Monitor
Making the health sector work for patients

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04/02/2016

By email

Dear

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of 14 December 2015 in which you requested information under the FOI Act. I apologise for the delay in replying.

<u>Your request</u>

You made the following request:

"I would like to see a copy of the minutes, agenda and papers for the meetings of the NHS Improvement Planning Steering Group".

As your request was received on 14 December, the request covered the papers for the first 3 meetings of the Group, held on 1 and 28 October and 7 December.

<u>Decision</u>

Monitor holds the information that you have requested.

Monitor has decided to withhold some of the information that it holds on the basis of the applicability of the exemptions in sections 36, 42 and 43 of the FOI Act, as explained in detail below.

The attached Annex sets out the details of the relevant information that we hold and whether that information is to be disclosed (in whole or in part) or withheld from disclosure. Where information is being withheld, we have identified in the Annex those exemptions which we consider to be relevant, being one or more of sections 36, 42 and 43.

Where we are able to disclose information to you, it will be provided to you electronically as identified by the document number in the Annex. The application of exemptions to the information referred to in the Annex is explained in the following paragraphs.
Please note that there were no final minutes of the meetings at the time of your request.

Section 36 – prejudice to conduct of public affairs
Monitor has decided to withhold some information on the basis that it falls within section 36(2) of the FOI Act (prejudice to public affairs) and that the public interest in maintaining the exemption outweighs the public interest in disclosure.

The information being withheld falls into 4 categories:
1. Papers and extracts concerned with policy on the 'NHS provider landscape'
2. Paper on NHS Improvement budget decisions
3. Paragraphs of an update paper on Organisation Design
4. A draft risk register.

The exemption is engaged in relation to this information as Monitor's qualified person (Jim Mackey, Chief Executive) is of the opinion that disclosure of this information would, or would be likely to, inhibit (i) the free and frank provision of advice or (ii) the free and frank exchange of views for the purposes of deliberation (section 36(2)(b)(i) and (ii)). The reasons are summarised below.

Papers on NHS Provider Landscape and NHS Improvement budgeting
The papers on the NHS Provider Landscape and on NHS Improvement budgeting contain detailed advice and views on policy options and proposals, in areas where the policy had yet to be finally settled and was subject to further discussion and negotiation with other bodies (e.g. the Department of Health). Disclosure would reduce the candour and frankness with which such advice or views was given by officials to the Steering Group on policy matters, particular on the risks and benefits of different policy options, as officials would be concerned about the possibility that those views and discussions would be made public. This would impact on the ability of the Steering Group, and Monitor more generally, to give effective consideration of policy issues informed by high quality advice, and may mean that policy options are not fully and properly explored.

Paragraphs in Organisational Design paper
These contain views and advice connected with the organisational design of NHS Improvement. Disclosure of the relevant paragraphs would be likely to reduce the frankness and candour with which individuals expressed their advice and views on these matters on future occasions

Draft risk register
The draft risk register, setting out risks in relation to the NHSI Integration Programme, was prepared for consideration and discussion by the Joint Working Group which reported to the Steering Group, and had not been finalised. The register consists advice on what risks should be noted, reported and dealt with, and views on the level/likelihood of each risk, to inform the final decision of the Working Group as to what should be recorded on the register. Disclosure of such a draft is likely to reduce the frankness and candour with which officials would express advice on risks, and the freedom with which views would be shared when making decisions in relation to risk. This would in turn reduce the quality of the risk management process for this and similar projects.

Public interest
Monitor's view is that in each case the public interest in maintaining the exemption outweighs the public interest in disclosure.

In considering the balance, we have considered the public interest in transparency and openness in relation to decisions by public bodies, in particular decisions affecting the NHS. In particular, in the present case, there is a public interest in patients and the public understanding the development of NHS Improvement and related policy.

We have however also considered the strong public interest in allowing officials in Monitor and the NHS Trust Development Authority to have free and frank discussions about policy options and related matters, informed by open, honest, frank and detailed advice. If discussions and advice such as these were generally made public, this would reduce the candour and frankness with which views were expressed or advice given, in turn reducing the quality of the policy decisions in relation to those views or advice. There is a public interest in ensuring that Monitor and the NHS Trust Development Authority are able to have the open and confidential discussions necessary to ensure the effective development of NHS Improvement and related policies. We have taken into account that, in relation to the NHS Provider Landscape and NHS Improvement budgeting, the opinion of Monitor's qualified person was that the prejudice would occur (i.e. it was more probable than not that the prejudice would occur). We have also considered that a substantial amount of information about the NHS Improvement integration work is publicly available, including the information published with this letter.

Taking into account these considerations, our decision is that the balance of public interest is in withholding this information.

Section 42 - legal professional privilege
Monitor has also withheld information in respect of which a claim to legal professional privilege could be maintained. This applies to information contained in the paper on the NHS Provider Landscape which consists of legal advice in connection the policy issues discussed in that paper.

Public interest
There is a strong public interest in safeguarding openness in all communications between client and lawyer to ensure access to full and frank legal advice, which in turn is fundamental to the administration of justice. Although there is a public interest in transparency and accountability of public bodies, we are satisfied that this does not outweigh the strong public interest in maintaining the section 42 exemption.

Section 43(2) – commercial interests
The information redacted from the paper on Technology and Budget consist of information about contracts, potential costs and budgets for developments in information technology in connection with the establishment of NHS Improvement. Disclosure of this information would be likely to prejudice Monitor's position in subsequent procurement and contracting exercises and therefore prejudice its commercial interests. This information is therefore being withheld on the basis of the exemption in section 43(2) (prejudice to commercial interests).

In addition, the papers for the 1 October meeting contained a confidential “note to market”, giving advance notice of the intention of the NHS Trust Development Authority and Monitor to issue an invitation to tender (ITT) for the provision of support on the establishment of NHS Improvement. That contract has now been awarded, although the ITT used in that exercise has not been published. The note to market was prepared before final decisions on the business case and precise scope of support, and may not reflect changes to the proposals for the service specification for the contract which were made after the note was issued. Disclosure of this note to market would be likely to prejudice Monitor’s commercial interests.

Public interest
There is a strong public interest in ensuing that Monitor can procure and negotiate contracts effectively and with a view to make the most effective use of public resources. Although there is a public interest in transparency and accountability of public bodies, particularly in relation to the expenditure of public funds, we note that –

- In relation to the Technology paper, we have disclosed most of the paper setting out the issues in relation to technology problems and solutions connected with the establishment of NHS Improvement.
- In relation to the note to market, further information will be published about the contract award, which will provide some transparency.

Our decision is that the balance of public interest is in withholding this information.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within Monitor of the issue or the decision. A senior member of Monitor’s staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review conducted by Monitor, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, Monitor, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to foi@monitor.gov.uk.

Publication

Please note that this letter and the attached information will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

Helen Buckingham
Chief Of Staff
Monitor

ANNEX

Number	Description	Dates	Decision and any applicable exemption
1.	Agenda for meeting on 1 October 2015	1.10.15	Disclosed
2.	Slide pack for items 2 and 4 of 1 October meeting	1.10.15	Disclosed
3.	Terms of Reference (item 3 of 1 October meeting)	1.10.15	Disclosed
4.	Note to Market (item 4 of 1 October meeting)	25.9.15	Withheld (s.43)
5.	Agenda for meeting on 28 October	28.10.15	Disclosed
6.	Slides on organisational design	28.10.15	Disclosed
7.	Future options for the Provider landscape paper	28.10.15	Withheld (ss.36 and 42)
8.	Agenda and papers for 7 December meeting (single document)	7.12.15	Partially disclosed Withheld information - • Redactions to paper on item 4 (Key Workstreams update) (s.36) • Paper on item 5 (NHS Improvement budgeting for 2016/17) withheld (s.36) • Redactions to paper on item 6 (Technology and Budget) (s.43)

Monitor
Making the health sector work for patients

NHS IMPROVEMENT STEERING GROUP
1 OCTOBER 2015, at 12:30-14:30

3.7, Wellington House, 133-155 Waterloo Road
London, SE1 8UG

AGENDA

1.	**Introduction**	ES
2.	**Programme Plan** (slides 1-9 attached)	RC / HB
3.	**Terms of Reference** (attached)	ES
4.	**Resourcing – internal & external** (slides 10-14 attached & note to market attached)	RC / HB
5.	**Initial discussion on vision & operating model**	ES
6.	**Dates of future meetings**	

Creating NHS Improvement

Scale, nature and resourcing of the task

September 2015 (V5.7)

Purpose of this paper

This paper presents a high-level view of how NHS Improvement can be created quickly and effectively. It covers:

- **A set of guiding ambitions for the work (slides 3 & 4);**
- **Core components of the task, covering design, transition and enabling activities (slide 5);**
- **High-level sequencing and phasing of the tasks (slides 6 & 7); and**
- **High-level people principles and resources required to undertake the work (slides 8-14).**

The Annex (slides 15-36) offers a brief overview of each of the components, including the core tasks therein, and the challenges, risks, opportunities and dilemmas which each brings to light.

This paper is designed to support structured engagement with and decision-making by senior leaders and potentially in due course with staff and stakeholders. All proposals at this stage are initial ideas which are open to challenge and debate.

Guiding ambitions (1)

It is important from the outset to have a clear sense of “what NHS Improvement is here to do” in order to provide clarity and generate enthusiasm for change. The below points offer a basis for establishing a compelling set of core ambitions for NHS Improvement:

1. Support as many providers as possible to improve the quality of services and achieve “Good” or “Outstanding” CQC ratings and ensure there are no providers in special measures
2. Support significant improvements in provider productivity as a core component of meeting the £22bn challenge
3. Support the changes to the structure and form of providers which will enable quality and productivity improvement, embracing and enabling the new models of care set out in the Five Year Forward View
4. Support the development of more, more effective and better supported Boards and leaders.
5. Support providers to deliver effective, locally-owned improvement methods; increasing scope for the identification and promulgation of good/best practice
6. Support providers to deliver sustainable performance standards, maintain financial control and demonstrate high standards of governance, while engaging effectively with staff and stakeholders
7. Support improvements to patient safety by NHS providers
8. Through high levels of collaboration with NHS England and other system partners, will
   - Ensure the payment system promotes quality and efficiency across health economies
   - Ensure the rules governing procurement, choice and competition operate to incentivise system behaviours which are in the best interests of patients;
   - Take a health economy wide approach to ensuring sustainable health care services.

Guiding ambitions (2)

Similarly, it will be important from the outset to have a clear set of ambitions for the creation of NHS Improvement in order to provide clarity and direction for staff and stakeholders. Below is a draft set of ambitions for discussion. By April 2016:

1. NHS Improvement will exist as an integrated structure providing support to all NHS trusts and Foundation Trusts.
2. NHS Improvement will incorporate Monitor's role as the economic regulator of the NHS including licensing independent sector providers
3. NHS Improvement will incorporate NHS England's current responsibilities for patient safety
4. While recognising and celebrating our diversity, staff working for NHS Improvement will share a single set of values and behaviours centred on providing support, development and constructive challenge for improvement by providers and working collaboratively across the system.
5. NHS Improvement will use one set of tools, systems, policies and processes for supporting, developing, overseeing and intervening with NHS trusts and NHS Foundation Trusts.
6. NHS Improvement's teams will be co-located wherever possible and plans will be in place to move to a single set of terms and conditions for staff.
7. Work with providers will be undertaken as NHS Improvement with clear governance arrangements to fulfil the statutory duties of the TDA and Monitor and manage any conflicts of interest.

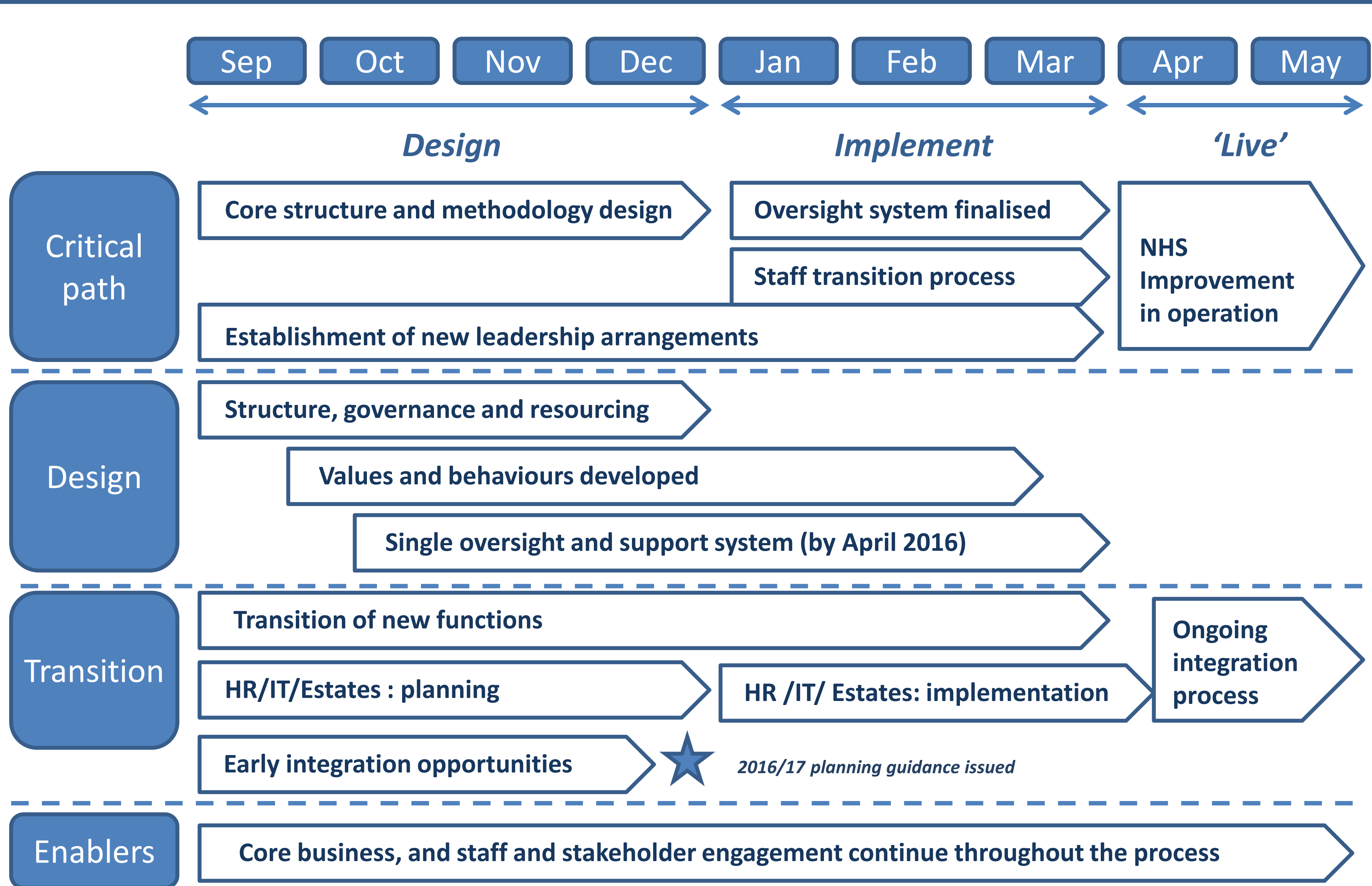
During the design and development phase which will lead to the April 2016 state it is important to reiterate that delivery of core business activity will continue to be a priority for the majority of staff across both Monitor and the TDA.

The components of the task

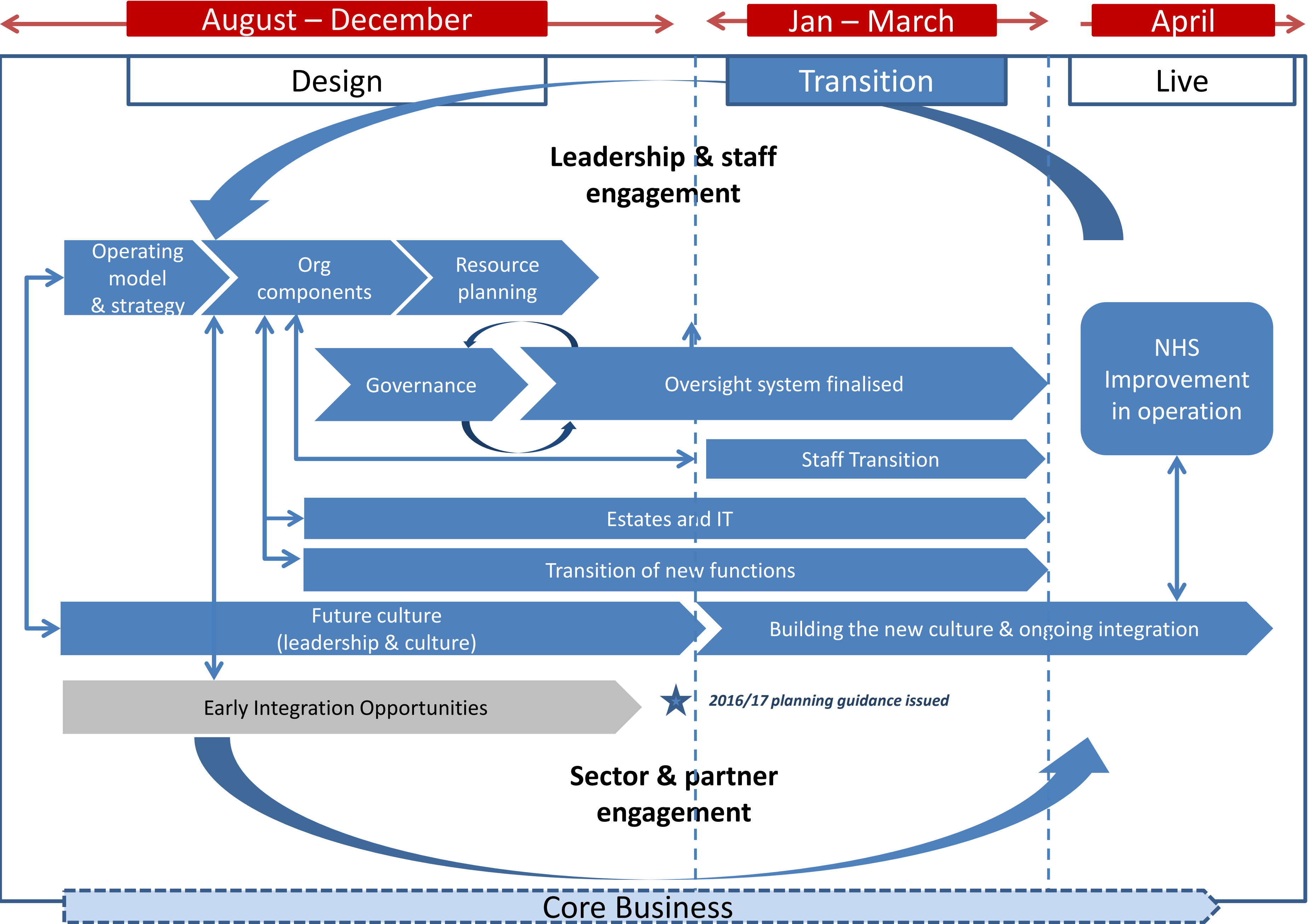
There are a number of key tasks which will need to be scoped, phased and executed effectively in order to ensure success. The diagram below presents one articulation of the core tasks, divided into design, transition and enabling activities. These activities are cross referenced with the proposed programme structure which can be found on slide 9.

Sequencing and phasing of activities (1)

A high-level view of phasing and sequencing of key activities allows the work to be divided into design (Sep – Dec), implementation (Jan – Mar) and 'live' (Mar+) phases



Sequencing and phasing of activities (2): Interdependencies



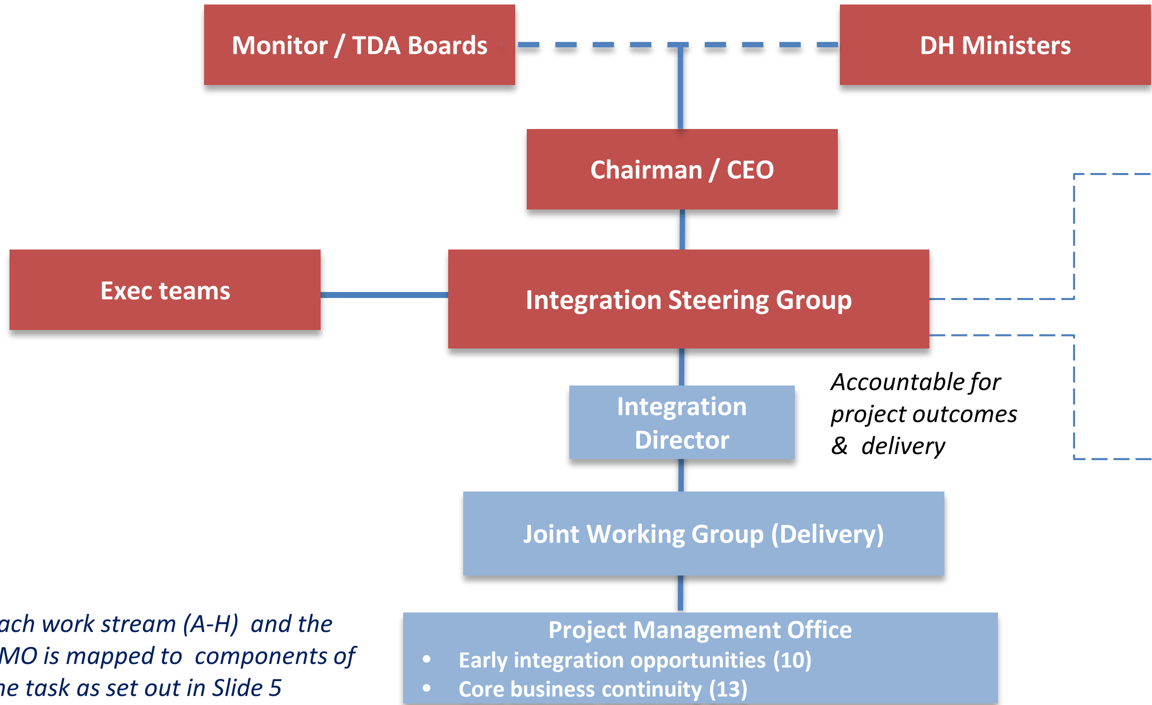
Resourcing the task (1)

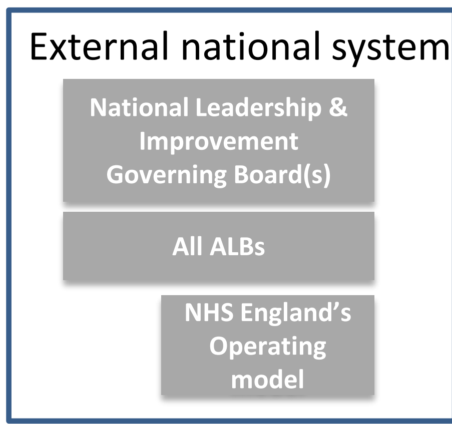
Managing this process effectively will require a significant amount of skill and diverse dedicated resource, as well as the ability of leaders and staff across existing organisations to release time to contribute to the process.

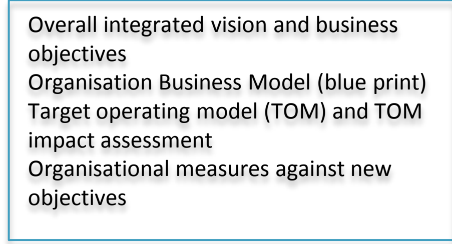
The tasks set out above point to the need for:

- Identification of dedicated resources for the design and transition process to allow the vast majority of staff in existing organisation to focus primarily on core business;
- The capacity of staff and leaders across existing organisations to release time to support the process;
- All staff to be given an opportunity to engage in the process;
- Dedicated senior leadership for the design and transition process;
- A small, skilled PMO to drive the overall process and align activities;
- Dedicated legal, finance, HR and engagement skills to support key activities;
- Concentrated resources to support engagement and HR change at scale at key times;
- External advice and commissions in key areas, potentially including support system design, governance design, review of improvement methods and cultural change and development.

Resourcing the task (2): Programme structure

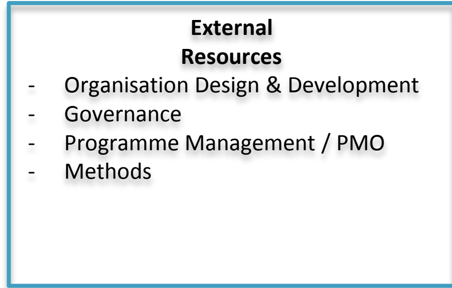






Each work stream (A-H) and the PMO is mapped to components of the task as set out in Slide 5

Project Management Office
- Early integration opportunities (10)
- Core business continuity (13)



Work streams and key activities

A – Culture and Values
- Culture, values and behaviours (3)
- Building the new culture (8)
- Leadership and staff engagement and communications (14)

B – Organisational Design
- End state design (1)
- Integrated oversight and support system (2)
- Improvement methodology (4)

C – Infrastructure
- Estates (11)
- IT and Integrated Information Systems (12)

D – Legal and Governance
- Governance Design (5)

E – Finance
- Resource Planning (6)

F – HR
- HR Processes (7)

G – External Engagement
- Sector and partner engagement (15)

H – New Functions
- Transition of new functions (9)

Resourcing the programme: overview of approach (3)

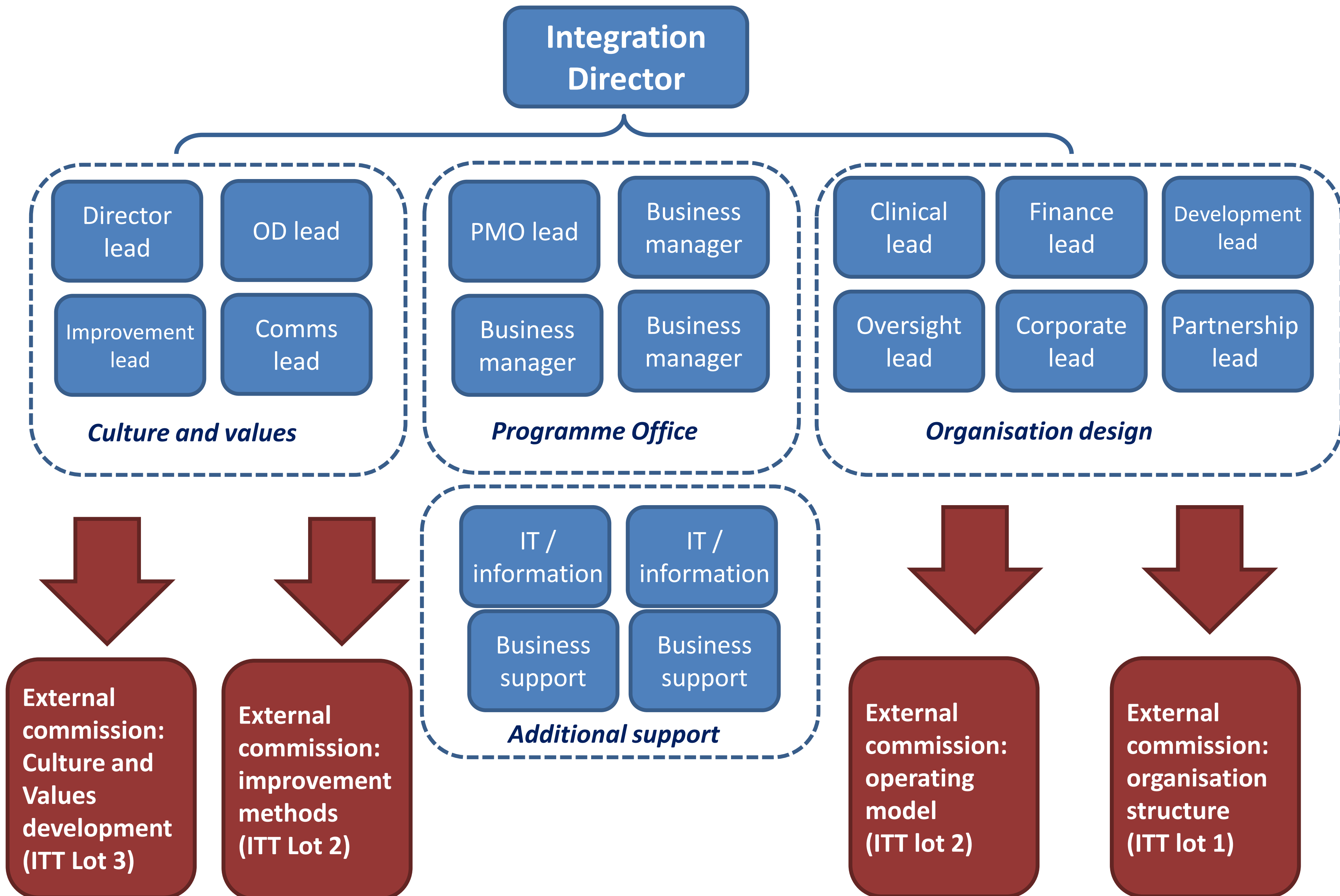
In determining the best approach to resourcing the creation of NHS Improvement, we need to balance a number of different factors:

- the need to use the process of creating NHSI to **engage and involve staff** from across Monitor, TDA and NHSE, recognising that many of the skills and much of the knowledge required are available in house,
- the need to maintain a clear **focus on today's business** through the transition period and avoid taking too many people "off the tools",
- the need for some elements of the process (e.g. organisational structure) to involve **independent scrutiny and challenge**, and
- the need to move at **pace**.

In order to balance these different factors, we are pursuing a core resource model which involves elements of both "make" and "buy", meaning we will have:

- **an internal term** (seconded from within Monitor, TDA and NHSE) of 15-20 staff with responsibility for oversight of the programme, guiding key elements of the process and engaging the broader staff bases of the organisations, and
- **external support** for key elements of the process, particularly organisational structure, operating model and development of culture and values.

Resourcing the programme: detailed view (4)



Work stream leads and counterparts

Work stream	Lead	Counterpart
Culture and Values	Helen Buckingham, Chief of Staff, Monitor	Rob Checketts, Director of Communications, NHS TDA
Organisational Design	Ralph Coulbeck, Director of Strategy, NHS TDA	Philippa Harding, Director of Operations and Performance (Provider Regulation), Monitor
Infrastructure: Estates	Liz Dimond , Head of Assurance, NHS TDA	Fiona Knight, Executive Director of Organisational Transformation, Monitor
Infrastructure: IT and Integrated Information Systems	Peter Sinden, Chief Information Officer, Monitor	Iain Wallen, Director of Information and Analytics, NHS TDA
Legal & Governance	Kate Moore, Executive Director of Legal Services, Monitor	Lynne Burgess, Senior Governance Manager, NHS TDA
HR	Fiona Knight, Executive Director of Organisational Transformation, Monitor	Maria Robson, Head of HR, NHS TDA
Transfer of new functions	Maria Robson, Head of HR, NHS TDA	Fiona Knight, Executive Director of Organisational Transformation, Monitor
External Engagement	Jeremy Mooney, Executive Director of Strategic Communications, Monitor	Rob Checketts, Director of Communications, NHS TDA
Internal Finance	Elizabeth OMahony, Finance Director, NHS TDA	Jason Dorsett, Director of Financial Risk and Reporting, Monitor

People Principles (1)

The following principles establish ways of working during the lifespan of the transition.

Leading the programme
Clinical input into all work streams as required - with specific reference to A&B

- This is a joint endeavour and input should be balanced across both organisations, taking account of any relative strengths or gaps in either;
- Membership of the Integration Steering group should be tight and senior – 2/3 representatives of each organisation plus the Integration Director (& work stream A & B leads). It will be chaired by NHS Improvement's Chair;
- Each work stream should have an identified lead in each body, with one of those leads being designated the overall lead;
- There should be a balance of overall work stream leads between the two organisations;
- Work stream leads should be as senior as they need to be to be effective, not necessarily at Exec team level, but senior and experienced enough to command respect;
- To share the load as far as possible, ideally work stream leads should not also be leading on 'quick wins';
- The Joint Working Group will be made up of the work stream leads plus PMO, and will be chaired by the Integration Director.

People Principles (2)

Engaging with the wider organisations

- There will be regular reports to Exec Committees and Boards of both organisations;
- There will be regular meetings for Exec Directors who are not members of the joint working group or integration steering group with the Integration Director as required;
- There will be regular opportunities for Exec teams to meet formally and informally;
- There will be a mapped approach, produced by the work stream lead, for engaging with wider staff group for their work stream. The PMO will hold ring on overall plan to maximise impact and minimise disruption to core business;
- Key opinion formers will be identified within the two staff groups and steps will be taken to ensure they are engaged;
- Regular opportunities will be provided for wider staff groups to meet informally in addition to work stream involvement.
- Celebrate successes

Engaging with wider stakeholders

- Key contacts in ALBs (especially NHSE & HEE) will be identified and engaged accordingly;
- Initial bilateral meetings with key stakeholders in representative bodies (inc Shelford and other 'groups') and think tanks will be established;
- Consideration will be given to establishing reference groups (NB: Ed will be establishing Chairs group);
- The relationship with the DH will be integrated.

Creating NHS Improvement Integration Steering Group

Terms of Reference

1. Purpose

1.1. The purpose of the Integration Steering Group to have accountability for the delivery of the Creating NHS Improvement Programme.

1.2. The Integration Steering Group delegates responsibility for the operational activity relating the delivery of the Creating NHS Improvement Programme to the Joint Working Group.

1.3. The Integration Steering Group will have oversight responsibility for the delivery of the programme workstreams, with direct reporting lines from the Joint Working Group and programme updates from the Programme Management Office.

2. Membership

- Ed Smith (Chair)
- Integration Director (John Wilderspin)
- Helen Buckingham (Chief of Staff, Monitor)
- Stephen Hay (Managing Director of Provider Regulation, Monitor)
- Adrian Masters (Managing Director of Sector Development, Monitor)
- Miranda Carter (Executive Director of Provider Appraisal, Monitor)
- Bob Alexander (CEO, TDA)
- Ralph Coulbeck (Director of Strategy, TDA)
- Dale Bywater (Director of Development & Delivery - Midlands & East, TDA)
- Dr Kathy Mclean (Medical Director, TDA
- Mike Durkin, NHS England

2.1. Other individuals may be co-opted as required.

3. Chair

3.1. The group will be chaired by the Chair of Monitor, Chair Designate of NHS TDA.

4. Secretariat

4.1. Representative from the PMO.

DRAFT

5. Quorum

5.1. At least 2 representatives from Monitor and the TDA should be present at each meeting; and either the Chair or the Integration Director.

6. Frequency of Meetings

6.1. The Integration Steering Group will meet fortnightly.

7. Reporting Responsibilities

7.1. The Integration Steering Group will report to the Boards of the NHS TDA and Monitor, and will be accountable to the Department of Health.

DRAFT

NHS IMPROVEMENT STEERING GROUP

28 OCTOBER 2015

Wellington House, 3rd Floor (3.7 Snow)

15.00 – 17.00 pm

Agenda items

1. Welcome and apologies; Chair
2. Transition update; John Wilderspin to lead
    - Recruitment of programme support resources; verbal update
    - Progress with procurement of external support
3. Organisational Design; Ralph Coulbeck to lead
    - Key questions and issues (paper enclosed)
4. Future options for the Provider landscape; Ralph Coulbeck and Miranda Carter to lead

(Future options paper and summary of options enclosed)

5. Any Other Business
6. Date of next meeting

NHS Improvement:

Key questions for the organisational design process

October 2015

Overview and purpose

This paper provides:

- An overview of the proposed elements and process for the organisational design of NHS Improvement

- An initial framing of critical questions across the different elements of the work, with a particular focus on functions and design principles that will underpin the design of the organisational structure and operating model

The purpose of the paper is to support: (i) engagement with senior leaders on the organisations design process and (ii) rapid orientation of internal and external resources focusing on these issues.

Key products in organisation design workstream

The scope of the organisation design work-stream covers the following 4 products:

1. A short document outlining the overall vision, strategy and approach which NHS Improvement will adopt, along with the core objectives of the organisation. This is proposed for release alongside the planning guidance in December and will be the subject of internal and external engagement prior to and following initial release.

2. Documents describing the high-high level functions and structure of NHS Improvement and mapping the transition from existing structures to new structures. These will be produced in draft by the end of November and following engagement will be finalised by early January.

3. Documents describing the operating model for NHS Improvement's interaction with NHS trusts and Foundation trusts to supersede the current Risk Assessment Framework and Accountability Framework. These will be produced in draft by the end of January and following engagement will be finalised by the end of March.

4. Policy advice on the best approach to FT assessment and the FT-NHS trust distinction to underpin broader organisation design. Initial advice will be completed by mid November with further work undertaken as necessary.

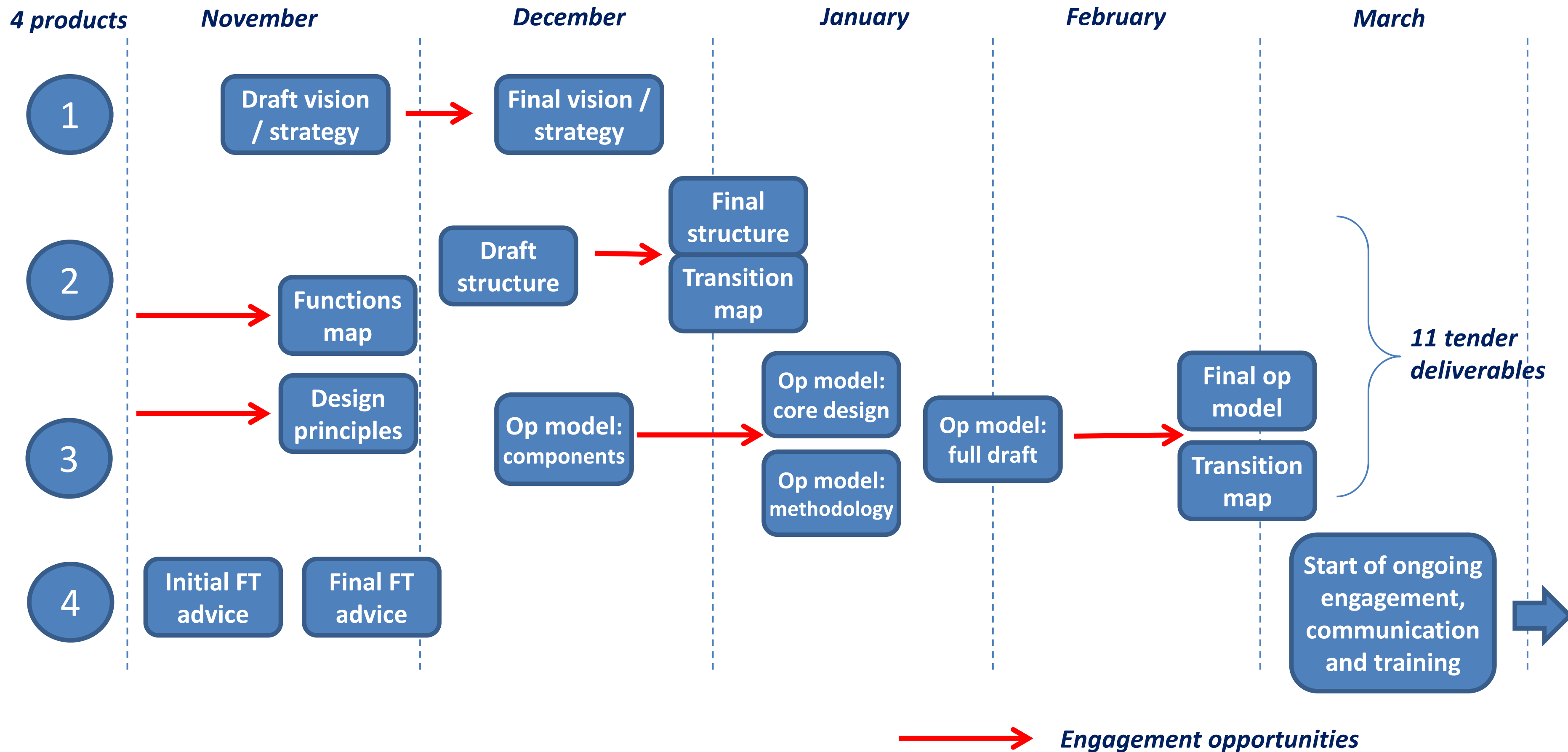
Deliverables within structure and operating model products

The following elements have been identified as part of the process for developing the structure and operating model:

Deliverable 1: The different functions to be undertaken by NHS Improvement and the associated capabilities.
Deliverable 2: A clear articulation of the key design principles.
Deliverable 3: A clear set of initial, high-level options (minimum of three) for the structure of NHS Improvement.
Deliverable 4: A final option for the high-level organisational structure for consideration and agreement.
Deliverable 5: A clear route map for transition from the relevant organisations to the single structure proposed for NHS Improvement.
Deliverable 6: Building on the above develop proposals for the core components of the NHS Improvement operating model for interactions with NHS trusts and Foundation trusts.
Deliverable 7: Develop proposals for the key elements of the operating model for interacting with NHS trusts and Foundation trusts.
Deliverable 8: Develop proposals for ensuring that NHS Improvement's operating model has an appropriate balance of different improvement methods and strategies.
Deliverable 9: Develop proposals on the overall operating model.
Deliverable 10: Develop the final option for the operating model of NHS Improvement for consideration and agreement.
Deliverable 11: Development of a clear route map for transition from the current operating models of Monitor, NHS TDA and the transferring functions to the single model.

Organisation design workstream: core timeline

The proposed timeline for development of the 4 products is set out below:



Establishing a clear set of design principles for NHS Improvement

The "design principles" should be a simple set of high impact statements which help staff, partners and the sector to understand NHS Improvement's fundamental approach and which can guide the more detailed design of the structure and operating model. The design principles could be used to position NHS Improvement's role in relation to a number of key tensions, for example:

- Oversight and scrutiny v support and development
- Performance management (shorter term) v capability building (longer term)
- Instinctive collaboration v rules-based partnerships
- National role v nationwide role
- Provider organisation focus v health system focus
- Pro-active driver of change v check and balance to local ambition
- Balance across quality, finance, performance and sustainability
- Setting strategic agenda v delivering on the front line

Establishing clear positions on these and other key issues will help to frame the broader development of NHSI and inform the initial high-level vision and strategy for the organisation. In many cases the answer will be "both" of course.

Developing a shared view of NHS Improvement's functions (1)

• A clear articulation of the NHS Improvement's broad functions will be essential in setting the foundations for the structure and operating model.

•To achieve this we need to consider not only all of the inherited functions from Monitor, TDA and NHSE, but equally the range of potential activities that could be needed to meet the challenges ahead.

•There will be different ways of describing and grouping functions using different lenses and cuts, as well as different views on what should and should not be included, which need to be reconciled.

• One approach to articulating and grouping a number of core functions is set out on the next slide.

Developing a shared view of NHS Improvement's functions (2)

Clinical / quality
-Special measures
-Challenged providers
-Patient safety functions
-Quality monitoring
- Issue specific support e.g. Infections, mortality
-Clinical leadership devpt
-Patient involvement
-7day services
-Professional regulation
- Whistleblowing

Finance / productivity
- Financial planning
- Financial monitoring
- Financial support
- Finance leadership devpt
- Capital approval
- Cash support
- Productivity: workforce
- Productivity: digital
- Productivity: back office
- Productivity: procurement

Strategy / sustainability
-Strategic planning
- New care models
- Chains
- Well-led framework
- FT assessment
- Transactions
- Success regime
- LHE solution development
- Policy development
- Economic analysis

Programmes e.g.
- Acute Care Collaboration
- Carter
- Virginia Mason
- CPT / TSA
- Peer Improvement
- Agency caps

Communications
- Communications (external)
- Media
- Communications (internal)
- Comms development
- Public / pt engagement

Performance / ops
- Access: urgent care
- Access: elective care
- Operational performance
- Winter planning
- Provider relationships
- Activity planning
- Workforce planning
- Intensive Support Teams
- ECIP
- COO development
- System improvement

Leadership / talent
- Talent management
- CE development
- Leadership development
- System leadership
- Advancing Change Team
- Exec appointments
- Non-exec appointments

Corporate/infrastructure
- Accountability
- Parliamentary
-HR (internal)
- HR (external)
- Organisational development
- Governance
- Legal services
- Investigations
- Estates
- ICT infrastructure
- FOI / correspondence

Sector regulation
- Pricing
- Competition
- Licensing
- Independent sector

Information
- Data collection
- Aggregation and scoring
- Analytics

Questions for discussion

It would be helpful for the steering group to consider the following questions:

1. Does the overall sequence of activities in the organisation design workstream (slide 5) make sense and does this feel deliverable?

2. Are the dilemmas on slide 6 the ones we need to resolve in agreeing the design principles? What is missing?

3. What are our initial views on each of the dilemmas set out on slide 6?

4. What are the different ways of articulating NHS Improvement's functions and how detailed a description is needed to support decisions on structure and operating model?

5. Does slide 8 offer a reasonable "starter for 10" on NHS Improvement's functions? Is anything obviously missing or unhelpful?

NHS Improvement – Integration Steering Group

Monday 7th December, 11.00am – 1.00pm

Elion Room, 3rd Floor, Wellington House, 133–155 Waterloo Road London SE1 8UG

Item	Papers
1. Welcome and apologies	None
2. NHS Improvement - Integration Programme Governance	Enclosed
3. Draft High Level Programme Plan	Enclosed
4. Key workstreams • Organisation Development • Values & Culture	Enclosed
5. NHS Improvement budgeting for 2016/17	Enclosed
6. NHS Improvement – Technology and Budget	Enclosed
7. Programme Risk Approach and draft Risk Register	Enclosed
8. Update on transitional leadership arrangements	None
9. Future Provider Landscape	None
10. AOB	

NHS Improvement Integration Steering Group

7 December 2015

Title:	**NHS Improvement Integration Programme Governance**
Item:	2
Purpose:	This paper proposes that the Steering Group in future be referred to as the NHS Improvement (NHSI) Integration Programme Board. Good governance practice indicates a programme board is required to provide strategic oversight and mechanism for high-level decision-making, and the established Steering Group is close to this in structure and function. There will be no change in the substantive role of the Steering Group. It is recommended that the programme structure be kept under review as new joint governance arrangements for NHSI become established.
Recommendations:	The Steering Group is recommended to • Agree the change in name to the NHS Improvement Integration Programme Board. • Approve the attached draft Terms of Reference. • Agree to keep the NHSI Integration Programme structure under review as new joint governance arrangements for NHS Improvement become established.
Submitted By:	Rebecca Williams, NHSI Integration PMO

NHS Improvement - Integration Programme Governance

1. Background & Purpose

The NHSI Integration Programme has been established and is operational, and the Chair and Chief Executive of NHS Improvement are now in post. With the programme established, it seems appropriate to take stock of the existing governance structure and review the roles.

This paper proposes that, in accordance with good governance practice, an overall programme board is required to provide strategic oversight and mechanism for high-level decision-making. As the established Steering Group is close to this in structure and function, it is proposed that the Steering Group in future be referred to as the NHSI Integration Programme Board. There will be no change in the substantive role of the group and it will continue to be kept updated on the risks, issues and progress of the programme.

It is recommended that the programme structure be kept under review as new joint governance arrangements for NHSI become established.

2. Accountability

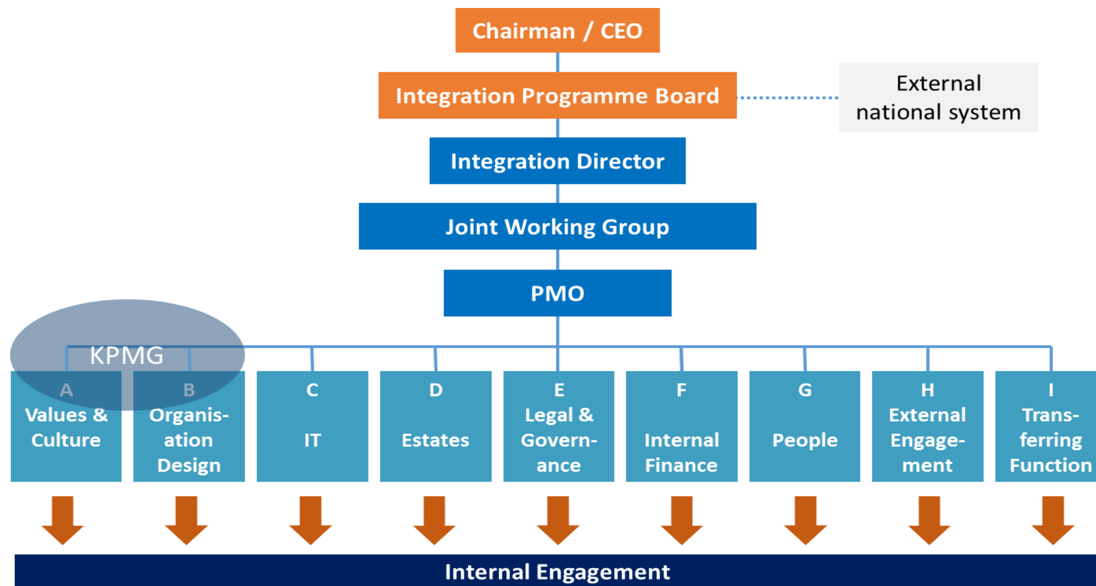
- The Steering Group has a specific remit to set the direction for the NHSI Integration Programme, support the Chief Executive in decision-making, oversee overall progress and have accountability for the delivery of the programme.
- The Steering Group delegates responsibility for the operational activity relating the delivery of the programme to the Joint Working Group (which has direct oversight responsibility for the delivery of the programme workstreams).

3. General Responsibilities

- Provide strategic direction for the NHSI Integration Programme and consider strategic external engagement approach with the wider system.
- Ensure that the programme remains on course to deliver and objectives of the programme are met.
- Have oversight of programme level risks and issues.
- Provide input into relevant key documentation as appropriate.

- Support high-level decision-making, providing both challenge and approval on issues affecting programme progress.

4. NHSI Integration - Programme Governance Structure



Recommendation:

The Steering Group is recommended to

- Agree the change in name to the NHS Improvement Integration Programme Board.
- Approve the attached draft Terms of Reference.
- Agree to keep the NHSI Integration Programme structure under review as new joint governance arrangements for NHS Improvement become established.

NHS Improvement - Integration Programme Board

Terms of Reference

DRAFT

1. Purpose

1.1. The NHS Improvement (NHSI) Integration Programme Board is the sponsoring group for the NHSI Integration Programme, and is accountable for delivering the programme.

1.2. The NHSI Integration Programme Board delegates responsibility for the operational activity relating the delivery of the NHSI Integration Programme to the Joint Working Group, which has direct oversight responsibility for the delivery of the programme workstreams. Each workstream lead is a member of the Joint Working Group, and will provide weekly workstream updates to the Programme Management Office.

2. Membership

- Ed Smith (Chair, NHS Improvement)
- Jim Mackey (Chief Executive, NHS Improvement)
- John Wilderspin (Integration Director)
- Helen Buckingham (Chief of Staff, Monitor)
- Stephen Hay (Managing Director of Provider Regulation, Monitor)
- Adrian Masters (Managing Director of Sector Development, Monitor)
- Miranda Carter (Executive Director of Provider Appraisal, Monitor)
- Adam Sewell-Jones, (Executive Director, Provider Sustainability, Monitor)
- Bob Alexander (CEO, TDA)
- Ralph Coulbeck (Director of Strategy, TDA)
- Dale Bywater (Director of Development & Delivery - Midlands & East, TDA)
- Dr Kathy Mclean (Medical Director, TDA)
- Mike Durkin (National Director of Patient Safety, NHS England)
- Karen Wheeler (National Director: Transformation and Corporate Operations, NHS England)

2.1. Other individuals may be co-opted as required.

3. Chair

3.1. The group will be chaired by the Chair of NHS Improvement.

4. Secretariat

4.1. Representative from the NHSI Integration PMO.

5. **Quorum**

   5.1. At least 2 representatives from Monitor and the TDA should be present at each meeting; and either the NHS Improvement Chair or Chief Executive, or the Integration Director.

6. **Frequency of Meetings**

   6.1. The NHSI Integration Programme Board will meet monthly.

7. **Accountability**

   7.1. The NHSI Integration Programme Board is accountable for delivering the NHSI Integration Programme

8. **General Responsibilities**

   8.1. Provide strategic direction for the NHSI integration programme and consider strategic external engagement approach with the wider system.

   8.2. Ensure that the programme remains on course to deliver and objectives of the programme are met.

   8.3. Have oversight of programme level risks and issues.

   8.4. Provide input into relevant key documentation as appropriate.

   8.5. Support high-level decision-making, providing both challenge and approval on issues affecting programme progress.

DRAFT

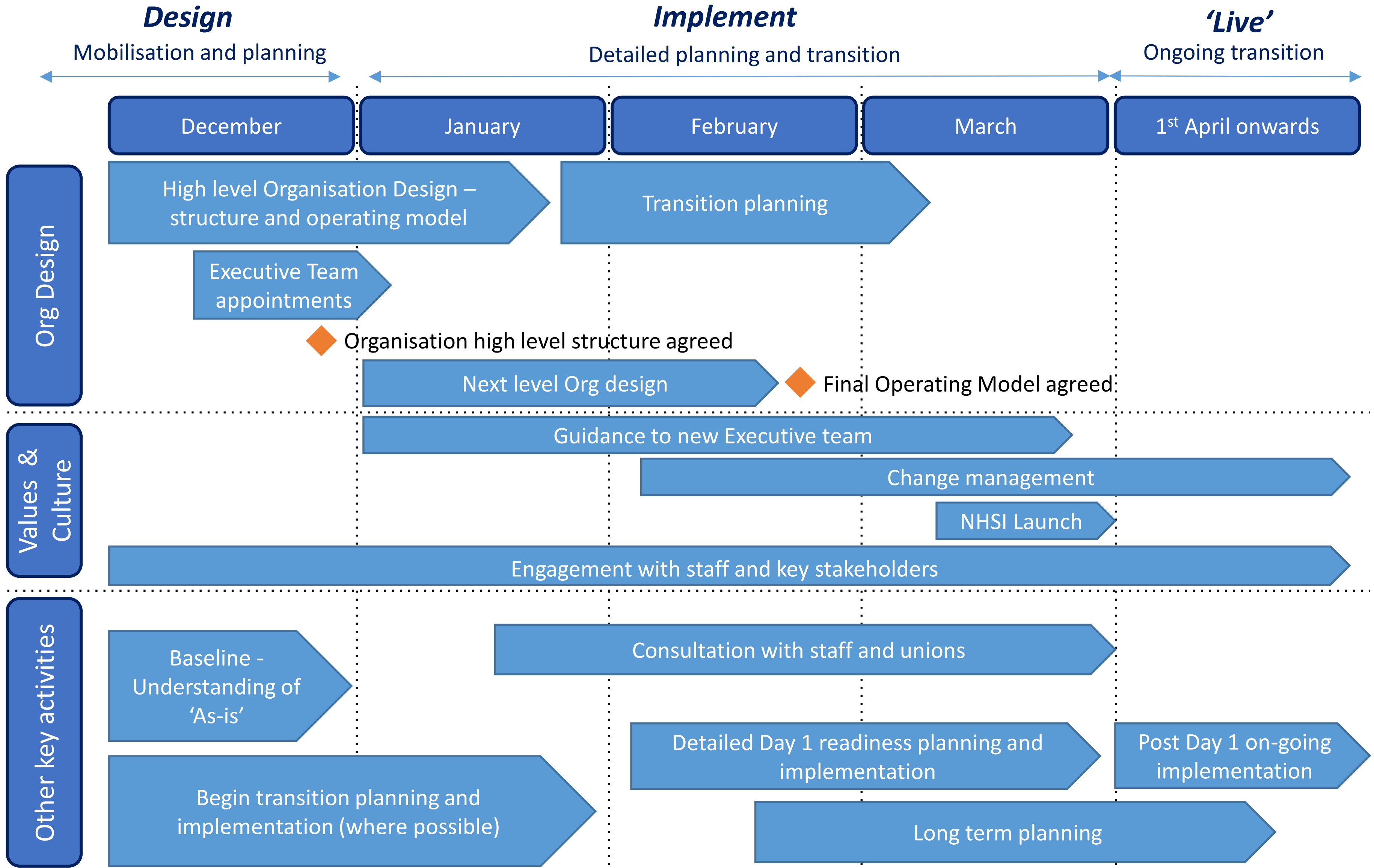
NHS Improvement Steering Group

7th December 2015

Title:	**Draft High Level Programme Plan**
Item	3
Purpose:	To present a draft high level programme plan, informed by current information regarding the programme.
Recommendation:	The Steering Group is recommended to note the draft high level programme plan.
Submitted By:	Nick Day, NHSI Integration PMO

NHSI Integration - draft high level programme plan

DRAFT



Note: This is a high level cross programme plan – there may be some variation across workstreams

NHS Improvement Steering Group

7th December 2015

Title:	**Key Workstreams**
Item	4
Purpose:	To provide the Steering Group with updates on two key workstreams in the NHSI Integration Programme • Organisation Design • Values and Culture
Recommendation:	The Steering Group is recommended to note the updates and comment on issues raised
Submitted By:	Ralph Coulbeck (Director of Strategy, TDA) Helen Buckingham (Chief of Staff, Monitor)

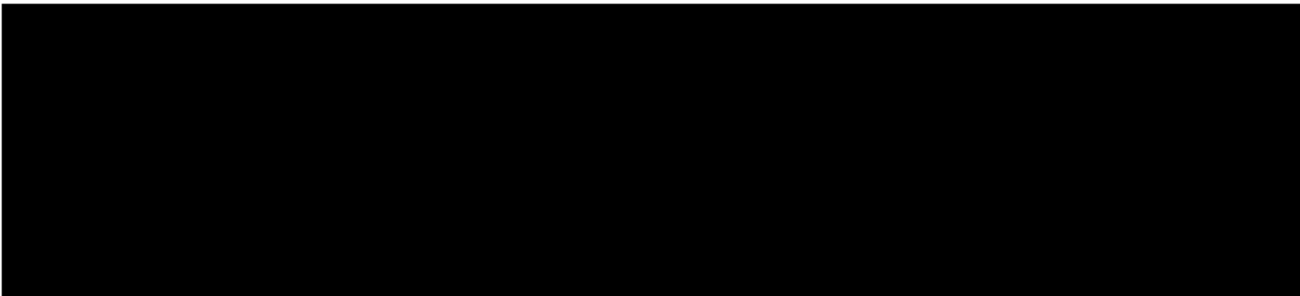
Update on Organisation Design workstream for 7 December Steering Group

Context

At its last meeting, the Steering Group considered an overview of the organisation design work-stream centred on the four key products: (i) the vision and purpose of NHSI; (ii) organisational structure, (iii) operating model, and (iv) policy work on the future of FT assessment, which was the subject of a fuller discussion. At the request of the programme director, this note provides a very brief update on products 1, 3 and 4.

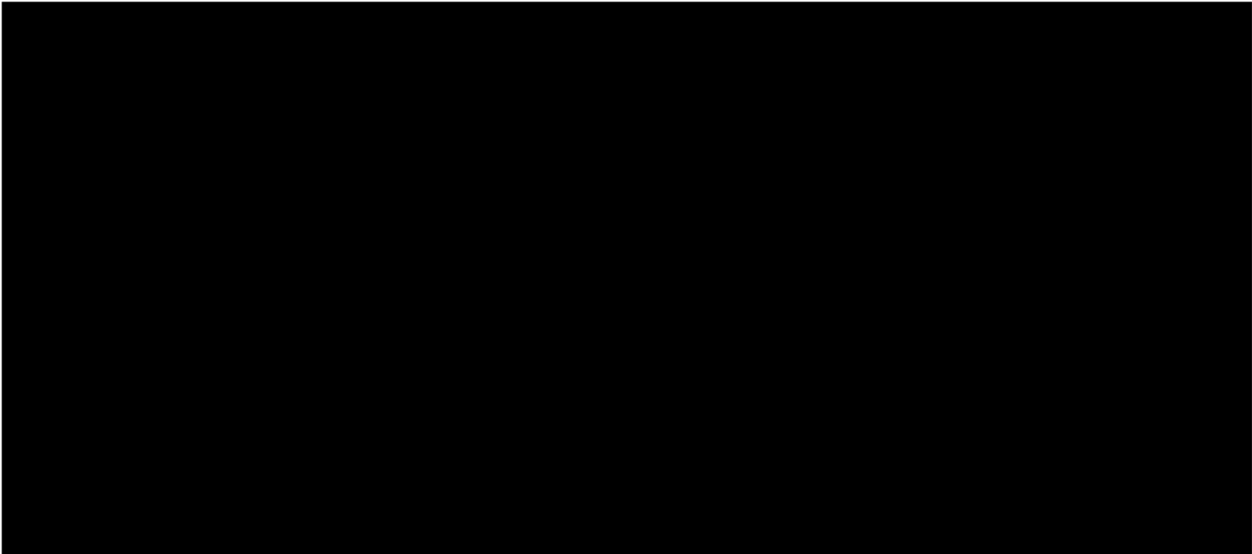
Vision and purpose

A draft document articulating the proposed vision and purpose of NHSI has been produced and shared widely with senior leadership. The document also covers proposed long-term and short-term goals for the organisation, ways of working, and a high-level description of the proposed operating model. This document is now being tested with staff through the focus group and survey processes, with leaders in more depth through the interview process, and with selected external stakeholders. Subject to feedback from this engagement activity, our intention is to publish a revised version of the document for broader engagement in late December.



Operating model

Developing the operating model of NHS Improvement is the largest and most complex element of the organisation design work. Work is now underway to scope the different elements of the operating model and to produce clear proposals on the structure and high-level content of the model for engagement in January.



__**Update on Values and Culture workstream for 7 December Steering Group**__

1. Workstream purpose

The purpose of the Values and Culture workstream is to support the development and embedding of a culture that enables NHS Improvement to achieve its objectives in an efficient, effective and sustainable way.

Workstream deliverables include the development of values, a behavioural competency framework and an employee offer aligned to the vision, purpose and target operating model; a culture assessment and culture change plan and facilitation of relevant activities. The latter will include supporting the development of a high performance new leadership team, promotion of the organisational values; skills, knowledge and behavioural training and team building, and other cultural levers and symbols, including a launch plan. The workstream is also responsible for providing the framework and tools for internal communications about the Integration and supporting the PMO and other workstreams in effective engagement and internal communication activities.

2. Focus to date

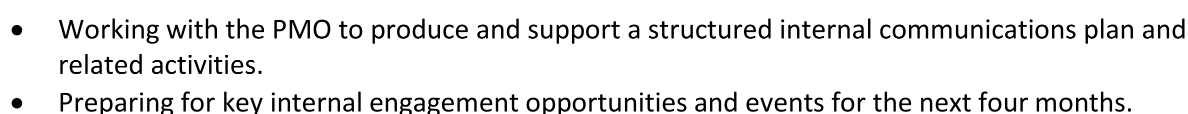
Our activities to date include:

- Devising communication channels and tools for the programme including a regular staff newsletter, contacts lists, cascade packs for Wider Leadership Team members and co-ordinating the joint WLT meeting in November.
- Designing focus groups, senior leader interviews and a survey to elicit staff views on the desired culture and values for the organisation as well as assessing the current culture of each of the integrating organisations.
- Carrying out desk based research on the values used by other organisations.
- Providing support to Monitor leadership colleagues on adaptive leadership. This programme will be provided to the TDA WLT in the New Year.

3. Activities in December

During the next few weeks our focus is on:

- Running focus groups, interviews and staff survey across all integrating organisations.
- Using the insight from this to prepare a report and facilitated sessions to help guide the new leadership team and all staff on the values set and the culture change needs.
- Working with the Organisational Design workstream to integrate values and behaviours thinking into the target operating model development. The later will in turn influence of the level of culture change needed for the integrating organisations.



- Working with the PMO to produce and support a structured internal communications plan and related activities.
- Preparing for key internal engagement opportunities and events for the next four months.

Our initial engagement activities are being well received and we are adapting our approaches and key messages in line with colleagues' feedback.

NHS Improvement Steering Group

7th December 2015

Title: **Technology and Budget (15/16)**

Item: 6

Purpose: This paper outlines the current known technical challenges, identifies constraints and assumptions and provides indicative budgets for key elements of the transition programme.

Recommendation: The NHSI Steering Group is asked to:

- Provide a clear steer regarding the level of ambition for full technical integration and to confirm availability of budget aligned to the desired outcome
- Provide a steer regarding the level of ambition for our corporate website on 1st April 2016.
- Agree budget envelopes by activity stream, in line with Appendix A, subject to formal call off controls once final solutions are clarified
- Confirm whether any employees can transition to an NHS Improvement email address prior to 1st April as this reduces risk but conflicts with current brand transition timelines.
- Incorporate a community of practice model into the OD Workstream for further consideration
- To initiate work to consider options for one organisation to act as the provider of shared business services to both organisations for essential back office activities (notably HR and internal finance) and to consider the impacts of not adopting this approach

Submitted By: Peter Sinden, CIO, Monitor

Introduction

Employees from 6 organisations are being brought together to form NHS Improvement. These currently operate over 4 distinct networks. The IT workstream's top level objective is to provide employees with as common an experience as possible (similar devices, similar applications, the ability to share files and services, unified internal processes – calendars, holiday submissions, expenses) with a shared brand (email, corporate website, intranet). The Workstream Charter attached as Appendix B provides additional detail.

The integration process is subject to several significant constraints that restrict options. Some restrictions are short-term. Some will persist. These are discussed below.

Budget is required to undertake integration and transition activities. Budget is also required to undertake technical upgrades anticipated within the originating organisations. These are presented together but distinguished below.

Key Activities

The integration programme comprises the following activity streams:

1) Network and file system access
2) Provision of additional equipment
3) Regional / Remote working / Communications / VC
4) NRLS transfer and redevelopment
5) Corporate web presence
6) Intranet
7) Organisational-wide access to modelling and analyses tools
8) Email, Calendars and Directory Services
9) Shared service integration
10) Communities of practice model & technical controls

The first seven activity streams require funding to deliver any change (ranges are provided in Appendix A). Item eight (email and calendars) may be deliverable with no additional expenditure but one option may require new spend. Activity streams nine and ten will add significant long-term costs of operating if not considered effectively within the overall integration programme and are therefore being highlighted as important to understand.

Final expenditure is likely to vary as the programme develops. The Steering Group is asked to provide a steer regarding the trade-off between investing early to integrate rapidly and reducing the scope or slowing the integration work and operating with lower efficiency as an organisation. The Steering Group is asked to approve initial budget envelopes within which solutions are delivered and to agree a process for changes required as solutions are developed.

Constraints

The following constraints limit our potential options and are provided to inform the Steering Group regarding choices and timelines available to NHS Improvement.

Duality of legal existence: Post-integration, NHSI will exist as two legal entities (Monitor and the TDA, with all other transferring entities being subsumed into the TDA). This impacts technology options in the following ways:

- Failure to align back office functions (notably HR and internal finance) into a single shared service (internal or external) will result in dual running of systems and limitations on ordinary management (expenses, holiday approvals, starters/leavers, file system access, etc.)
- Information Governance controls will need to operate between employees of each organisation, in line with the different legal powers (for example, the TDA can hold patient level data whereas Monitor cannot hold, or access)
- Mechanisms will need to be agreed for managing contracts with external supplier and licenses across both organisations, this will also impact financial controls.

Duality of networks: Post-integration, NHSI will have, at a minimum, two networks

File sharing may need to be managed through a cloud service in the short-term, to enable access from either primary network.

Existing contracts: Current contracts for several services will run for some time after the integration and will need to be honoured. This limits timing and costs of integration work.

Existing equipment: It is not financially feasible to align all equipment to a common standard. This will need to be achieved during an ordinary refresh cycle.

External controls: GDS controls will need to be met for any corporate web development.

Procurement and spend controls: Timelines for moving from decision to implementation are constrained by control timelines. These will impact delivery timelines and some decisions will need to be made soon. Notably:

- Operating Model – functions, distribution of personnel, locations, employment status (TDA/Monitor), required equipment, internal shared services approach, governance/controls, estates strategy
- Branding and scale of ambition for pursuing digital as an improvement strategy

Communities of Practice

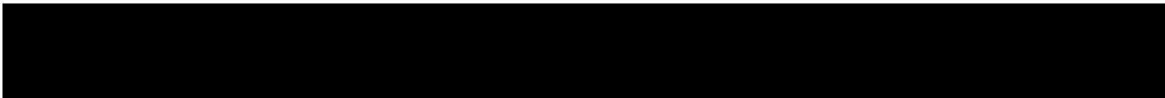
NHSI is a larger organisation than any of the integrating organisations. Standardisation of approach, in many areas, will be essential to efficient operation. An operating model that builds in a common approach to development across distributed teams will inevitably improve change at scale. Alternatively, pockets of siloed working and individual approaches will lead to unsustainable and unsupportable solutions. The Steering Group is asked to consider formal incorporation of a community of practice model into the OD Workstream. For essential skillsets, notably analysts and project management, this would enable:

- coordination across business functions,
- consistency around training, tools, approaches, methodologies and technical choices,
- built in quality control,

- accelerated sharing of best practice,
- improved career development,
- greater flexibility as an organisation, and
- effective benefits realisation from investment in tools and ways of working.

Summary

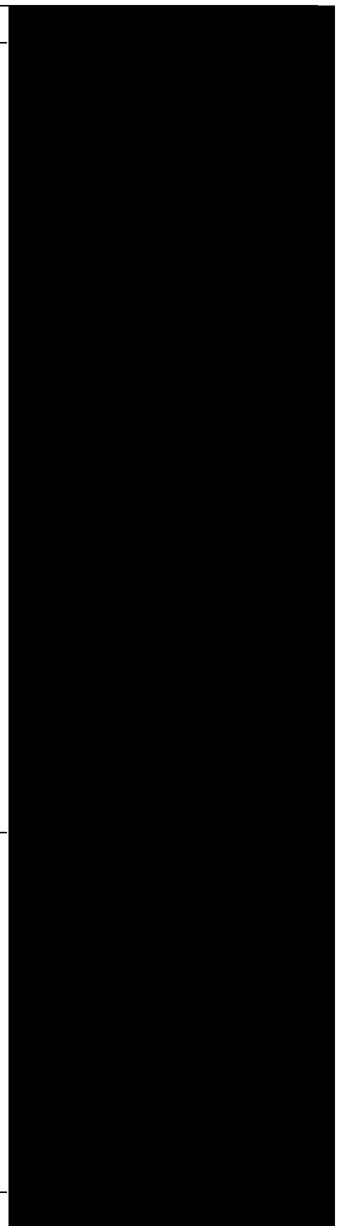
Final solutions are not yet defined. They will come on line in different timeframes for the identified activity streams. Final solutions are dependent on both internal and external constraints, some of which are well understood, some of which are awaiting decisions. Implementation work will begin in earnest soon. A steer on the scale of ambition and approval of a budget aligned to scale of ambition is essential to move the integration work forward at pace, subject to financial and procurement controls.



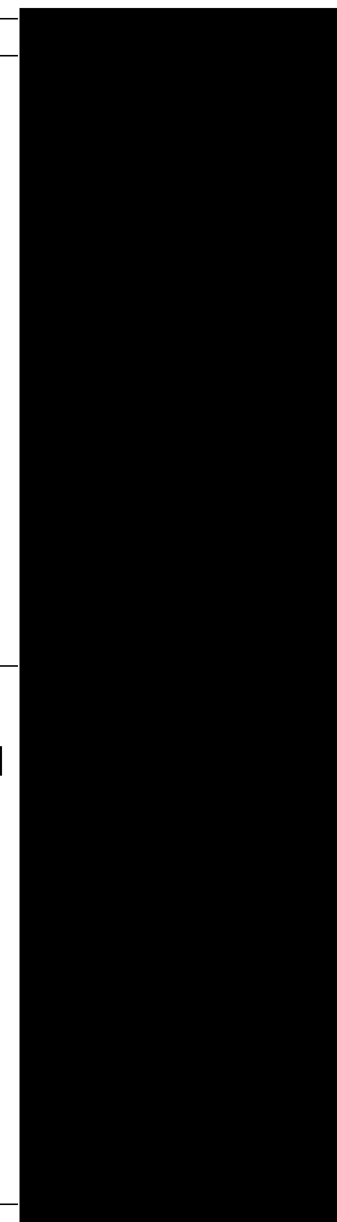
Item 6 - Appendix A – budget envelopes by activity stream

Activity Stream	Description	Objectives	Assumptions	Risks / Issues
Network and file system access	By April to provide an employee experience that enables ordinary working practices but which does not fully align technology or networks. To put in place a strategy for longer term fuller integration.	Provide a mechanism to share files, potentially off-network. Align employees to one or other primary network (function / team based). Identify where shared services are to be located.	Transferring employees bring technology with them and there are no additional costs of transfer. It will be possible to legally move staff to the required network based on role rather than employing organisation.	Agreements are needed between multiple parties. Procurements may be needed which will impact timelines. Transferring staff require new equipment. Imperial not well understood.
Provision of additional equipment	Employees will require access to appropriate devices to deliver their work. Short term alignment will focus on filling gaps. In the longer	Each employee can access services from the relevant network based on role. Some employees will operate a laptop based strategy – this will be	Current staff levels remain as is or grow. Staff adopt a more regional and remote strategy. iPad and mobile devices	Procurement delays and DH sign-off delay implementation. Assumptions do not align with the target operating model and

Activity Stream	Description	Objectives	Assumptions	Risks / Issues
	term, we will align devices based on role as devices are naturally refreshed.	aligned to remote working where possible. Fixed office staff will adopt a VDI device strategy as their primary connection method.	are already included within costs of existing telephony contracts. TDA analysts and potentially others require access to Monitor analytical tools. We do not provide dual access to both networks for all staff. We are not actively reallocating existing devices between staff from differing originating organisations. We desire to adopt changes before 1st April.	OD. Network limitations require additional investment in workarounds requiring additional spending on multiple devices.
Regional / Remote working / Communications / VC	Employees are enabled to work in the field and with staff working from different locations.	Provide log on to systems from any location. Provide access to other services through a second logon where required due to networking / dual legality constraints.	The workforce will be operating over split locations. The workforce will, where possible, be co-located with staff from other ALBs. Phone systems will not be	Current VC technology choices limit options – especially where provided as part of a wider contract. Software based solutions are not permitted under the

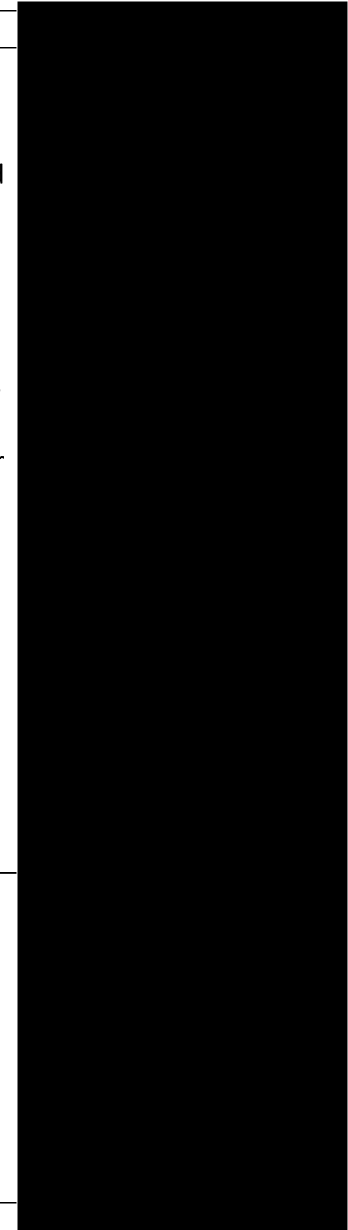


Activity Stream	Description	Objectives	Assumptions	Risks / Issues
		Provide video conferencing facilities for both high quality fixed point-to-point connections and for less formal interactions between all employees from their desks.	integrated prior to 1st April 2016.	Atos contract. Procurement delays and DH sign-off delay implementation. Assumptions do not align with the target operating model and OD. Network limitations require additional investment in workarounds.
NRLS transfer and redevelopment	The NRLS database needs to be moved from its current NHSE hosted services.	Transition NRLS database. Transition Imperial equipment.	The new developments are out of scope for 1st April but the Workstream will assist with transition through DH controls. The existing service will need to move to TDA (legally) as it holds patient level data. Imperial equipment can be moved.	Imperial equipment cannot be separated from existing Imperial network and needs to be commissioned and rebuilt at an unknown cost.

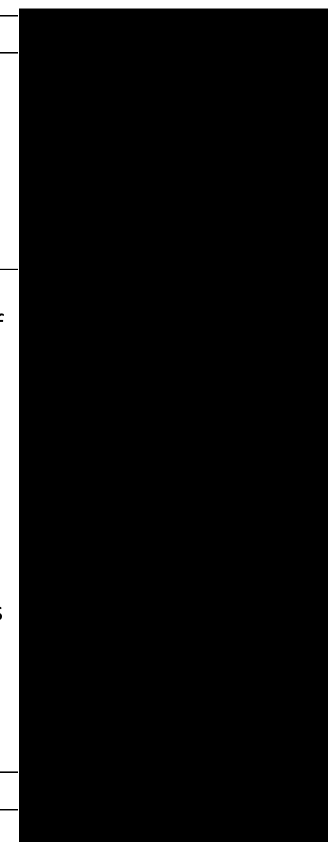


Activity Stream	Description	Objectives	Assumptions	Risks / Issues
	A new service is under design.			
Corporate web presence Intranet	Provide a unified brand and digital service for NHSI	Combine the current websites for the integrating bodies into a single service. Understand and align the digital strategy for improvement work. Rebrand sites not being redeveloped (e.g. data collection portals).	A unified digital presence is important for a brand launch. We wish to combine formerly disparate sites. We have a desire to employ a digital strategy as a component of our improvement model. We need to align the work with existing broader projects, notably with the NHS IQ initiative being developed jointly by NHSE and NHSI (led by NHSE).	Lack of clear ownership over content and direction while the OD is unclear. The NHS IQ website becomes the digital brand for improving the NHS but is not controlled by NHS Improvement. GDS controls (£0 control) limit the options regarding how the services are developed, leading to additional cost and scope. Procurement issues prevent on-time delivery.
Email , Calendars and Directory Services	Transition all staff to a single email address and shared calendars.	Move all employees to nhs.net by 1st April. Move many employees	Existing emails used for service provision (e.g. monitoring, licensing, data submission) may be	Single transition on 1st April based on branding guidelines may result in service

Activity Stream	Description	Objectives	Assumptions	Risks / Issues
		to nhs.net prior to 1st April to enable dual running of email accounts while we transition.	left in place for some time to avoid disruption to operational systems. Room booking systems will become disconnected from calendars and email. Integration exists between Exchange and other systems at Monitor such as Independent Sector Licencing system and Monitors current CRM solution.	outages for some or for some time. Individuals may need to dual run accounts (rather than forward) for some time. IG risks may increase when members of the TDA and Monitor are not distinguishable.
Shared service integration	Enable core services that control access rights and management of individuals to align with single IT delivery.	Create single mechanism for allowing access to services irrespective of employer: • starters • leavers • expenses • holidays	A dual system will be developed unless flagged. A dual system will add significant cost. A dual system will add significant risks.	Alternative reasons for not combining result in an expensive, risky and inefficient services running for some time.



Activity Stream	Description	Objectives	Assumptions	Risks / Issues
		• calendars • tools		
Communities of practice model & technical controls	Enable employees carrying out similar tasks in different functional units to benefit from shared learning, methods, tools, services, and quality.	Create a Head of Community profile. Align governance with the community. Align architecture controls with delivery of services. Align career development and training across the organisation.	A mechanism is needed to ensure standardisation across different functions emerging from the TOM as they are developed at lower levels. The organisation wishes to spread and share best practice internally as well as within the NHS.	This is not directly considered as part of the integration as there is unclear ownership. The organisation suffers later as inefficiencies, local solutions and work is developed that does not scale.
Total				



Appendix B - workstream charter – **IT**

Workstream: IT | Sponsor: Peter Sinden | Updated: November 2015

Objectives

- Provide an IT infrastructure to NHS Improvement with supporting governance and security
- Enable all employees of NHS Improvement to work across regional locations and remotely
- Provide technical component of an initial public-facing internet service and internal intranet service
- Identify and plan for IT capability to support the new operating model

Resourcing

- Technical integration lead (6-9 mths)
- Technical integration coordinator (6-9 mths)
- Technical transition contractor to provide hands on technical support (3 mths)
- Records management support staff(1-3) for 6 mths to transition and control information.
- Support from Atos for transition and integration with TDA networks

Key Milestones

Pre-Day 1:

Landscape mapping, target definition, options analysis and transition, to:

- Consolidate network access (with interim workarounds)
- Produce target architecture vision , identify opportunities and roadmap
- Provide interim file sharing capabilities
- Enable remote working and system access from multiple locations
- Expand video conferencing capability
- Manage the development of a new internet presence
- Manage the development of an intranet presence
- Transfer files and data from legacy networks where needed
- Oversee transfer of equipment and data from NHSE transferring functions
- Define longer term transition plan for fully integrated working

Day 1

- Website official launch
- Transfer to new email address
- Intranet launch (potentially pre)

Post-Day 1

- Roll out of key systems continues (18-24 months)
- Consolidation of service providers, licensing and other contracts
- Improved employee experience as one organisation, one set of systems
- Consolidation of data collection, processing and analytics
- Consolidated device management and replacement policy
- Further portal consolidation
- Digital support for Improvement activities (with comms)
- Expand on website development

External Partners involvement

- Business partners
- Atos
- Advanced 365

- Potentially:
- London CIO Council & other technical stakeholder networks

Scope

In-scope:

- Infrastructure (desktop – VDI; laptops, networking, email, active directory)
- Informatics (data collection, processing, analysis, toolsets, standards)
- Web services (internal and external; jointly with digital in comms)
- Remote working
- Information Governance, DSAs, records management and security
- Transfer of existing NRLS database
- Line of business applications assessment

Out of scope:

- Funding of the NRLS patient incident reporting solution
- Funding to kit out any additional floors within Wellington House

Interdependencies

Dependencies IT has on others:

- Estates – staff location needs to be established to enable IT to purchase relevant devices (laptops, VDI and remote working tokens)
- Organisation Design (operating model) – lack of clarity regarding ownership for designing IT and its associated functions either causes confusion or fails to feed into the top level design
- Organisation Design (operating model) – plans are needed to budget and plan for the necessary IT demands for emerging needs (e.g. analytics and data collections)
- External Engagement – branding decisions by December 2015 to enable website design for launch on 1st April 2016
- Transferring functions, for equipment, technology and information needs – notably NRLS
- Legal & Governance – records management requirements

Dependencies others may have on IT:

- External Engagement / transferring functions – joint working on web presence consolidation
- Organisation design – transfer / upgrading of IT systems will require IT support

Assumptions and Constraints

1. Assumption: transfer of IT equipment ownership
2. Constraint: clarity of senior decision makers, time table and procurement constraints limit options and scope of what can be achieved
3. Constraint : the HR implications and practicalities of NHSI being two statutory bodies.

Key concerns/issues

1.Operating model developed without sufficient collaboration to understand the interplay between people, process and technology
2. Impact of not giving due regard to technical constraints in timelines for delivery of target operating model
3. The future technical governance of a 1000 person organisation is not considered
4. Delays in procurement process
5. Strain on existing business as usual support
6. Accuracy of budget for transition costs as the operating model evolves
7. Insufficient budget made to deliver the target state post-April
8. Additional new BAU requirements emerging in parallel with design (e.g. new reporting requirements; changes to pricing; new functions)

Item 6 - Appendix C

Integrating IT between TDA and Monitor

The vision

If time, money and the differing legal statuses were not an issue, then in an ideal world by the 1st April 2016 we would implement a single IT infrastructure across NHS Improvement.

But given the above constraints this is not possible, so we need to implement a solution that is possible to achieve, The core to such a solution would utilise the current strengths of both organisations with the aims of:

- Providing a common look and feel for all users
- Enable collaborative working – independent of location
- Keep the need for multiple logins and credentials to a minimum.

The primary strengths of the services provided by ATOS (IMS3) to the TDA are:

- PSN accredited Wide Area Network (WAN) connecting all the buildings used by TDA
- Ability for staff to log into networks at any building
- Distributed desk side support for staff.

The primary strengths of the Monitor IT system (supported by Advanced 365)

- Large number of analytics tools and infrastructure in place e.g. Microsoft APS, Tableau Server, SAS
- Extensive data storage availability
- Highly integrated systems
- High levels of user satisfaction.

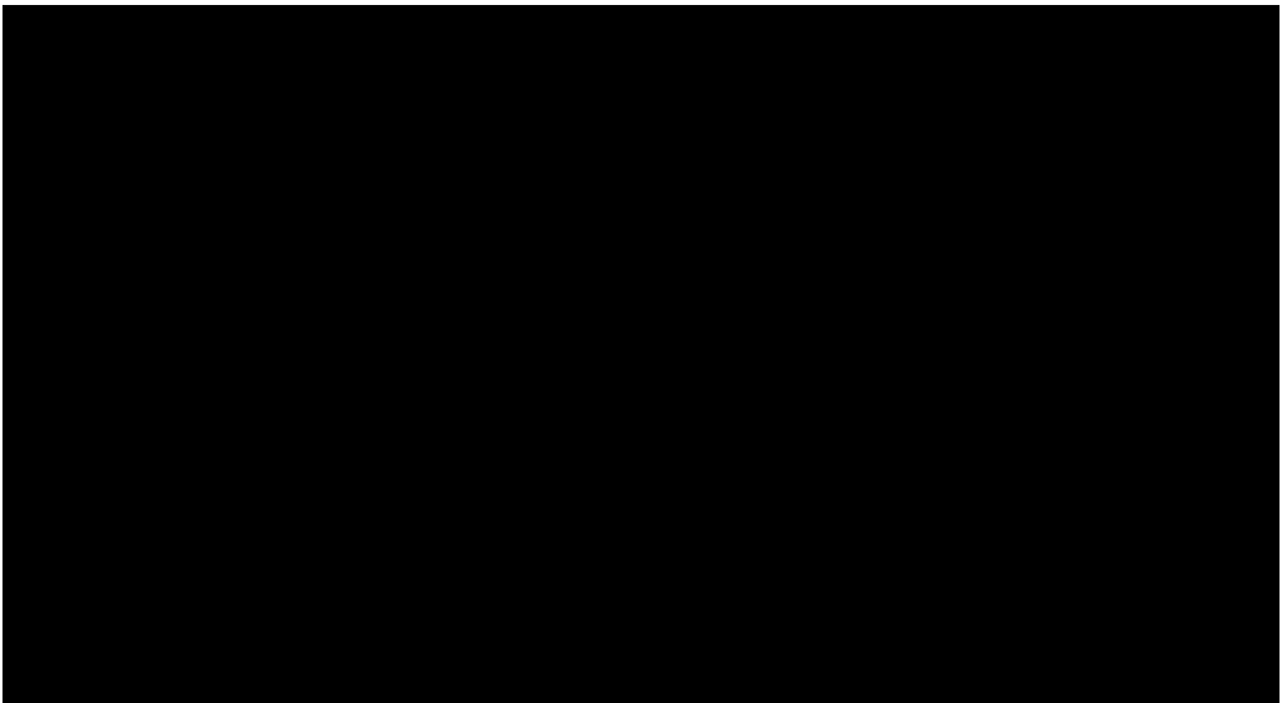
Common Look and Feel

Currently both Monitor and the TDA (and NHSE) use end user devices based upon Windows 7 with Office 2010, and as such a common look and feel already exists.

Collaborative Working

In order to enable collaborative working we need to establish the following:

- Secure e-mail between staff members – this will be achieved by implementing NHS Mail for all staff at Monitor – it will also enable all staff on Monitor's active directory to be visible on the NHS Mail directory
- We will use Kahootz (already in place for TDA) to enable collaborative working across NHS Improvement and with other partners
- Implement an additional VDI farm to enable remote workers (including TDA staff) to access Monitor's analytics tools
- Enable Lync (Skype for Business) to enable desktop sharing and instant messaging across the joint organisation
- Improved video conferencing across the joint organisation and with partner organisations (DH, NHSE and N3 users).



NHS Improvement Steering Group

7th December 2015

Title: **Programme Risk Approach and draft Risk Register**

Item: 7

Purpose: To update the Steering Group regarding the approach to Programme Risks and to provide an initial overview of draft Programme Risks. The attached Risk Register is an initial draft which is being finalised through the Joint Working Group.

Recommendation: The Steering Group is recommended to

- Agree the risk approach set out in section 2 in the attached paper. This proposes that operational risk management will take place through the Joint Working Group, and that the Steering Group will receive the updated risk register at each meeting.
- Note the draft Risk Register for the NHS Improvement Integration Programme, and suggest amendments or additions required.

Submitted By: Nick Day, NHSI Integration PMO

1. Background and context

The NHS Improvement Integration Programme is now up and running and needs to move at pace to deliver ley outcomes by 1st April 2016. A key aspect being considered is the approach to managing risk and ensuring that roles and accountabilities are clear.

2. Proposed Risk Management Approach

The programme will adopt a simple approach to managing risk, as set out below:

- **Workstreams**: each workstream will develop and maintain a workstream risk register. Workstream leads will inform the fortnightly Joint Working Group meeting of material changes to their risks.
- **Programme**: The Programme Office will develop and maintain the programme Risk Register, with input from workstreams, and will make updates to the risk register identified by workstreams and the Joint Working Group

  The **Joint Working Group** will have operational responsibility for overseeing the programme risk register including progress made in implementing the mitigating actions. The Integration PMO will share the monthly risk register with Monitor and TDA business as usual risk leads.

  The Steering Group will receive monthly updates to the risk register.

3. Draft Risk Register

A draft risk register is attached at Appendix 1. This will be finalised through the Joint Working Group.

4. Recommendation:

The Steering Group is recommended to

- Agree the risk approach set out in Section 2.
- Note the draft Risk Register for the NHS Improvement Integration Programme, and suggest amendments or additions required.