Intensive Planning Support to NE London

Deliverable 3: Final Report

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1. Overview of project delivery

The McKinsey team (working with NEL CSU, Ruth Carnall and to a limited extent Deloitte) has supported the two parts of North East London – the inner CCG group covering Waltham Forest, Tower Hamlets, Newham and City and Hackney, and the outer group covering Barking, Havering and Redbridge. The relevant providers include: two challenged acute trusts – Barts Health and BHRUT, together with 3 FTs: Homerton, North East London FT and East London FT.

As you are aware, City and Hackney have only partially engaged in this process as they do not see themselves as part of a challenged health economy given Homerton is not currently facing clinical or financial failure, and their elective referrals flow East and West in similar proportions. We would question this perspective given the unresolved health challenges in the CCG and their position compared to target allocation.

The deliverables completed in this programme are a shared understanding of:

- The case for change, considering quality and population health gaps and the projected financial position across the health economy to 2018/19
- The financial drivers of the current deficits at Barts and BHRUT; forecast 18/19 system financial gap at NEL, BHR and WEL levels; and the forecast gaps by provider
- Current status of Integrated Care, Primary Care and Urgent Care Transformation
- Actions required to close financial gaps in WEL, with a focus on Barts Health, and in BHR
- Forecast capacity requirements reflecting population change and QIPP initiatives by commissioners
- Private car and public transport travel time modelling using transport for London HSTAT data for NEL region
- High level capacity and financial impact of reconfiguration options in WEL (impacting Barts and Homerton sites)
- Requirements for KGH reconfiguration and high level impacts on adjacent sites
- High level actions and timeline required to deliver KGH reconfiguration
- Changes to governance and resourcing to accelerate delivery and implementation

Some of these deliverables have been incorporated into the SPG plans, however due to the timing of the work, some have not (and some do not have full support from SPGs).

Working with Alwen Williams and local leaders, we have prioritised local ownership of plans resulting in closing ~75% of gaps, rather than forcing 100% closure and "losing" local leaders who do not believe full closure is possible by 2018/19.

Where gaps remain, we have identified the stretch required in each of WEL and BHR – this will either be a stretch in provider productivity, or a change in actual tariff efficiency requirements (though this would require savings to be made elsewhere in commissioned spend).

We have had an intensive series of meetings and engagement in BHR and WEL with material senior time and have complemented this with numerous sessions with Chairs, CEOs, Clinical Leaders and Finance Directors. This engagement has been focused building alignment around the case for change, on forcing the pace of this work and also in scoping future governance changes to sustain more rapid future delivery.

In addition to this note, we are submitting detailed powerpoint documents on both WEL and BHR separately to the SRO, Alwen Williams. This note has not been shared in its entirety with WEL or BHR regions, however the SPG specific sections of the paper and the two local powerpoint documents have been shared.

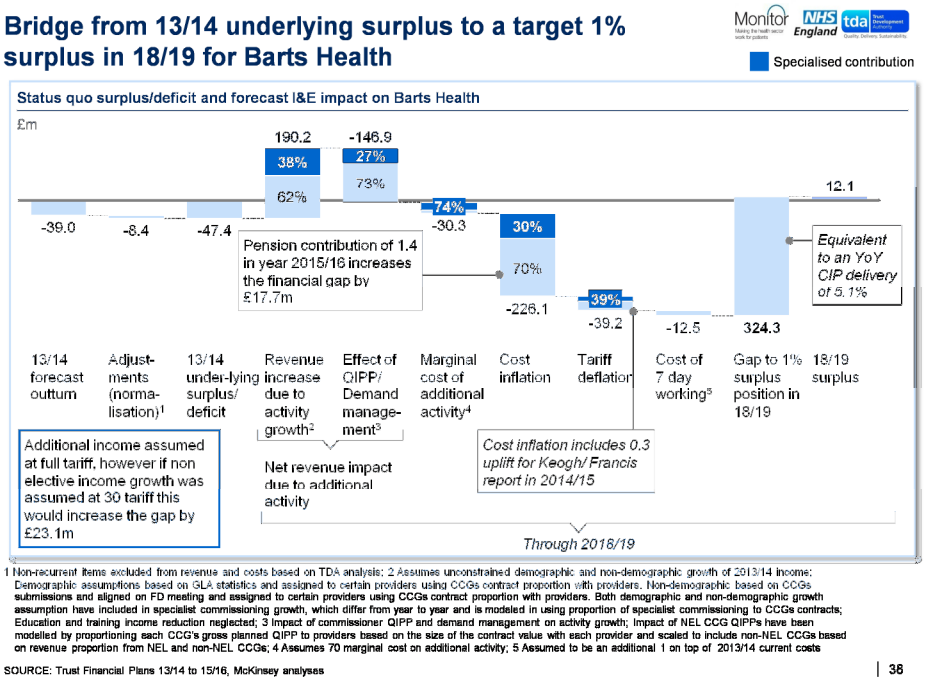
2. WEL Conclusions

2.1. Case for change

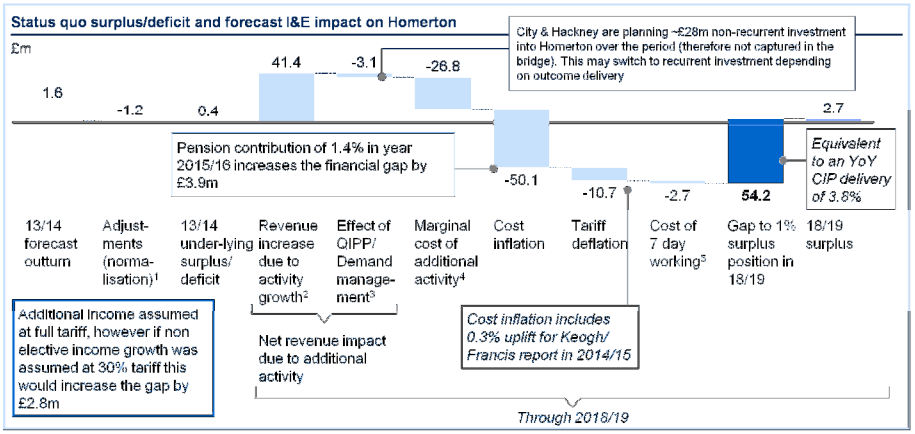
Overall, WEL is facing several challenges. The region has lower than median life expectancy compared to national figures, and has a higher level of potential years of life lost than the rest of the country. Among its key challenges are: Improving support for early years e.g., vaccination (with the exception of Tower Hamlets) and reducing child obesity; Enhancing support for people with long term conditions; and Improving positive experience of care across the board – from primary to acute, including access to services.

2.2 Financial bridge

Aside from the clinical challenges, WEL is also facing a substantial financial challenge. The system gap by 2018/19 is estimated to be £282m for WEL commissioners (before tariff efficiencies and QIPP) and £434m for providers within the region (Barts Health ~£324m, Homerton ~£54m and ELFT ~£56m). The 'WEL commissioner' share of the total provider challenge would be less ~£188m - based on the provider income split by commissioner: 48% of Barts Health, 5% of Homerton, and 53% of ELFT.



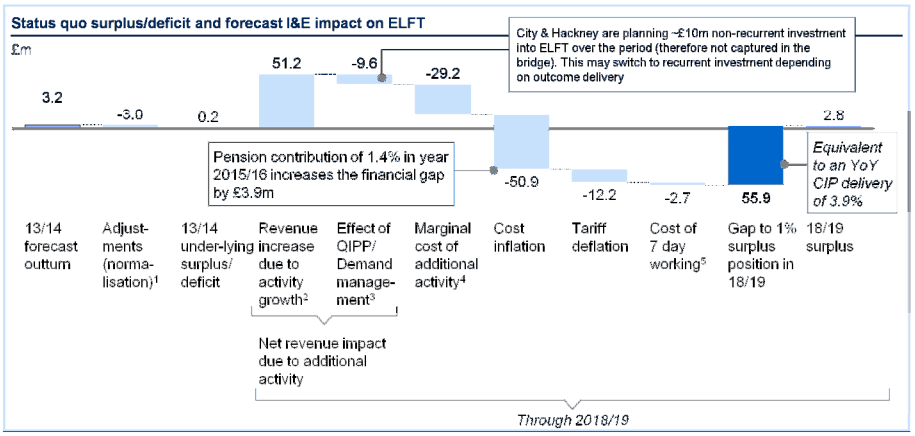
Bridge from 13/14 underlying surplus to a target 1% surplus in 18/19 for Homerton



1 Non-recurrent items excluded from revenue and costs based on Trust financial plan and aligned with a trust; 2 Assumes unconstrained demographic and non-demographic growth of 2013/14 income; Demographic assumptions based on GLA statistics and assigned to certain providers using CCGs contract proportion with providers. Non-demographic based on CCGs submissions and aligned on FD meeting and assigned to certain providers using CCGs contract proportion with providers. No specialised commissioning growth considered as LAT contracts not included in Homerton financial submission; 3 Impact of commissioner QIPP and demand management on activity growth; Impact of NEL CCG QIPPs have been modelled by proportioning each CCG's gross planned QIPP to providers based on the size of the contract value with each provider and scaled to include non-NEL CCGs based on revenue proportion from NEL and non-NEL CCGs; 4 Assumes 70% marginal cost on additional activity; 5 Assumed to be an additional 1% on top of 2013/14 current costs

SOURCE: Trust Financial Plans 13/14 to 15/16, McKinsey analyses | 40

Bridge from 13/14 underlying surplus to a target 1% surplus in 18/19 for ELFT

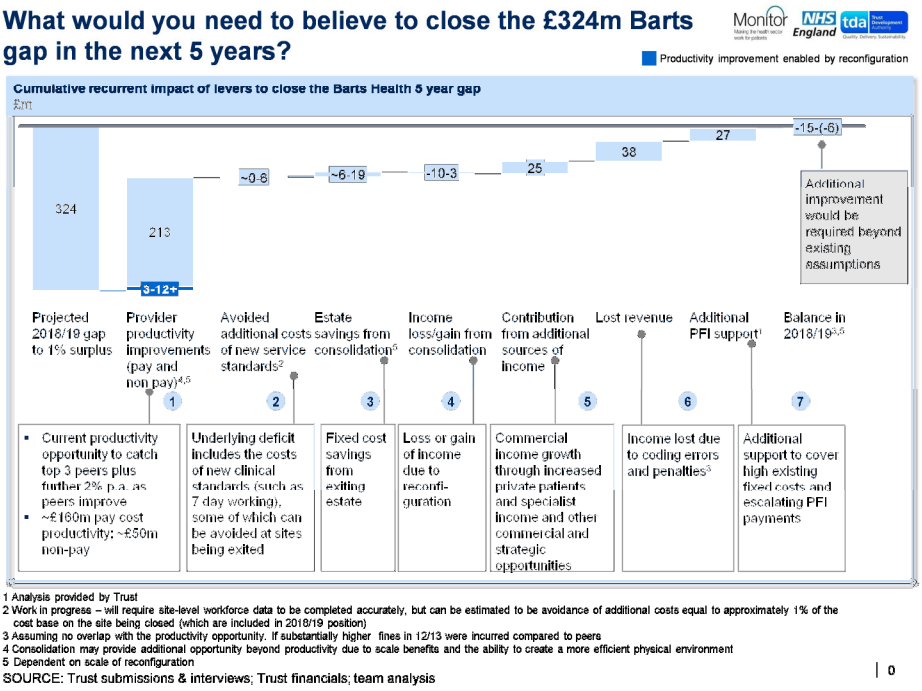


1 Non-recurrent items excluded from revenue and costs based on Trust financial plan and aligned with trust; 2 Assumes unconstrained demographic and non-demographic growth of 2013/14 income; Demographic assumptions based on GLA statistics and assigned to certain providers using CCGs contract proportion with providers. Non-demographic based on CCGs submissions and aligned on FD meeting and assigned to certain providers using CCGs contract proportion with providers. Both demographic and non-demographic growth assumption have included in specialist commissioning growth, which differ from year to year and is modeled in using proportion of specialist commissioning to CCGs contracts; 3 Impact of commissioner QIPP and demand management on activity growth; Impact of NEL CCG QIPPs have been modelled by proportioning each CCG's gross planned QIPP to providers based on the size of the contract value with each provider and scaled to include non-NEL CCGs based on revenue proportion from NEL and non-NEL CCGs; 4 Assumes 70% marginal cost on additional activity; 5 Assumed to be an additional 1% on top of 2013/14 current costs

SOURCE: Trust Financial Plans 13/14 to 15/16, McKinsey analyses | 39

In our methodology, commissioner gaps are addressed by QIPP plans to improve health and ensure a more cost effective pattern of health care commissioning. This then leaves the system gap as the aggregate provider impact. For WEL, the dominant portion of the

gap is in Barts Health. We have worked closely with the Barts Health Executive Team to understand the potential to close the gap.



Around two thirds of the gap can be closed through productivity improvements which would require Barts Health to achieve upper peer performance and then improving at a 2% per year basis. The additional 2% per year is on the basis that current top performers will continue to improve their performance over the next few years.

There are then further elements required to close the gap by 2018/19: payment at full tariff, avoiding significant penalties and fines (recognising that these first two will require further commissioner changes/qipp schemes to compensate), expansion of commercial and private patient income, reduction in fixed costs through estates consolidation, and subsidy to reflect the RPI growth in PFI unitary payments.

If the system was unable to close any portion of the provider gaps over the next 5 years, the cost of the accumulated debt from resulting deficits would amount to ~£1.4bn (this scale of figure is unlikely as providers will be able to deliver a percentage of the required CIPs).

The impact of acute reconfiguration in WEL is to support the productivity savings, enable fixed cost reductions and reduce the costs of compliance with clinical standards by consolidating teams and rotas. Some significant service reconfigurations are already built into the Barts Health plan (e.g. relocation of London Chest) but changes affecting core secondary care services have not been built into current plans.

The estimated value of reconfiguration is between ~£10-40m per annum with larger savings being achieved as more services are consolidated onto fewer sites. These are early numbers and a full financial analysis combined with a review of other criteria e.g. access impact, quality impact, deliverability etc., would need to be considered before options can be evaluated.

In addition, in order for these to be considered, substantial changes are required:

- Significant reduction in admissions and length of stay from integrated care
- Understanding of the flows following the redesign of King Georges to become an ambulatory, elective and community care centre
- Cost effective fit out of spare space on the 14th and 15th floors at Royal London (currently only a shell)

2.2. Key areas for focus to take the work forward

The major next steps requiring action relate to plan development and delivery:

Plan development

1. Incorporate feedback from Tri-Partite and work completed by this programme in second half of June into the submitted plans

2. Continue to drive development of the early reconfiguration options, modelling and engagement work, to develop consultation ready materials with clinical support for delivery by the end of the year

3. Work with NHS England to factor in real detail on specialised commissioning into forward planning.

4. Continue to develop the draft case for change to capture the compelling story of: poor population health outcomes in each CCG, variable primary care performance, weak clinical outcomes and losses nearing £1m per week at Barts

Plan delivery

5. Whilst there has been an increase in tempo, there could be stronger ownership of the current system gap (and the well recognised health challenges). There needs to be enhanced pace on redesigning the system, focusing on in hospital, out of hospital, and on acute reconfiguration to resolve this.

Changing this dynamic requires:

- Creation of a smaller TSCL leadership group with an external Chair[1] to drive delivery who can focus on the system gap independently of NHS organisations
- Significantly increased local delivery resourcing to ensure rigour and pace for each of: in hospital, out of hospital, and acute reconfiguration efforts
- Much more interventionist and robust leadership and active engagement from NHSE, TDA and Monitor
- Increased participation of NHSE as a major commissioner in the region
- Requirement to hit key milestones on a delivery plan on a monthly basis to avoid system failure, and metrics for Barts Health financial improvements and LOS reductions, and commissioner led reductions in ED attendances and non-elective admissions
- An NEL wide overarching Programme Board with an independent chair, involving the senior leadership of both WEL, BHR and C&H together with TDA, NHSE and Monitor, to bring together the programmes of work particularly around specialised commissioning, primary care co-commissioning, service reconfiguration and workforce
- Genuine consequences for both commissioners and providers from delivery failure – the tri-partite will need to take a view on appropriate consequences, and we imagine that this will be a combination of: progressive loss of local autonomy, loss of historic CCG surpluses, loss of CCG income in excess of target, requirements for closer CCG integration, and replacement of Trust leaders as part of a TSA process.

6. Whilst the work to date leaves a residual gap, this is due to our use of nationally approved assumptions of 4% annual productivity requirement versus what we and the local system are forecasting for annual performance improvements of ~2% in 17/18 and 18/19. We would suggest focusing on accelerating delivery and closing the gap to 16/17 rather than focusing on residual problems in 18/19.

2.3. Commitment of the local system to lead the change

Over the last week the WEL steering group has considered how the existing governance and priorities can be strengthened to enable the system to move at increased pace. On the

[1] An external Chair can take a truly independent view and could help to provide support and challenge. This can promote additional debate and alignment. In other health economies an independent Chair has been appointed by the local CCGs on behalf of the Transformation Board.

20th of June a series of recommendations were made to the group, many of which have been taken forward:

	Changes to accelerate delivery	Proposal Agreed
1 Gover-nance	Establish clearer **terms of reference** anchored on accountability to plan and deliver system sustainability	✓
	Hold a **fortnightly Board meeting** (involving CEOs) to drive delivery, with strong tri-partite presence and delegate leadership responsibility for specific workstreams to individuals	Propose monthly
	Set formal **quarterly reporting** to national level with tracking against agreed milestones	✓
	Establish **independent chair** (either from Local LA or externally) to provide added challenge to groups	For further discussion
	Hold bi-monthly joint NEL Board meeting to discuss regional linkages e.g. specialist service change and acute service change	✓
	Single dedicated **SRO leaders** for each workstream to oversee and drive progress and an **additional CEO level SRO** for the overall Transforming Services Together programme	For further discussion
	Participation from NHSE as a major commissioner in the region and active engagement from other tri-partite organisations	✓
2 Work-streams	Create **clear line of sight** for each workstream reporting to overall Board as an integrated delivery plan	✓
	Ensure as much focus on **out of hospital delivery** as in hospital delivery	✓
	Create **system wide enablers** as most supporting changes need to happen across organisations	✓
	Ensure **fortnightly reporting** into Board	Propose monthly
	Formalise **communications and engagement** to manage internal and external stakeholders	✓
3 Mile-stones	Set clear **milestones for success** anchored on delivery by September 2014, March 2015, September 2015 and March 2016 to coordinate major system changes	✓
	Set **impact and outcome targets** as well as progress milestones to support system sustainability	✓
4 Re-sourcing	Establish **programme management office**	✓
	Set up **programme monitoring team** to track progress and report delays to system Board	✓
	Significantly **scale up resources** for delivery in each of WEL and BHR to deliver – create full time and dedicated teams wherever possible whilst minimising fragmented roles on many workstreams	✓

Change needs to be driven hard. Primary care and integrated care initiatives need to start materially impacting admissions as well as attendances. Providers will need to achieve top 3 peer performance in terms of productivity (e.g. driving down length of stay), expand alternative sources of income and improve the use of assets (e.g. through seven day working) or release them. This requires fundamentally new ways of working and some form of reconfiguration to both enable the productivity improvements and to unlock stranded fixed costs.

This level of change can only be delivered collectively. The WEL and tripartite leaders will need to continue to discuss, test and challenge their underlying beliefs in order to create an aligned leadership coalition and in turn, to align wider stakeholders.

3. BHR Conclusions

3.1 Financial bridge – BHR

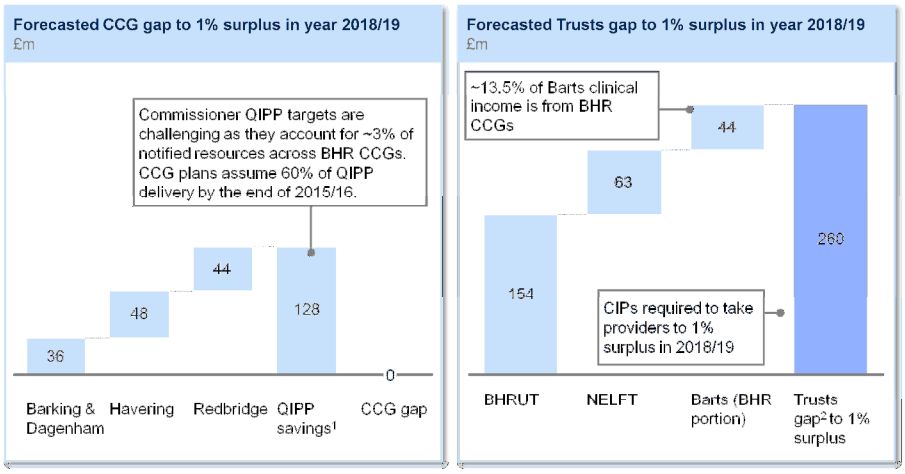
The BHR system gap by 2018/19 is estimated to be £128m for commissioners (before tariff efficiencies and QIPP) and £260m for providers. This includes all of BHRUT and NELFT and the 13.5% NHS revenue share of Barts Health for BHR patients. For BHR, we have worked closely with the Integrated Care Coalition which combines all NHS organisations together with Local Authorities and worked in depth with a leadership sub group.

Whilst the aggregate gap numbers in BHR are smaller than in WEL, the starting point for BHRUT is much more challenged as the ~£40m deficit in 13/14 was after a £16m PFI subsidy, and the deficit as a % of income is far larger than Barts. We have spent significant time aligning the local players on the causes of the deficit, scale of challenge and agreeing on what can be achieved in the period to 18/19.

Acute reconfiguration of the King Georges site is worth ~£25m annually by supporting productivity improvements, reducing the burden of compliance with clinical standards through fewer sites, and by enabling estates consolidation across BHR providers.

To fully close the gap will require further stretch productivity achievement beyond the levels agreed locally, as well as additional PFI support and closing the gap to CCG allocation (which is then "paid through" to providers as a subsidy).

CCGs need to close £128m financial challenge through QIPP programmes while BHR providers face a ~£260m gap



1 Represents net QIPP achieved through delivering investment of £7m, required to bridge projected funding gap and deliver surplus of 1% for Redbridge and 2% for Barking & Dagenham and Havering in 2018/19 2 Gap to 1% surplus position in 2018/19; Modelled assuming unconstrained demographic and non-demographic growth of 2013/14 recurrent income and cost deflation in line with Monitor guidance Includes impact of commissioner QIPP and demand management on activity growth;
2 Assumes 70% marginal cost on additional activity; and additional 1% on top of 2013/14 recurrent costs for 7 day working

SOURCE: Providers and CCGs financial submissions, McKinsey team analysis

What you would need to believe to close the ~£260m BHR provider gap in the next 5 years

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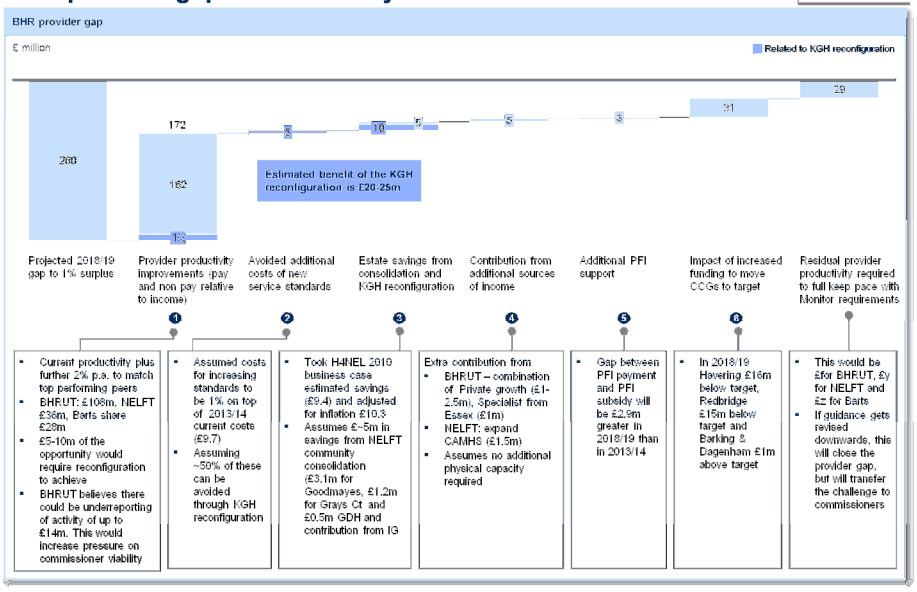

SOURCE: CCG submissions, provider plans, H4NEL business case; McKinsey analysis

3.2 Key areas for focus to take the work forward

The major next steps requiring action relate to plan development and delivery:

Plan development

1. BHR will need to improve submitted plans to incorporate feedback from Tri-Partite and work completed by this programme in second half of June. The main areas will be to improve rigour of CCG plans and re-think acute contracting savings; increase detail on provider plans; and expand BHRUT leadership capacity to deliver

2. There is a significant requirement for out of hospital improvements – improving primary care, urgent care, and integrated care, which will reduce ED attendances, non elective admissions, and reduce bed pressure at Queens. The rigour of plans and associated pace of delivery needs resourcing and acceleration.

Plan delivery

3. There has been real progress across the BHR system by shifting to a weekly Programme Steering Group chaired by Cheryl Coppell from Havering LA and with senior participation from CCGs, NELFT and BHRUT. Sustaining this much more intensive pace of oversight will be needed to drive delivery: in hospital; out of hospital; and on KGH reconfiguration. Barts Health will need to change this group or be part of an NEL wide governance process to ensure link up with plans at Whipps and Newham.

4. The Integrated Care Coalition is an effective large scale forum which will need to move from quarterly to monthly meetings to ensure wider oversight of the system change

5. In order to assure against delivery given the ~£1m per week system gap requires:

- Significantly increased local delivery resourcing to ensure rigour and pace for each of: in hospital, out of hospital, and acute reconfiguration efforts
- Much more interventionist and robust leadership and active engagement from NHSE, TDA and Monitor
- Increased participation of NHSE as a major commissioner in the region
- Requirement to hit key milestones on a delivery plan on a monthly basis to avoid system failure, and metrics for BHRUT financial improvements and LOS reductions, and commissioner led reductions in ED attendances and non-elective admissions
- NEL wide overarching Programme Board with an independent chair, involving the senior leadership of both WEL, BHR and C&H together with TDA, NHSE and Monitor, to bring together the programmes of work particularly around specialised commissioning, primary care co-commissioning, service reconfiguration and workforce

- Genuine consequences for both commissioners and providers from delivery failure – the tri-partite will need to take a view on appropriate consequences, and we imagine that this will be a combination of: progressive loss of local autonomy, loss of historic CCG surpluses, top-slicing of CCG to fund BHRUT losses, and replacement of Trust leaders as part of a TSA process.

6. Whilst the work to date leaves a residual gap, this is due to our use of nationally approved assumptions of 4% annual productivity requirement versus what we and the local system are forecasting for annual performance improvements of ~2% in 17/18 and 18/19. We would suggest focusing on accelerating delivery and closing the gap to 16/17 rather than focusing on residual problems in 18/19.

3.3. Commitment of the local system to lead the change

As in WEL, although the majority of the BHR system's leaders recognise the scale of the challenge, individuals and organisations hold beliefs that make it difficult to build a shared commitment to drive implementation.

The BHR and tripartite leaders will need to continue to discuss, test and challenge each other in order to create an aligned leadership coalition and in turn to challenge their own organisations. It is likely to require some form of Organisational Development intervention to galvanise closer working and build a single system view. For instance, one mitigating intervention could be a structural approach through the creation of cross directorships to help bridge organisations.

4. Risk assessment for delivery and recommended next steps

We discuss the main recommendations in the section above. We see the main risks as:

Main risks	**Recommended mitigations**
Lack of sufficiently rapid updates to strategies and implementation plans	Set deadlines for end July and end August for updates
Lack of sufficient detail on Specialised Commissioning	Require London Commissioning Strategy and planning guidance by mid-August
Lack of sufficient changes to WEL/BHR governance	Require new governance to be in place during July and to be signed off by tri-partite
Lack of effective NEL wide governance	Require new governance to be in place during

	July and to be signed off by tri-partite
Lack of sufficient tri-partite involvement to ensure system leadership	Define tri-partite involvement to reflect the most effective lessons from the national CHEs and over experience. Tri-partite to make clear proposals to build this into July update
Lack of sufficient out of hospital accountability, resourcing and delivery pace	Require approved resourcing with defined teams with full time FTEs and clear milestones
Lack of sufficient in hospital leadership and delivery pace	Set clear milestones, and metrics for success including monthly financial targets for break even for Barts Health and BHRUT, as triggers for intervention
Lack of credible consequences for failing to meet key milestones and achieve KPI improvement	Tri-partite to define WEL and BHR system failure in terms of: in hospital, out of hospital, and reconfiguration delivery, and detail consequences for CCGs, GPs and providers
Rapid deceleration of effort in July and August as the pressure from June deadline and McKinsey support disappears	Consider national or local funding of support during July on a tapering basis as milestone plans are developed and governance is changed

5. Lessons learned

The elements that worked well are:

- Acceleration of system progress (both on plans and in changing delivery resourcing and governance) which would not have otherwise occurred over this period
- Refocusing on major system strategic issues as local organisational focus is centred on near term delivery and operational concerns
- Much more interventionist and challenging approach (in second half of project) compared to more supportive approach in first half of project
- Anchoring our work in the separate WEL and BHR health economies was value adding. We created energy when we stopped trying to enrol City and Hackney (which requires system changes e.g. moving them to target now) and when we stopped trying to run our programme as an NEL wide system.

What could be improved upon:

- The WEL and BHR teams believed that the external consultancy was to "support", local leaders when in reality it was designed to "challenge" plans and pace.
- We did not engage enough with Alwen Williams as SRO in the first 5 weeks of the project to ensure tight alignment with NEL and national tri-partite priorities
- In practice, McKinsey had 4 clients through this project: WEL, BHR, NEL working Group, and the National Steering Group. In addition there were separate interactions with the SRO who was not able to regularly attend any of the four groups. For the most part, each group was made up of different individuals and we should have forced in a more regular local Steering Group to increase alignment.
- The "hands off" mode of the tri-partite in WEL and BHR made it harder to drive progress at pace, and feels different to the other patches McKinsey is supporting

Appendix: Size of the challenge by provider and commissioner

The tables below capture the size of the challenge.

Estimated size of the provider gap before provider productivity improvements

As providers serve more than one SPG area, the system gap will depend on the proportion of deficit from given providers that are allocated to the systems they serve. We have shown each provider gap below, however in the text we start to apportion gaps to given systems.

£m	Barts Health	Homerton	BHRUT	ELFT	NELFT
Estimated provider 5 year gap to 1% surplus before CIPs (2018/19)	324	54	160	56	63
Projected Total Income (2018/19)	1210	285	452	290	373
% of total income	27%	19%	35%	19%	17%

Estimated size of the commissioner gap before QIPP

Commissioners have non-recurrent expenditure in their plans and retained surpluses that are carried over each year. In showing the commissioner gap we have shown the total gap between allocation and projected spend before QIPP, assuming that all the planned non-recurrent spend materialises and that a 1% surplus needs to be generated beyond any funds carried forward.

£m	BHR	WEL
Commissioner Gap to 1% surplus after tariff efficiency but before QIPP (2018/19)[1]	128	115
Commissioner Total Budgets (2018/19)	985	1180
% of Total Budgets	13%	10%

1. Includes non-recurrent expenditure; Commissioners already have a 1% surplus – if they continue to carry this forward, the commissioner gap would only be £12m lower in WEL and £13m; BHR assume a 2% surplus for Barking and Dagenham rather than 1%.