properly defined and accounted for?	…or is uncertainty either being ignored or inducing paralysis?
7	Does it balance commitment-rich choices with flexibility and learning?	…or is there too much planning and too little focus on choices that can unfold over time?
8	Have alternatives been evaluated without bias or false inference?	…or does your strategy fall victim to biases and faulty logic in the way decisions are made?
9	Is there true conviction to act?	…or are the old beliefs behind the new strategy left unchanged?
10	Is your strategy translated into clear actions, a workforce strategy and reallocation of resources?	…or is it a vague statement of intent that doesn't connect to new actions, workforce or resources?

Source: Anonymised NHS provider example

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Supporting resources

Stage	Monitor resources	Other resources
Testing your strategy	• Monitor planning and reporting requirements	• Ten Timeless Tests of Strategy, McKinsey Quarterly, January 2011 • 'In the cold light of day: 10 demanding tests for hospital strategy', McKinsey Discussion Paper, 2014