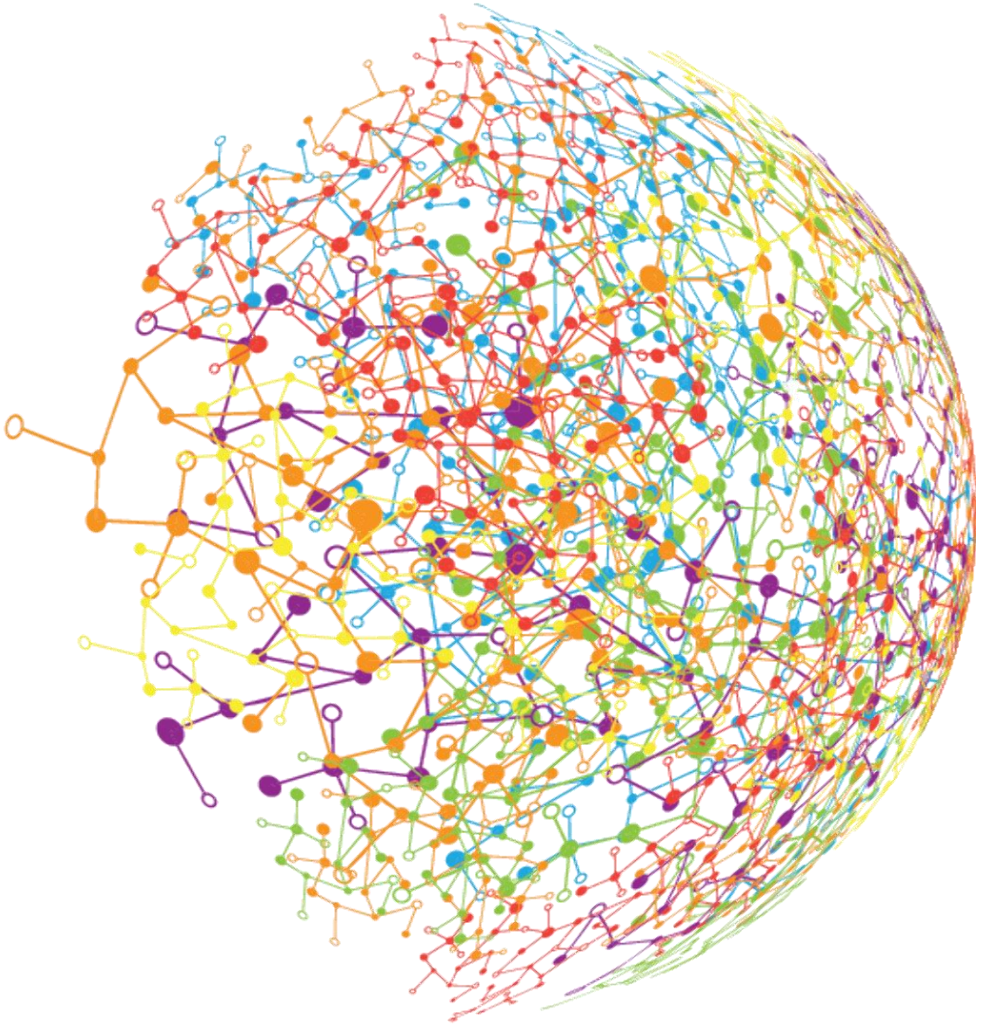
NHSE Investigation & Intervention Programme

5 Learnings to Sustain I&I and Financial Recovery



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Your session speaker

Liz May

I am a Partner at Deloitte and the Deloitte supplier lead for the NHSE Investigation and Intervention Programme. As a specialist in NHS financial and operational improvement, with extensive experience in Turnaround, cost reduction and delivery transformation; I am supporting I&I programmes nationally including with Staffordshire, South Yorkshire and Norfolk and Waveney ICBs.

I'm excited to share my learnings with you and feel free to contact me if you have questions on this session or more broadly on my experiences.

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NHSE Investigation and Intervention Programme

What is it?

Background

- In July 2024 NHSE agreed to undertake an investigation and rapid intervention process ("I&I") at a system level for those systems for which we have concerns regarding them meeting their financial plans.
- The criteria for those we will consider was agreed to be moved to >2.5% deficit compared to allocation, alongside the proposed >£100m deficit.
- The process was intended to identify and deliver material financial benefits in FY24/25 to the systems identified.
- Designed to deliver rapid improvements to run rates
- Since the start of the programme 19 ICS (out of 42) have now been placed in NHSE's investigation and intervention regime.

Designed as 2 phases:

1. **Phase 1: Investigation (approx 4 weeks)**
   - Assess the whole system's grip and control processes, pay and non-pay spend trends, and other operational productivity saving opportunities
   - Identify key recommendations for up to 4-6 interventions to be implemented across the system to improve the run rate and efficiency programmes of the system in order that they meet their agreed control total in FY24/25.
2. **Phase 2: Intervention (approx 12 weeks)**
   - Support the system in designing, developing and implementing the interventions identified in Phase 1.
   - The Supplier should support the system to implement each of the interventions, and support handover to system, so that upon departure of the supplier after 12 weeks of intervention support, each intervention will continue to deliver the benefits required.

NHSE Investigation and Intervention Programme

What is it?

How is I&I different to Recovery Support Programme?

- The national Recovery Support Programme (RSP), provided to all trusts and integrated care boards (ICBs) in segment 4 of the NHS Oversight Framework
- Organisations in the RSP receive support (for example, financially and through the provision of additional resource) for a time-limited period with exit criteria agreed that will demonstrate sustainable improvement and recovery.
- The RSP approach can be applied to an individual NHS organisation, or across a whole system, comprising the ICB and constituent NHS providers.
- Organisations that are part of the RSP are subject to a greater level of scrutiny over spending decisions by regional and national NHSE teams.
- Several of the potential system I&I targets have one or more organisations in the RSP programme.
- I&I teams, we will work closely with the RSP team to ensure cohesion, and it may be that RSP resource has a change of focus, or RSP work is leveraged to support intervention more widely across the system than just the organisation in NOF4.

5 Learnings to Sustain I&I Financial Recovery

NHSE Investigation and Intervention Programme

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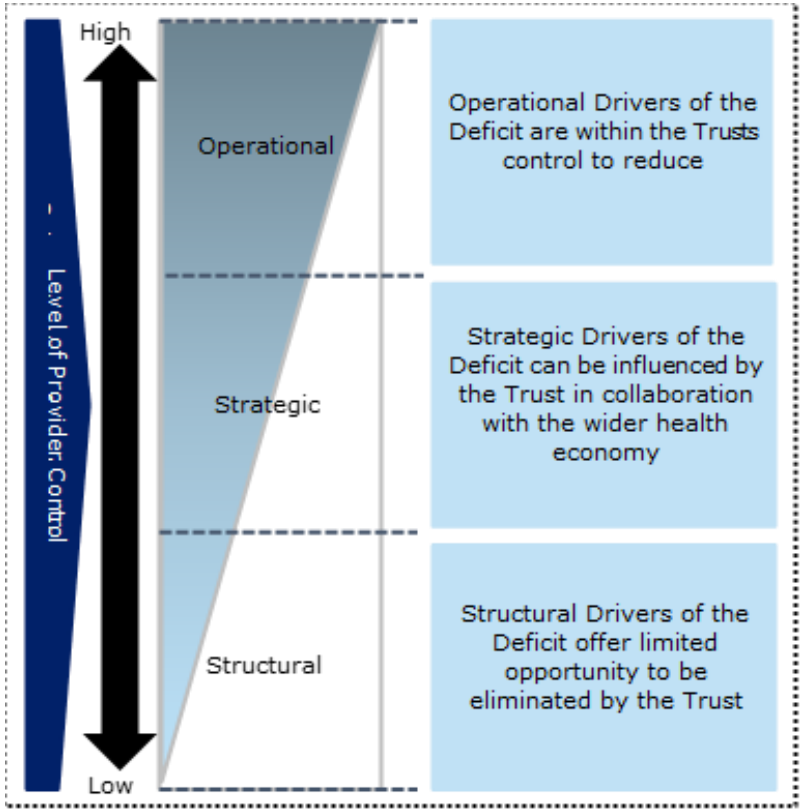
Ownership

Key Learnings:

- I&I is a system intervention and therefore ownership needs to be joint ownership across the sytem
- Understanding and owning the drivers of the deficit is key split between:
  - Operational
  - Strategic
  - Structural
- Recognition of the elements within your control at individual Trust / collaborative / system.
- Strategic and structural drivers requiring increasing levels of complex, multi-agency solutions to address the underlying cause of the drivers.
- Embracing the intervention as supportive will accelerate benefits
- Many systems are defensive and lack self-awareness which causes delays
- Joint ownership across the entire organisation / system and not just the finance department – including consistent messaging



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Focus on run rate whilst also looking forward

Key Learnings:

- Delivering ‘today’ whilst transforming for the ‘future’.
- Grip and control will only go **so far to stabilise position.**
- Huge **surge in demand** and need for acute escalation capacity – significant transformation work required to understand and address the root causes. Needs focus on **front and back door.**
- Demand management programmes are often **immature and not at scale - Place or ICB level.**
- **Data not sufficiently focussed on primary care variation,** activity pain points and fragile specialties.
- **Evidence based** models exist
- **Operational pressures are hindering innovation in new care models –** requires primary and secondary care collaboration.
- Transformation of **back office** should also be considered at scale
- Includes non-acute areas such as CHC

Admission Avoidance clinical pathway models

Integrated Neighbourhood Teams

Care coordination hubs

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Accountability and Governance

Key Learnings:

- **Clear accountability** is essential to drive delivery - with **SROs** responsible for delivering cross-cutting programmes across multiple sites, and Clinical Divisions clear on their contributions to each programme.
- **Strong 'engine room'** for monitoring and tracking impact, ensuring continuous pace and focus on **run rate improvements.**
- **Delivery Unit capacity & capability** required to 'do the do' – not to project manage but implement change and complete actions.
- Continuous focus on **financial improvement alongside operational delivery**, with clear messaging that transformation can deliver savings AND improve flow.
- **Clear communications** that celebrate success whilst continuously reinforcing the need for **financial sustainability as a requirement for all people in all roles**.
- Embed a **culture of continuous improvement**, constantly re-assessing how resources are prioritised and focused to deliver cash-releasing savings.

NHS University Hospitals Coventry and Warwickshire NHS Trust

UHCW implemented **delivery capacity** to cross cutting programmes

NHS Portsmouth Hospitals University NHS Trust

Portsmouth implemented a matrix approach to delivery (Programmes vs Divisions). Revised and implemented CIP governance to ensure robust **grip and control** from Executives and Divisions. Developed central **PMO structure**, **resource** and **delivery units** for additional programme support.

NHS Guy's and St Thomas' NHS Foundation Trust

GSTT ran Theatre **improvement squads** as truly blended MDT team of internal and external support with senior sponsorship

Making tough decisions and delivering on them

Key Learnings:

- **Benchmarking & Idea Generation**: best practice from other healthcare systems, harnessing local expertise to compile a comprehensive list of potential cost-saving initiatives.
- **Rigorous Prioritisation**: dedicated panel of cross-organisational representatives to evaluate and prioritise initiatives based on patient impact, implementation feasibility, and potential savings.
- **Data-Driven Analysis**: Co-ordinated detailed financial modelling and impact assessments for prioritised initiatives, ensuring robust decision making.
- **Clear roadmap for implementation**: Outline proposed governance and EQIA for initiatives.
- **Delivery resource:** delivery leads in place for each intervention
- **Further series of cycles to prioritise next set of interventions**

Decommissioning

Restrictions / policy thresholds

Service reconfiguration

Collaboration / shared services

Contract management

Standardisation of policies across system

Review planned investments / disinvestment

Policy compliance e.g. evidence based interventions

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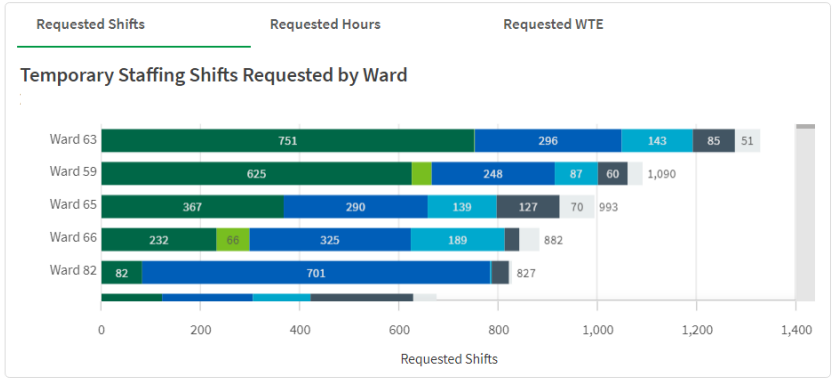
Workforce Grip and Control

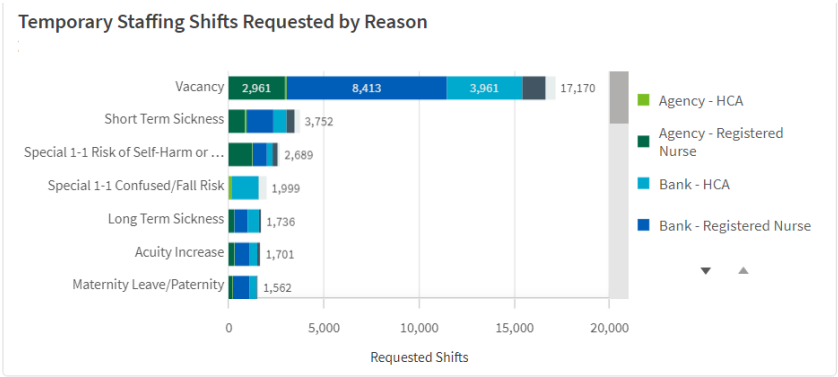
Key Learning

- There is **significant variation in controls** over workforce spend including vacancy control, temporary staffing spend, rostering and additional shifts and overtime.
- Overleaf shows an example of this variation against the Deloitte workforce grip and control assessment. We would expect that all organisations in an I&I system move towards **enhanced levels of control**.
- Access to data that leaders need to monitor controls is immature and is often stored within **offline spreadsheets that are difficult to use.**
- Staff members responsible for the check and challenge often report that they do not have the evidence and information they need to feel confident **in challenging clinical areas** on the appropriateness of temporary staffing requests.
- Controls need to be **prospective** to enable action **before** work has taken place.

At Barts the deployment of additional controls governance and our **workforce application** reduced overall temporary staffing spend by 10% and reduced spend on agency staff by 32 %

NHS Barts Health NHS Trust





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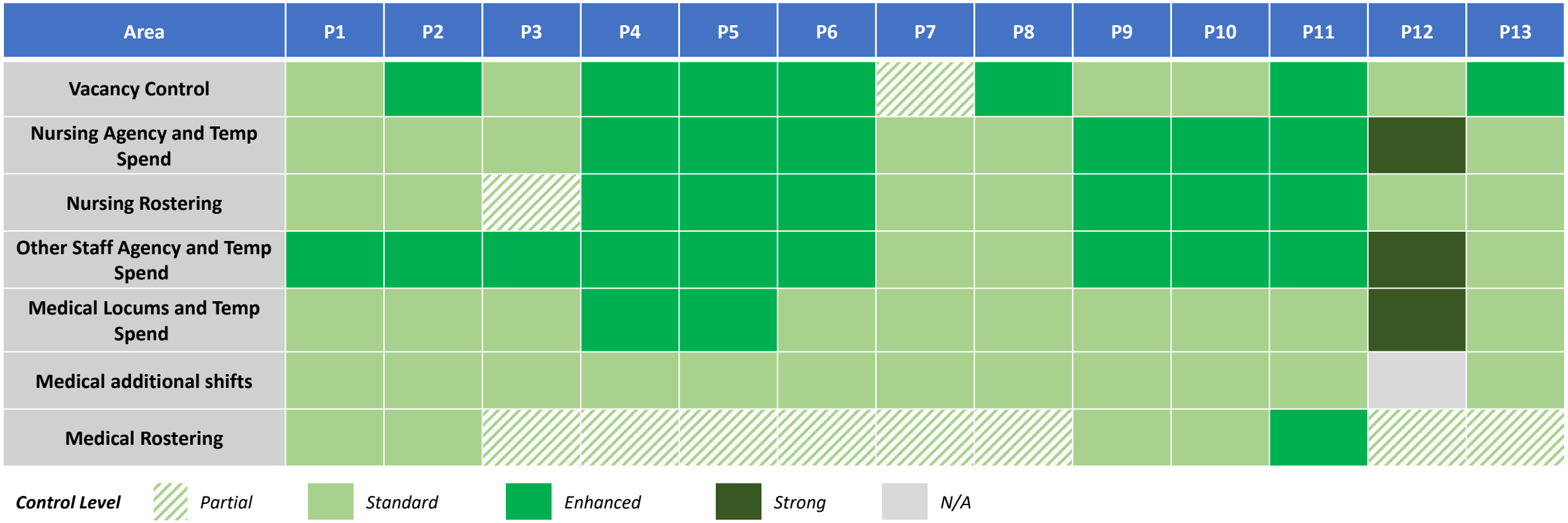
Controls assessment Peer Group Comparison

Comparator Providers (Acute and Mental Health / Community)



Examples areas:

- Variable bank rates and use of off cap rates
- Benefit in using a bank calculator / shift caps for nursing bank use inc. where wards are at establishment
- Automated MI for tracking and monitoring agency and temp spend, triangulated to e-Roster
- Restrictions on A&C including patient facing e.g. medical secretaries
- Limit additional shifts / WLIs
- Roster approvals in advance
- Overtime policies and review
- Real time tracking of job planned delivery
- Oversight of resident doctor rostering

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