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Accelerated transformation programme for healthcare services: structure, function and the lessons learnt

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ABSTRACT

The Kingdom of Saudi Arabia's (KSA) Ministry of Health's (MOH) healthcare transformation strategy aims to improve the quality of life of Saudi citizens in line with the 'Vision 2030' strategic objectives. The MOH is reforming the way healthcare will be managed in the future and is in the process of transferring healthcare service delivery responsibilities to clusters with ratified boards, while also moving the MOH from a provision of service model to a regulatory one. Several early pathfinding clusters were initiated in the eastern central and western regions. To ensure northern and southern regions were not left behind, the early innovation, while awaiting cluster nomination status, the northern and southern business units of Health Holding Company implemented the accelerated transformation programme (ATP). The ATP's remit was to develop capabilities and stimulate local engagement and ownership in the healthcare transformation process. This paper summarises the process of healthcare transformation undertaken in the northern and southern regions of KSA to date. It reviews the success in engaging with local healthcare professional communities in a standardised way and the learning from previous clusters, and elaborates on emerging implementation issues and how we may overcome them and introduce the lessons learnt from this journey.

INTRODUCTION

Healthcare transformation programmes are usually planned toward enhancing patient safety, quality of care, accessibility, equitability and sustainability of health services. They are meant to guide the thorough planning and phased implementation of broad healthcare system changes throughout jurisdictions.¹ They become precedence worldwide over the following years.² Significant transformations in the healthcare systems are usually driven by digitalisation, population growth and increased financial constraints, and accelerated by emergent diseases such as MERS-CoV and COVID-19.² However, changes are usually conducted slowly or, in many cases, fail to achieve the targeted outcomes, which delay the transformation process and hinder attaining positive effects, especially in large-scale projects.^{2,3} Significant shifts in the healthcare systems need to be promoted with a set of knowledge, skills, attitudes and specialised resources for the health of individuals and society that will be required for system-wide achievement.⁴ The acceleration of healthcare transformation programmes

represents an opportunity to reach the targeted outcomes in a reasonable time. However, it is challenging and may pose potential risks and resistance if not supported by the experiences of previous similar sustained projects or managed improbably.

Over the last few decades, the Kingdom of Saudi Arabia (KSA) has made considerable public health improvements.⁵ For example, the average life expectancy at birth increased to 75 years in 2015 compared with 64 years in 1964 and is planned to be 80 years by 2030.⁵ In addition, the access to emergency departments within 4 hours improved from 36% in 2016 to 87% in 2021.⁵ Despite the positive indicators of health in KSA, many challenges still need further effort, such as population growth, the high rates of avoidable injuries, inadequacy of primary healthcare, gaps in the quality of services provided, variations in access and health investment, gaps in human resource capacity and increasing number of non-communicable diseases.⁵ To address this challenge, the Ministry of Health (MOH) developed a transformation strategy for health sectors that aims to improve the quality of life of Saudi citizens, the quality and consistency of services, and the cost and outcomes. It has outlined a roadmap toward delivering value-based healthcare services, taking into consideration the institutional and economic needs and controlling healthcare spending, which aligns with Vision 2030 strategic objectives.^{5,6}

As part of the healthcare transformation programme, the MOH planned to transfer and merge all its healthcare providers into healthcare clusters.⁵ At the same time, the MOH will change its responsibilities towards regulation and oversight of healthcare and set and monitor implementation of the strategic agenda. These clusters will be distributed to approximately 20 geographically defined areas that on average serve 1–2 million people per cluster. The clusters were initiated first in the eastern region (Riyadh, Makkah and Qassim). More are following through various waves using the lessons learnt from the pathfinding clusters. Developing a cluster requires developing cluster-level leadership, strategic management, governance, public engagement, information and management systems. A cluster in the first stage is nominated with a prominent chair and board to drive and deliver the organisational development and deliver the healthcare transformational goals for the specific population. Each cluster will contain at least one medical city; for example, King Saud Medical City was

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incorporated with cluster one of the central region, and the King Fahad Medical City was incorporated within cluster one of the eastern region, with a plan to finalise the corporation process for all existing MOH providers by 2030.⁵ Thus, many other areas started to apply healthcare transfer into their clusters. As part of the preparation for cluster development in the north and south of KSA, the accelerated transformation programme (ATP) approach was developed. Reporting and disseminating the activities, efforts and outcomes of such projects have great value and are essential to generate healthcare experience and help facilitate a higher opportunity to share healthcare improvement experiences.⁷ The studies or reports describing the journey and lessons of applying healthcare transformation or ATPs that include significant shifts are limited. Thus, here, we report our experiences and lessons learnt from designing and using international best practice for ATP in the northern and southern regions of KSA. By publishing our growing journey, we hope that the readers of this report will get beneficial and practical information about the structure, functioning and lessons learnt from applying for an ATP in healthcare. In addition, we hope this report contributes to encouraging others to share changes in healthcare system opportunities worldwide.

Defining the ATP goals and methods in non-clustered regions

An ATP was conducted to commence several workstreams for a considerable amount of time in advance of the inception of the cluster announcement. The ATP was initiated through northern and southern business units that work with the regional clusters in the north and south of the country. Working through the business units facilitates conducting different high-value and complex projects simultaneously, diminishing potential risks of the competing works. For example, in our case, the ATP began with the work of the northern business unit, which worked in collaboration and intensively with the Hail Cluster. As part of

this process, the business unit supported the development of the governance for the ATP with Hail for 6 months through the development of a steering committee to manage the competing works and volume of risks through multiple workstreams and ensure delivery. The steering committee reported to the Hail Cluster board, which was fully engaged in this process at the time. Lessons learnt such as the delay in the announcement of executives were key characteristics of shaping future plans for clusters.

In November 2020, it was determined to develop a strategy for all non-clustered regions in the north and south to encourage and improve engagement with all of these places. In this regard, the northern and southern business units had eight Regional Health Directorates (RHDs) awaiting cluster announcement at the time. Based on what was learnt from the work done with the Hail region and the learning from other regions with clusters, the idea of the ATP was developed and implemented directly with the RHDs to encourage involvement, promote local ownership of the transformation in partnership with the business unit, improve knowledge transfer training and change awareness that involves speeding up the process ahead of the imminent chair announcement. This strategy helped to prepare the local teams for the new cluster when announced in order to get the local people involved, and will build the capacity for the future to benefit from the transformation process. The following were the key objectives of the ATP:

- ▶ To promote engagement and awareness of the RHD in terms of the healthcare transformation process.
- ▶ To encourage local ownership of the transformation in partnership with the business unit.
- ▶ To accelerate the preparation process for the impending cluster chair announcement (Ministerial Resolution 1):
 - To have a dynamic local team ready for the new cluster when the chair is announced.

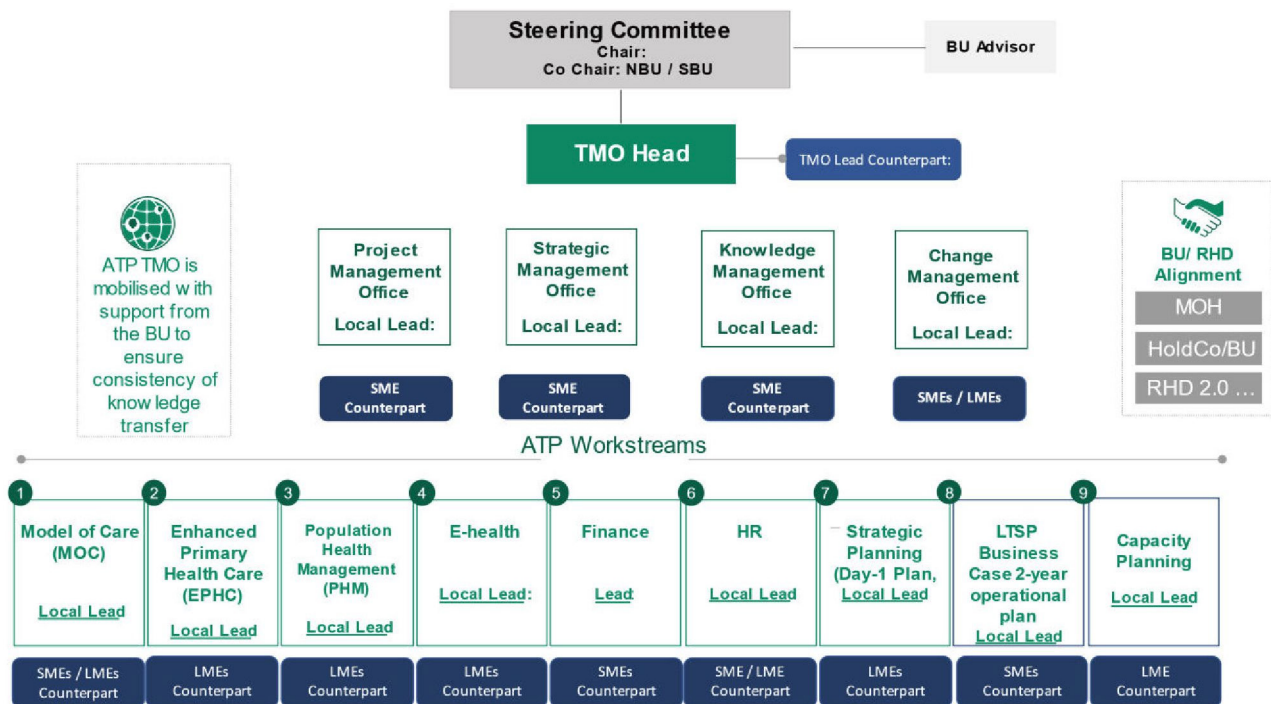


Figure 1 The accelerated transformation programme (ATP) structure. BU, business unit; HR, Human Resources; LTSP, long-term strategic plan; MOH, Ministry of Health; NBU, Northern BU; RHD, Regional Health Directorate; SBU, Southern BU; SME, subject matter expert; TMO, Transformation Management Office; LMEs, Local Subject Matter Experts

- To encourage local people to make a difference in the future of healthcare for ‘their’ population and get involved.
- To improve knowledge transfer training and development.
- To train RHD members in the transformation process in a practical, engaging and proactive way.
- To build capabilities for the future to benefit from the ‘transformation process mindset’.

What regions were involved?

The ATP was initiated in partnership with northern and southern business units, with many areas covered as part of this programme, ranging from Al Qurayyat on the border with Jordan and Najran close to the country’s southern border. Nine regions were covered over a period of between 6 and 9 months in the north and the south. It has been estimated that there has been a participation of around 400–500 people across the eight regions, with the average team size of about 50 people. Over that period, at least three steering committees and two delivery review meetings (DRMs) were held in all areas. This required a comprehensive schedule and resource management across the programme. A key consideration is the sheer geographical expanse of the programme and a central ATP team was formed and coordinated between the northern and southern business units to ensure coordination and successful implementation.

ATP structure and governance

The ATP is mainly chaired by the steering committee and co-chaired by the business units’ senior clinical leads (in delegation of the northern and southern business units’ vice president). In the cluster, the Transformation Management Office (TMO) and the workstream leads were formed and the northern and southern business units recruited local and international subject matter experts (SMEs) to ably support this process. The local national expert counterparts are used in all workstreams and TMO areas to assist RHDs in their training, development and knowledge transfer.

The ATP is governed through the mutual relationship between the RHD lead with the northern and southern business units’ leadership and teams. The relationship between the business units and the RHD was very good due to the success of the model of care (MoC) delivery in these areas particularly during the COVID-19 period where it was tactically agreed to continue with the process during this period, which developed relationships with the RHD communities. Because of this, there were solid foundations to develop the ATP steering committee, the ATP DRMs and multiple workstreams in the eight localities. The ATP steering committee was responsible for endorsing strategic decisions before the board meeting and supporting resolving escalated risk issues. The steering committee also monitors the project progress, monitors programme finance, tracks key strategic milestones and approves the requested changes. The RHD lead (supported by senior advisory and clinical support from the business unit) is responsible for preparing the strategic directions and risk management plan. They also track critical path progress and approve change requests. The DRMs are more technical as they set the priority for the projects, manage integrated planning, develop progress reports to leadership, report on key performance indicators, report risks, ensure efficient delivery of the projects, manage dependencies and develop teams. A workstream could consist of one or multiple initiatives (figure 1).

Steering committee and DRM process

Figure 2 shows the flow chart of the high-level sequence of handover to cluster process followed by all RHD ATP regions. At each stage, specific high-level deliverables must be met to be clear for the steering committee chairs to approve the next stage towards the final handover. In between steering committees, there are DRMs, which are TMO and workstream meetings supported by counterparts to go through and firm up plans and deal with issues, risks and dependencies in more detail.

From the outset, it is clear to the RHD members that this work is to be undertaken to support the transformation in advance of the handover to the cluster chair. At the time of writing, the Al Jouf Cluster has been announced as with the Asir Cluster with a southern-combined board being announced. We are witnessing a group of staff transferring from the RHD to the cluster and being ready and aware to move. While they were waiting, the TMO will continue monitoring the progress of continued business unit visits to ensure continued strong engagement while they wait for cluster chair and board to be announced. Figure 2 shows the progression of ATP as a journey and how it links with the forming of a cluster.

Establishing a fully functioning TMO

To benefit from the previously established clusters in other regions, the ATP mirrors what is required at the cluster to provide learning and acceleration when the chair is announced. The TMO includes four main management offices: the Project Management Office (PMO), the Strategy Management Office (SMO), the Knowledge and Communications Management Office, and Change Management Office. The PMO monitors and manages the implementation of workstreams, initiatives and risks, and develops project progress reports. The SMO conducts quality assurance, ensures workstream coordination and develops cases as required. The Knowledge and Communications Management Office assesses and identifies the communications needs and develops and implements a communications plan and stakeholder assessment. The Change Management Office develops and manages the implementation and strategic communications and coordinates change management efforts. All of the ATP regions formulated a fully operational TMO.

The TMO followed a standardised set of procedures, with international best standards for healthcare transformation programmes, and in line with lessons learnt from other cluster experiences, to keep consistency and promote learning among the business unit teams and regions. At the beginning of the steering committee and DRM, many followed the process with a set of prepared manuals supported by the international SMEs and local experts. As part of the programme, there was a strategy for a programme expert to take them through the process for the first two steering committees and first DRMs and then a handover to the local PMO and permanent business unit staff, showing an active learning process. The TMOs would have to take the reins from the steering committee there but would be encouraged to take a very active part before then.

The communications plans focused on training needs assessment and implementing change management training courses for internal team members across the portfolio. There has been a clear focus in certain communities on the training of RHD in the transformation, with Jazan being the real trailblazer in the south with sessions for 6700 on transformation awareness. Arar set the pace in the north with sessions for engagement with a host of transformation cafés.

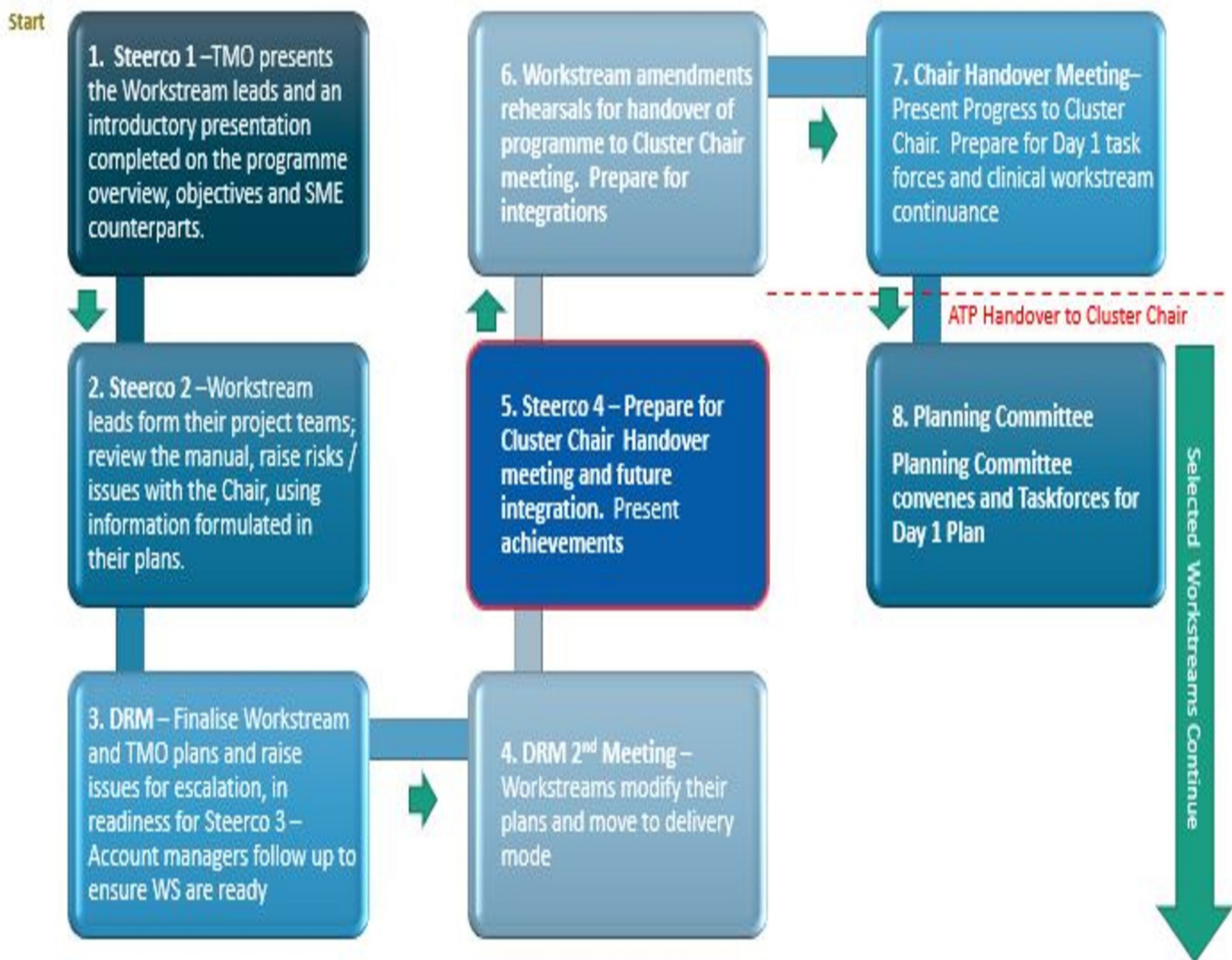


Figure 2 Flow chart of the sequence from handover to cluster chair announcement (Ministerial Resolution 1). DRM, delivery review meeting; SME, subject matter expert; Steerco, steering committee; TMO, Transformation Management Office; LMEs, Local Subject Matter Experts

Change readiness and population health management (PHM) questionnaires with a target of 3000 people were conducted. The numbers provide evidence of ATP engagement in the south, which was excellent. Physical transformation roadshow programmes had the highest attendance for Health Holding Company (HHC) sessions through their live Zoom link and with attendance of RHD leaders. In the south alone, there were 2500 attendees for the transformation roadshows on the Zoom link. A recent change readiness questionnaire has been sent out to the regions with almost 3700 respondents across the north and south before concerted follow-up. There were various approaches between the north and south, meaning there were differing outcomes. More concentrated messages will need to take place to embrace the communities with the rationale behind the MoC and the RHD workforce in the reasons for changes ahead.

The ATP workstreams

The workstreams of the ATP were set to support the RHDs in their training, development and knowledge transfer. There were nine workstreams supported by business unit expert counterparts in each to go through and firm up a plan and deal with issues, risks and dependencies in more detail: MoC, enhanced

primary care (EPC), PHM, E-health, finance, Human Resources (HR), long-term strategic plan (LTSP), business case and capacity planning.

Model of care

MoC is a massive programme of work across the nation, and it can be noted that MoC would have continued, irrespective of ATP being in place.⁵ In addition, the successful pathfinding work of the MoC process has actually enabled the ATP to take place. The ATP has allowed the MoC to be integrated into the transformation activities, and the ATP has allowed immediate high-level escalation points at the RHD leadership level. The integration of the transformation has allowed all other workstreams, particularly in the corporate areas, to learn the importance of MoC in this instance. It is equally crucial for MoC teams to take note and understand better the intricacies of corporatisation that they will so rely upon in the future.

The MoC teams in the north and the south successfully delivered their plans across the board during this period. The principle areas of delivery are the activation of the key performance indicators and subpathways of five MoC pathways. As part of this work, focus has been on training and development of frontline staff to initiate the said paths. This forms part of the

first phase in the local communities, the bedrock from which the scale-up and initiation of a further 15 pathways will take place over the next period. The ATP has provided the additional benefit of raising issues related to equipment and staffing issues and garnering the outright support of the RHD.

Enhanced primary care

EPC has shown great success in the northern and southern regions. Critical indefinable deliverables across the entire north and south stand out in terms of delivery nationally: baseline data collection and analysis and primary healthcare readiness assessment; EPC training of frontline staff; EPC rollout of registration in the first phase of sites; implementation of basic health assessments in these sites; and collaboration and support for MoC initiatives. Impressive strides have been made with this programme in terms of EPC. Across the north and south, 120 primary healthcare centres have initiated two teams enrolling, on average, 2000 patients per practice, which could mean up to 240 000 patients enrolled. The scale of the training across the 240 teams would be impressive.

Population health management

The PHM programme in the north and south had core deliverables around setting up the team, determining the source of local data and assessing the required skills. Understanding the population needs assessment was also key to combining deliverables. These formulate the key building blocks of PHM.

The review has found a different approach where the northern team has followed the Accountable Care Organization (ACO) manual (a local gateway process towards movement from cluster to ACO in various defined and monitored stage gates in specific workstream areas) principles as part of the development by drafting the operating model and identifying the team's training needs. The south did not focus on this but looked at information governance and started the process of regional geographical division by zones. It is recommended that the PHM teams undertake a session for lessons learnt and adopt a more unified approach moving forward, which compliments the ACO journey and brings in best practices regarding data sharing arrangements.

E-health

The E-health programme had two consistent deliverables across the regions. First, there was a process of baseline data collection and assessment of the E-health systems and infrastructure. Second, there was a current state assessment report delivered. The southern team focused on forming a capabilities assessment team in all localities and completed that successfully. The northern team concentrated on supporting the resolution of issues in line with the blueprint, such as increasing or implementing bandwidth and even supporting MOH inquiries for Picture Archiving and Communication System in hospitals. The two areas were recommended to combine their intelligence and learn from each other and the other regions.

Finance

The finance workstream had a uniform approach across the north and south, beginning with learning exercises with the financial 'Blue Book'. The process of data requests internally in the RHD and to the MOH commenced in all areas, with some progressing quicker than others. Theoretical development of what the budget carve-out would look like was investigated to develop capabilities. What a future operating model would look

like and related job descriptions for any of the roles were also designed to enhance knowledge for future work.

Human resources

The HR workstream began through training with two key points of learning for members—day 1 transfer of people and the LTSP—the strategic planning document provided by the cluster's executive and board). Standardised templates were created to enable data collection. The RHD workforce profiles were put in preparation in terms of day 1. The cluster concept was discussed and hypothesised within the LTSP target operating model context.

Capacity planning

This extremely important workstream was set up to accelerate the local level of understanding in capacity planning and accelerate the process of collecting data which we know can take a long time. This workstream followed a standardised intensive workload of piloting data collection before widening the scope in each area. With the announcement of Al Jouf and Al Qurayyat forming the first cluster, it accelerated the process of data collection, taking less than 3 months to complete the data collection phase in advance of the modelling. This serves two purposes:

1. Beginning the development process for the continuous need for future clusters and developing the capabilities to undertake this ongoing task will be significantly beneficial over time.
2. Beginning local appreciation and knowledge of this work in advance of the cluster work will be beneficial on the development of the LTSP.

Delivery of this workstream across all workstreams has been a huge success in terms of meeting its original objectives and knowledge transfer. There is only one remaining area for data collection, which is purely due to the programme cascade. Given that this area was commonly a sticking point for many of the early clusters, this is some achievement indeed.

Long-term strategic plan

The LTSP workstream objectives involved building the members' knowledge in developing a cluster's LTSP. There were three key areas of focus for the workstream delivered across all regions: develop a strategic framework, define data requirements and begin a collection, and define outputs for financial model criteria. Other activities were included to widen the knowledge across the portfolio. For example, a training session on LTSP exceeded the 100 limited spaces allowed at the time on Zoom—130 in the waiting room. Those moving to the cluster completely understand why this work is being undertaken and will seek to form part of it and develop the local capabilities to do this in the future.

Strategic planning: day 1 plan workstreams

The day 1 plan was touted as the next step in the cluster journey once the chair had been announced. The day 1 teams were trained in the next phase of day 1 planning. The original baseline assessments were reviewed, and additional data were collected for further information and detail. The baseline assessment was refreshed in line with any other data, and activities were mapped to ATP workstreams to ensure that workstreams would be ready to participate in the task forces when the planning committees were set up. In the newly formed cluster, we could see how active the day 1 planning workstreams were and that the development of local leadership was present. They had already experienced

working in a programme, and this gave them knowledge and confidence of what they needed to do. Those new members of the cluster were able to liaise and learn from their colleagues and benefit from local development.

Overview of measurement of achievements

The ATP's development has been reviewed through its documentation, which reports progress toward plans. Detailed data have also shaped judgements of how they perform by observing their presentations to steering committees and the quality of their ongoing reports. The eight areas used a portfolio strategy with a standardised transformation programme approach with critical incremental stages to construct them. The standardised format concentrated on formulating governance, meeting structure and terms of reference, TMO and workstreams, and standardised agenda, and developing transformation plans per workstream. These can be measured in terms of the quality of programmes designed and delivered.

The ATP achievements and the lessons learnt

Two of the main objectives of ATP implementation were to promote the engagement and awareness of the RHD about the transformation and develop capabilities to benefit local transformation initiatives. The original remit of the business unit is in supporting the development of the cluster, and the rationale of this programme is that we could not do this in these areas without building them and without building the business units' capabilities. Initiating the ATP resulted in active involvement in an integrated programme to enable people to see how the pieces are put together in reality. The process of learning is thereby experiential—not out of a book or checklist. For example, the RHD lead is co-chair with a business unit lead. All workstream leads and TMO teams are locally supported by business unit counterparts. Thus, there was potential to lift and shift many parts of the programme from the RHD to the cluster as required. All the workstream leads and TMO team are locally supported by business unit counterparts, and business unit members are also present to develop their experiential capabilities.

The ATP encouraged local ownership of the transformation in partnership with the business unit. The ownership is a great asset in this transformation. The programme is locally owned; for example, the Al Jouf Cluster chair has received handover meetings with Al Jouf and Al Qurayyat RHDs and was impressed with the extent of preparedness and engagement and local ownership of the RHD. This led to different RHDs bringing their own unique personality and flavour to the programmes as one would expect but through standardised methodologies and practice.

Moreover, the ATP process involved comprehensive induction and engagement through visits to improve knowledge transfer training and development. For this purpose, manuals, training-related activities and installation about the transformation were produced. This is expected to enhance knowledge transfer training and development and build future capabilities to benefit the transformation process. Figure 3 shows a summary table of the ATP achievements in different workstreams.

Escalated issues and resolutions

Some multiple issues and risks were mitigated through the ATP. For example, the lack of workforce availability to implement clinical workstream changes and those with the necessary skills to support the transformation was presented as a huge cross-cutting issue. This has been managed by using the counterparts

to support and train members and the governance to raise issues to the RHD leaders to ensure future recruitment in these areas (consultants, general practitioners, etc). The lack of medical equipment represented another issue, particularly to support EPC, which was consistent across the programme. The ATP steering committee was the perfect group to raise such issues. In some cases, it was resolved if they had availability but possibly needs more central consideration on how the change was funded and supported as it scales up and from a portfolio basis, how are the dots and interdependencies joined up. The MOH changes to primary care management through public health also presented as an issue due to a change in priorities and parallel programme initiation, which may have conflicted rather than complimented the work underway. Thus, better coordination of initiatives is required at HHC/MOH level. With the recent move of all operational leadership to HHC, such issues will be resolved.

Escalated risks and resolutions

Conducting a large-scale, complex programme unearths multiple risks. However, the cooperation between business units and the regions mitigated or rose awareness of them. Inaccuracy and availability of data are huge across the whole spectrum of the programme. LTSP recommended an information sharing agreement form as part of the memorandum of understanding (MoU) agreed by the RHD and cluster to ensure adequate sharing of data for strategic planning purposes.

Another risk was that conflicts of RHD members with other work responsibilities became pertinent at the outset of future clusters. For this risk, RHDs must be encouraged to maintain the space they have created for the transformation as the new cluster is formed—governance around this through the MoU. From a business unit perspective, there was a huge risk with the delay in the announcement of the cluster chair and the potential loss of engagement and business unit credibility as a result (particularly pertinent in the south). A clear process for cluster rollout and a bridge between ATP and day 1 process need to be designed to ensure continued engagement. At the time of writing, this appears to be resolved but will still pose as an issue for those last in the line in terms of nomination, and clear communication about this will be required to keep them engaged. Furthermore, the lack of resources and expertise has meant that northern and southern business units have had to share resources across the business units to deliver ATP. There is a risk of burnout, and attrition is not sustainable, with a number of core members having to take a more significant workload to support capability gaps. Business unit capabilities must be developed to help the corporatisation process. The necessity for SMEs—particularly in finance (even for pre-cluster activities)—was an ongoing issue for the programme as well as the wider national transformational development. For a sustained period the ATP had one financial SME stretched across eight regions which was a huge challenge. Business units have had no HR support since March 2021. This ATP issue is now translating as a corporatisation risk for HHC.

Lessons learnt

Many lessons were learnt during the ATP conduction. Building strong positive relationships through concerted engagement was a key asset to any transformation process.⁸ Involving the RHDs empowers them to understand and own the transformation in a better way. A critical lesson for transformation success is making people on the ground aware of the transformation to feel confident and learn how to do it. This is because people have the capabilities but have never undertaken a transformation

ATP Achievements Summary

<p>1. TMO / PMO/SMO</p> <p>1. Fully activated TMOs across ALL areas in line with Cluster Stand-up requirements. Up to 500 people engaged as part of this programme 2. TMOs (PMOs and SMOs) in place and trained specifically as leaders of local healthcare Transformation Initiatives. 3. PMO Workstream Meeting Schedules, 1-1 and TMO W/S meetings taking place. 4. WS 90 -180 day plans developed 5. Risks, Issues and Dependencies 6. Steercos and DRMS schedules fully completed – RHD as Chair. Transformation KPI requirements for TMO set-up Complete</p>		
<p>2. Comms and Change Management</p> <ul style="list-style-type: none"> ✓ Comms & Change Management Teams formed ✓ Change Management Training Course for Workstream members in North and South ✓ Change Readiness Survey rollout – 9590 respondents North and South in first three weeks (aim for 25,000) ✓ Transformation Workshops undertaken by SBU had 2500 attendees over the four Southern Regions ✓ Continuance of Transformation Cafés in the North 8b 	<p>3. E-Health</p> <ul style="list-style-type: none"> ✓ Baseline data from all facilities in N&S ✓ Current state Assessment Report Complete ✓ South – Formed Capabilities Assessment Team ✓ North – Increase bandwidth PHCs / Hospitals ✓ North - support Request for PACs for Hospitals <p>Differences of approach for North and South with North providing operational support on resolving issues and South Focusing on Assessment report</p>	<p>4. Finance</p> <ul style="list-style-type: none"> ✓ Training of team members through counterpart SME ✓ Began collecting data ✓ Commenced draft of the budget carve out model for training purposes ✓ Work on an indicative financial operating model
<p>5. Model of Care</p> <ul style="list-style-type: none"> ✓ 5 priority Pathways rolled out to 10% of Population of the North and South ✓ Regional prioritisation and agreement plans for 2 year Scale up complete ✓ Preparation for next five Pathways ✓ Gate 1 readiness awaits Lift and Shift to Cluster <p>Note: ATP provided a learning experience of the RHD corporate members about the clinical Transformation</p>	<p>6. Enhanced Primary Care</p> <ul style="list-style-type: none"> ✓ 120 PHCs have initiated the two teams for enrolling patients – exceeding 10 practice per region target ✓ Estimated 420,000 patients registered in the North and South ✓ ATP Steercos dealt with highlighting and resolving issues around equipment and staffing <p>Note: ATP offered benefits of raising issues in an open forum with RHD leadership for resolution – such as manpower and equipment.</p>	<p>7. Population Health Management</p> <ul style="list-style-type: none"> ✓ PHM teams set up ✓ Data requirements determined with list of requirements ✓ South focused on Geographical zones and Information Governance ✓ North BU regions Arar, Al Jouf and Al Qarrayat are 50% towards ACO Gate 2 requirements complete (in line with NBU Hail's assessment) South not providing this focus
<p>8. Human Resources</p> <ul style="list-style-type: none"> ✓ Training and Preparation for Day 1 – Workforce Migration ✓ Training and development of LTSP (Long Term Strategic Plan) - Target Operating Model requirements L1-L3 ✓ RHD workforce profiles in preparation ✓ Data collection standardised <p>Next Steps Cluster to review Transfer development of LTSP and training on the ACO Manual HR requirements</p>	<p>9. Long Term Strategic Plan</p> <ul style="list-style-type: none"> ✓ Workstream and ATP wide training and coordinate requirements to the LTSP complete ✓ Training on the financial model and strategic framework attended by 100 with 130 in waiting room ✓ Identification of data Requirements <p>10. Day 1 plan</p> <ul style="list-style-type: none"> ✓ Review and renew Baseline Assessment ✓ Preparation of Taskforces and Planning Committee (crucial next step – post MR1) 	<p>11. Capacity Planning</p> <ul style="list-style-type: none"> ✓ Formulation of Regional teams ✓ Alignment with VRO methodology ✓ CPU training sessions complete ✓ Identification and Collection of Data ✓ Completion of pilot Phase in all areas (Bisha currently being rolled out) to complete learning and development pre cluster

Figure 3 A summary of the ATP achievements in different workstreams. ACO, Accountable Care Organization; ATP, accelerated transformation programme; BU, business unit; DRMs, delivery review meetings; HR, Human Resources; KPI, key performance indicator; LTSP, long-term strategic plan; MR1, Ministerial Resolution 1; N&S, north and south; NBU, Northern BU; PACS, Picture Archiving and Communication System; PHCs, primary healthcare centres; PHM, population health management; PMO, Project Management Office; RHD, Regional Health Directorate; SBU, Southern BU; SME, subject matter expert; SMO, Strategy Management Office; Steercos, steering committee; TMO, Transformation Management Office; VRO, Vision Realization Office; CPU, Capacity Planning Training; Unit; LMEs, Local Subject Matter Experts

like this before. Thus, building their capabilities will empower the transformation.⁹ Local engagement requires visits to develop relationships; however, the visits can be made by holding most of the meetings online, which is best economically and works well under emergent situations.¹⁰

An array of talent is required to deliver the transformation requirements in the localities with the need for finance, HR, PMO and SME support. The business units will need the resources to undertake this work and walk them through the stages via SMEs and locally trained experts. One fears the reliance on consultancy like in the past will get them through the gateways but will not have anyway the same level of knowledge transfer and local ownership. If we think we can provide them with a manual for them to do without expert support, it will fail, as the experts can be an essential source of solutions. Learning from the experiences has significantly impacted the transformation's success and cost savings.¹¹ From a learning perspective, the whole business units of the north and south have been part of these as supportive teams and counterparts. The business units are more confident working in large-scale programmes and

presenting in forums with senior stakeholders, which bodes well for future cluster support. The southern and northern business units' leadership teams believe the highest performing teams in the ATP should have been prioritised to influence future cluster announcement decisions and request more involvement in the future decision process. This support process accelerates the cluster journey and builds required capabilities to ACO gate 1 and beyond. Evidence of this is emerging from Hail as it moves through the process of gate 1, and early impression from the Al Jouf Cluster from their development process in terms of the level of engagement and knowledge of the transformation. Because they are not starting from scratch, experts do things differently, and those without transformation experience are more likely to vary delivery. HHC must ensure all future clusters get the same standards of support. The risk relating to data accessibility and quality was one of the largest areas of concern we found. This could be managed centrally through HHC's data management office to consider information sharing agreements with RHDs/ MOH to facilitate successful access to data. The ATP only achieved success because of pooled resources across northern

and southern business units which were supported by the MOH and HHC leaders alike. But there was not enough resource to go around, and it relied on certain people to take on higher workloads. This is not sustainable and creates another problem of individual business units not developing their capabilities.

CONCLUSIONS

In this report, we shared our experiences regarding applying ATP in the northern and southern regions of KSA. We discussed its structure, composition and functions. We also elaborated on the issues and risks that challenge the implementation and how we overcame them. In the end, we introduced the lessons learnt from this journey.

This project contributed to the active development of RHD staff through their participation in a large-scale transformation programme. There were a multiple of skilled people in the RHDs who just lacked transformation experience. The transformation team is set up in each journey, ready to support the transformation over the forthcoming years. Whether those involved end up in the RHD as regulator or in the cluster, the learning about the transformation will be valuable. These people will become the national healthcare transformation leads of the future. In this ATP, the governance set-up is in line with cluster programme standards, if not better because of the levels of SME support. The TMO set-up is in line with ACO gate 1 requirements and has consistently delivered across the whole programme. At the same time, the workstreams have successfully delivered activities across the board, some with consistency across the north and south, and others with slight variation and innovation. We have found that there are different E-health, PHM and communications approaches in certain circumstances where there are different leads. Because of the size of the programme, it was difficult also to get all the members of the business units orchestrated to standardise everything; but on the other hand, we could test things against each other where there was variance and learn from that. In the MoC, there has been a systematic rollout of five pathways across all the ATP regions. The EPC has enrolled an estimated quarter of a million people. From a communications perspective, we have large-scale engagement with the transformation events, with almost 2500 people attending in the south. In the north, we have had excellent engagement with transformation cafés. The change readiness questionnaire for the north and south has recently been sent out, and we have, at the time of writing, 3600 responses across these regions but with a poor response rate from Tabuk, which shows potential disengagement as an ATP trailblazer due to their lack of cluster announcement. Such things can take the highest of performance teams and disengage them. This is a good example of the importance of engagement and relationship management. The programmes are locally owned, and we have observed this through the programme as we have handed over responsibility recently to two RHD teams completing the cycle, presenting work as 'their' work to hand over to the chair of the Al Jouf Cluster with more to follow. The chair of the southern cluster is already seeing the benefits of the programme in the southern region. The recent events in the south have shown engagement and involvement. We have witnessed the development of the teams and development of their capabilities through the improvement in the quality of their materials and presentations through the steering committees and DRMs.

The ATP has successfully engaged with RHDs, but that success must not be dwelled on. There is evidence that RHDs may lose momentum and faith in the transformation due to long delays

to cluster announcement or if the reliance of consultancy is too high. The northern and southern business units retained levels of engagement with those regions to prevent disillusionment and disengagement as best as possible.

There is a cross-cutting issue around the lack of availability of workforce as well as those with the necessary skills to support the transformation, which was mitigated to some extent by using the support of SMEs and local and national experts as counterparts. Greater thought must be given on how the transformation is positioned to provide expert-level support and training particularly as clusters go through the ACO gateways.

The main compound risk for the programme is around data availability, and quality information sharing agreements must form an explicit part of the MoU between the RHD and cluster with clarity of what the data will be used for and by whom and the governance arrangements around that. There was a shortage of SMEs available to support the next phase of transformation, in line with supporting the clusters as they develop in the same way as ATP. The northern and southern business units combined resources to be able to undertake ATP, but this did not come without cost. It meant a high risk of burnout for those working across two regions, and individually, the two business units need to build up capabilities to undertake this work. There is also a high level of transfer of business unit staff, which means the levels of internal support skills will also diminish over time.

That said, we leave eight regions with thorough knowledge of the path that is in front of them and have provided them with the motivation to take on the next challenge of the transformation and shape the healthcare services in their region and nationally. Early signs suggest they will be able to carry the baton to the next stages and support the transformation locally, which was the intent and purpose of the ATP.

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