



North West London



10 MAY 2010

North West London Process for 'Creating a Strategy'

Contents

1. Executive summary	3
2. Drivers for change	5
3. Aims and objectives of the programme.....	6
4. Timeline and work programme	7
5. Programme governance	11
6. Resource requirements for 2010/11	14
7. Benefits and risks	15
Appendix 1: Stock-take feedback.....	17
Appendix 2: Terms of reference	22
Appendix 3: Example of decision making for unscheduled care	31

1. Executive summary

Context

North West London (NWL) Sector is the largest and most complex sector in London, with the first Academic Health Sciences Centre (AHSC) and a high concentration of specialised hospitals within its geographical area. There are a number of compelling reasons why health care services in North West London need to change, including the need to improve residents' health, the need to improve the quality of primary care and the need make better use of resources to respond to challenging economic circumstances.

The sector therefore needs a robust strategy for North West London that improves healthcare, and health outcomes, for patients and is financially viable. This paper sets out the programme of work that would be needed to create a strategy, using new ways of working together. An integrated approach will ensure that the clinically-supported and locally understood strategy is affordable and deliverable.

Strategy development 2009/10

Delivering a successful, clinically-led strategy requires three components to be in place:

- A cadre of people occupying the clinical and managerial leadership roles in organisations within the sector to lead the development and delivery of the strategy.
- A well developed, clinically-led, robust, whole system plan to implement.
- Successful public engagement and, potentially, fuller consultation.

Although progress has been made in these areas in the last year, there is still a substantial amount of work to be completed in order to:

- Deliver an integrated strategic plan by end September 2010, in line with expected national guidance.
- Deliver enabling strategies for people & organisational development, finance, IM&T and estates by end December 2010.
- Be ready to go to consultation on options for change by January 2011, if required.

Strategy development programme 2010/11

A detailed timeline and work plan has been developed for the programme which includes:

- Programme initiation
- Clinical leadership development
- Stakeholder engagement
- Localising care pathways and clinical service models
- Developing enabling strategies for people & organisational development, estates, IM&T and finance
- Developing site specific options, agreeing evaluation criteria, pre-consultation business case, and potentially consultation, if required.

Clinical leadership

To be successful, change in the NHS needs to be led by clinicians. Clinicians will be at the heart of this programme, working through care pathway Clinical Working Groups (which build on the work of previous Clinical Working Groups) to localise care pathways and develop high quality service models for North West London that improve healthcare for patients. Enabling groups will ensure the strategy is affordable and implementable whilst delivery groups based around settings of care will consider delivery. Groups will include

people from across the sector including primary, secondary, tertiary, mental health, social services, public health, training and research.

Patient, public and staff engagement

A Patient and Public Reference Group will review proposals from a patient and public perspective. The People and Organisational Development Working Group will oversee staff engagement activities and mechanisms. There will be extensive engagement with local boroughs, staff, patient groups and the public to develop and improve services.

Programme management

Creating a strategy for North West London is an ambitious task, and clarity of leadership, roles and decision-making will be crucial. The programme will have senior clinical and managerial leadership to achieve this. Clear roles will ensure that groups communicate effectively and do not duplicate effort. Extremely robust management by the Programme Office and Steering Group will make sure that the groups communicate and work together effectively.

Resources

Sufficient resources would be required to ensure delivery of this ambitious programme of work to the required timescales. These resources include clinical leadership time, managerial support for the work, communications and engagement resources, a clinical leadership development programme, external support where skills are not available internally, independent impact assessments and resources to run a consultation, if required. Many of these resources would be funded through current or central budgets. Given the importance of this work and the fact that it will benefit everyone in North West London, it is proposed that all PCTs and providers who are represented on the Strategy Board are asked to provide funds for the programme.

Risks

A number of risks and mitigating strategies have been identified of which the greatest are:

- Inability to reach agreement from stakeholders on recommendations
- Failure to deliver the Operating Plan for 2010/11
- Potential policy changes

Robust risk management arrangements will be put in place to ensure risks are managed and mitigated.

Benefits

To ensure that the benefits of the programme of work are captured we are proposing new and innovative approaches to creating a strategy. This has already been started by holding a highly interactive 'gallery walk' with over 100 clinicians and leaders in the sector to scope the case for change. By operating in this new way, a coalition for change will be created that will mean change is clinically led, supported by staff and the public and focused on patient care and tax payer value for money. The strategic plan will deliver a range of outcomes including:

- Improved patient health outcomes
- Reduced health inequalities
- Improved access to primary care for patients
- Improved management of long term conditions
- Optimised use of resources
- Recurrent efficiency improvements

This coalition will be able to create and deliver plans that will improve the quality of healthcare services in NWL and assure delivery of efficiency improvements.

2. Drivers for change

North West London (NWL) Sector is the largest and most complex sector in London, with the first Academic Health Sciences Centre (AHSC) and a high concentration of specialised hospitals within its geographical area. The clinical quality of hospital services is generally good, and the Sector is currently in overall financial balance. However, there are a number of compelling reasons why health care services in North West London need to change, as shown in Figure 1.

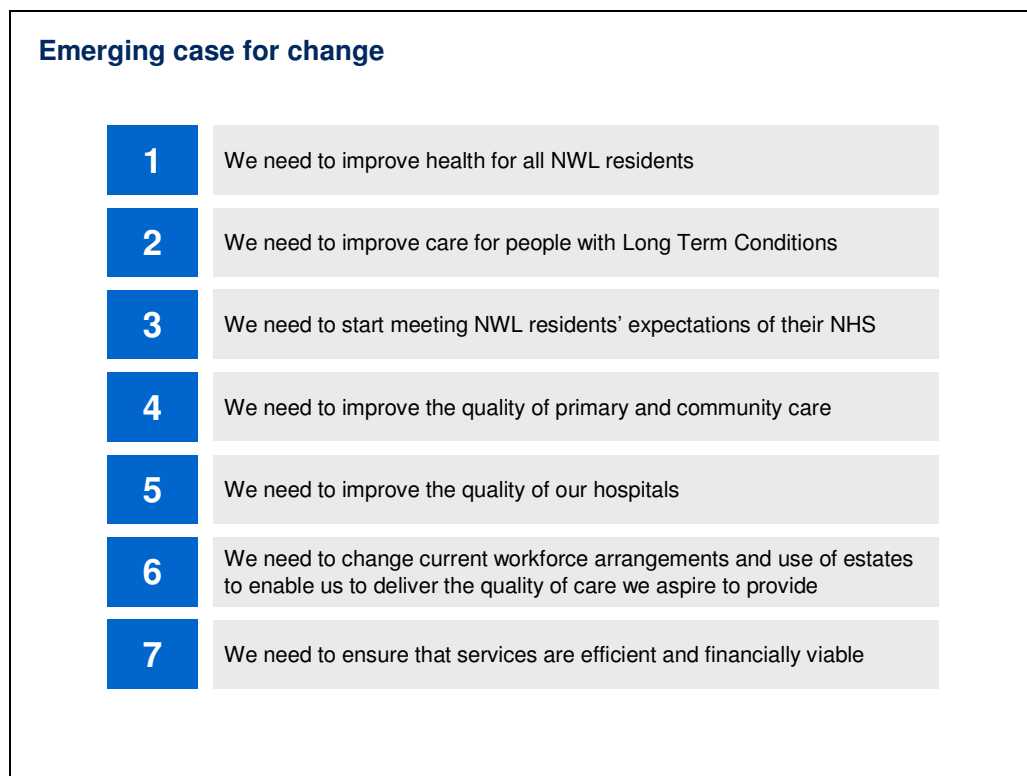


Figure 1: emerging case for change

In order to address these issues, the Sector needs to create a strategy to change the way services are delivered in North West London and improve healthcare, and health outcomes, for patients.

This business case sets out the programme of work to deliver this strategy, using new ways of working together.

3. Aims and objectives of the programme

The aim of the Creating a Strategy programme is to produce a robust, clinically-led, strategy for North West London that improves healthcare, and health outcomes, for patients and is financially viable. The objectives of the programme are shown in Figure 2.

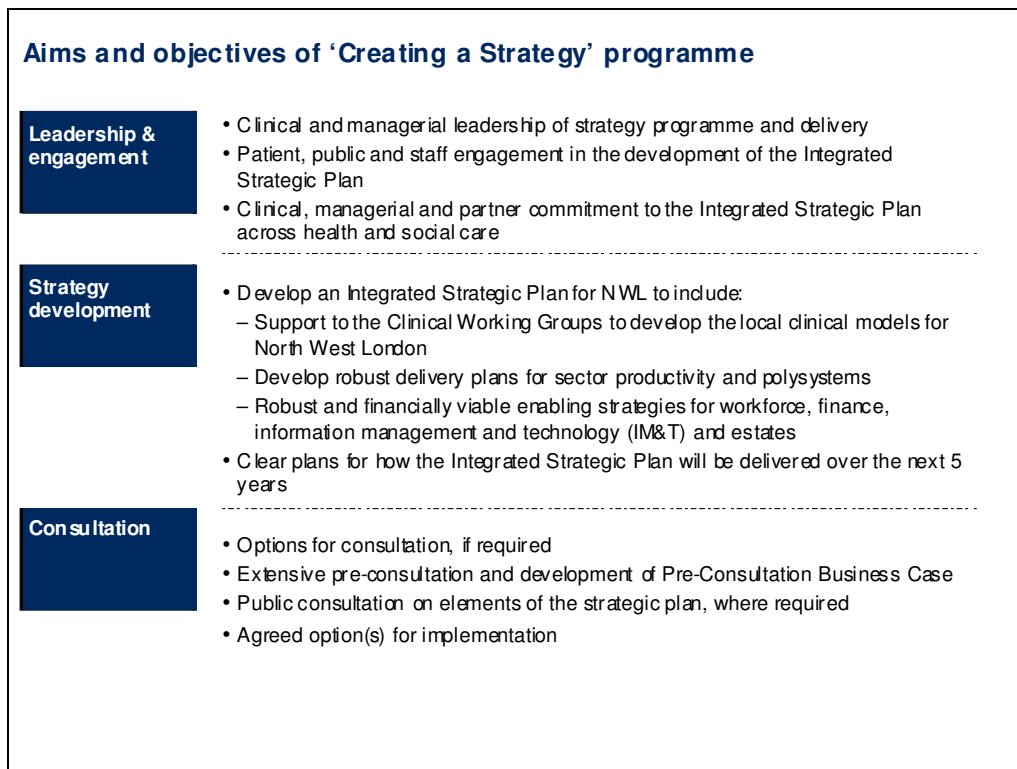


Figure 2: aims and objectives of the programme

The North West London 'Creating a Strategy' programme will be an ambitious strategy development programme because from the outset it will link strategic planning across all settings of care with the delivery of the Operating Plan and the productivity agenda. This integrated approach will ensure that the strategy is implementable and focussed on delivery.

4. Timeline and work programme

An extensive stock-take of work already completed by the sector has been undertaken, and an assessment made of the further work that is required to deliver clinical leadership and engagement, a robust strategy and successful engagement and, potentially, fuller consultation, if required. As shown in Figure 3, extensive work is required.

Elements for success of the programme going forwards			Low	High
Phase	Required elements for success	What we have already	Work required	
Start up and programme initiation	Case for change	<ul style="list-style-type: none"> Evidence base Stakeholder engagement 		
	<ul style="list-style-type: none"> Robust case for change evidence base (analytical & qualitative) Sector stakeholder agreement Compelling narrative 			
Leadership and engagement	Programme architecture	<ul style="list-style-type: none"> Some existing structures 		
	<ul style="list-style-type: none"> Robust governance structures Programme brief and resources 			
Strategy development	Leadership	<ul style="list-style-type: none"> New organisational structures Legacy organisations Wide range of perceptions of what is required and high variation in skills 		
	<ul style="list-style-type: none"> High performing governance bodies (e.g., Clinical Strategy Group) Clear narrative and story Sector wide leadership capabilities and capacity Clearly defined ways of working 			
Consultation	Stakeholder communications and engagement	<ul style="list-style-type: none"> Limited engagement 		
	<ul style="list-style-type: none"> Extensive engagement with public, staff and partner organisations 			
Consultation	Sector delivery plans (productivity and polysystems)	<ul style="list-style-type: none"> CSL support TBD 		
	<ul style="list-style-type: none"> Clearly defined opportunities for PCTs and providers Capability and capacity to deliver Clarity of polysystems plans and service assumptions with consistent and robust activity & finance modelling 			
Consultation	Care pathways and clinical service models	<ul style="list-style-type: none"> Early consensus around C4C and major issues High-level future models of care but a number of gaps Traditional approach to working Acute focus and little PC engagement Mix of leadership skills Estates review - Grant Thornton (acute only) KPMG activity / finance model Preliminary workforce strategy 		
	<ul style="list-style-type: none"> Overall lead, chairs & membership of each group Structure which focuses practically on complete clinical pathways Clear goals and "research questions" for each CWG, grounded in CWG C4C Robust support (analytics, facilitation) 			
Consultation	Enabling strategies	<ul style="list-style-type: none"> Estates Finance Workforce IM&T 		
	<ul style="list-style-type: none"> Pre-consultation business case development Activity forecast <ul style="list-style-type: none"> Overall activity, settings of care, site options, patient flows Capacity and finance implications <ul style="list-style-type: none"> Required capacity, estimated income and cost Robust criteria and decision making process in partnership 			
Consultation	Public consultation	<ul style="list-style-type: none"> KPMG activity / finance model 		
	<ul style="list-style-type: none"> Extensive and robust public consultation, if required Decision-making 			
		<ul style="list-style-type: none"> None 		

Figure 3: work required to deliver programme aims and objectives

A detailed work plan has been prepared, in order to meet the aims and objectives of the programme and:

- Deliver an integrated strategic plan by end September 2010, in line with expected national guidance
- Deliver the enabling strategies for workforce, finance, IM&T and estates by end December 2010
- Be ready to go to consultation on options for change by January 2011, if required

A proposed timeline is shown in Figure 4.

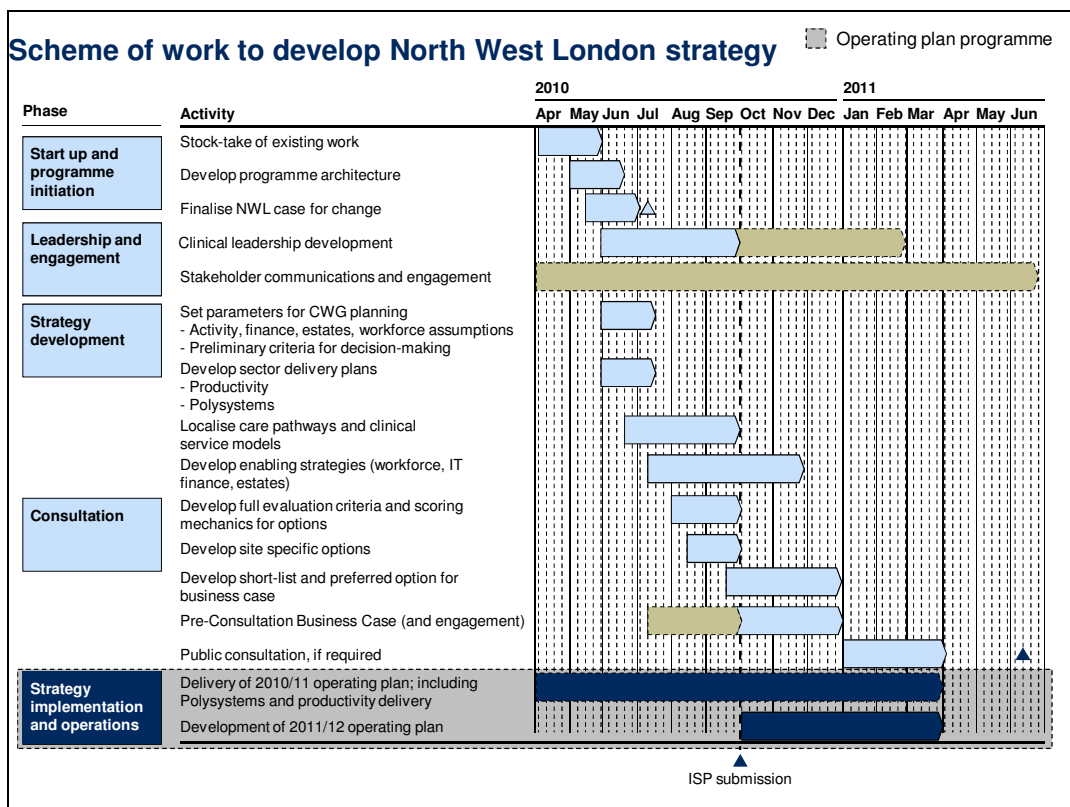


Figure 4: proposed workplan and timeline

Startup and programme initiation

This phase of work ensures that the programme has clear aims and objectives, is based on a clear case for change and has robust governance structures:

- **Stock-take of existing work:** to develop a Sector understanding of where it is with the strategy and case for change, and to agree next steps. The detailed report is shown in Appendix 1.
- **Develop programme architecture:** putting in place all the required governance arrangements and resources to develop the strategic plan and developing a workplan and timeline.
- **Finalise North West London case for change:** to establish the key areas to be addressed by the strategy considering factors such as quality, productivity, patient experience, access, workforce and health outcomes.

Leadership and engagement

Strong clinical leadership and extensive engagement is key to delivering transformational change. Work in this phase is a key component of the programme:

- **Clinical leadership development:** work completed as part of the stock-take has shown a number of areas where the sector needs to develop the way it works together. This includes being better at making decisions as a clinical leadership group and developing strategy from a sector rather than organisational perspective. A programme of clinical leadership development will therefore be commissioned, in collaboration with Leading for Health, to ensure that the programme aims are met, as shown in Figure 5.

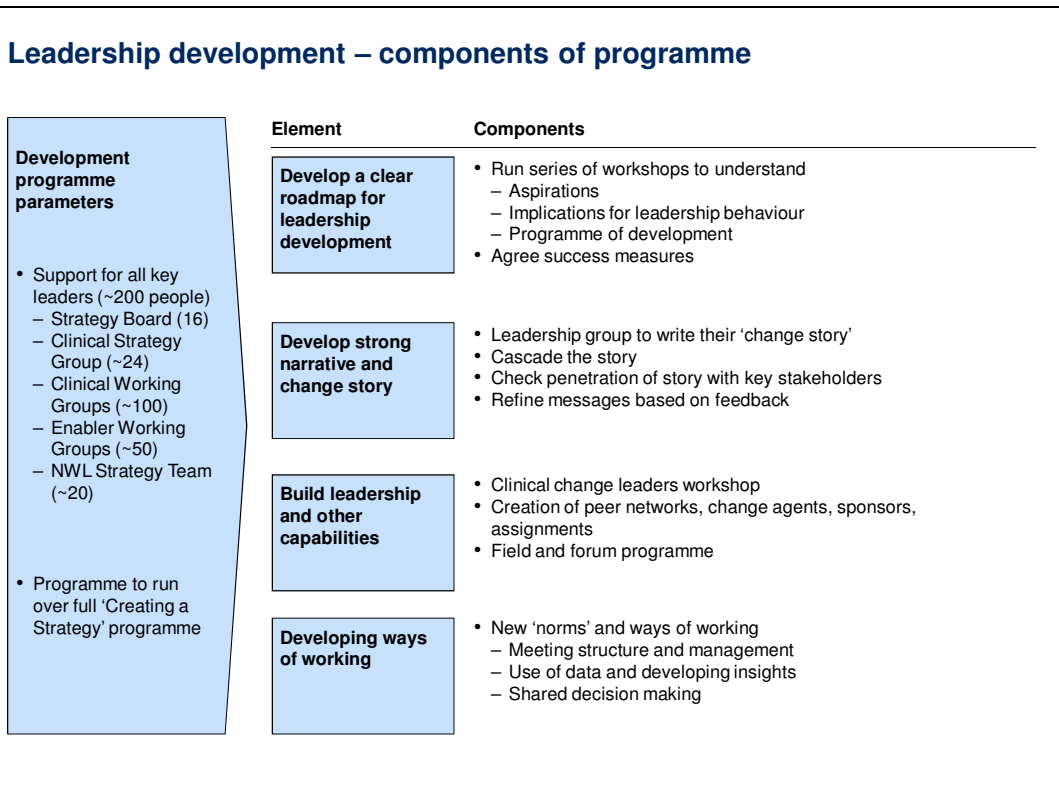


Figure 5: components of clinical leadership development programme

- **Stakeholder communications and engagement:** in order to develop a robust and deliverable strategy, it is very important to engage with a wide range of stakeholders including the wider clinical body, other staff groups, patients and the public, local authorities, the media, MPs, etc. A consultation would require a more intense communication and engagement phase. This communications and engagement will be co-ordinated through the Communications and Engagement Group with support from the People and Organisational Development Group.

Strategy development

This phase of work will focus on the development of the strategy, including enabling strategies for people & organisational development, finance, estates and IM&T. It will be led and driven by clinicians from across all care settings:

- **Set parameters for Clinical Working Groups:** around, IM&T, workforce, estates, finance and productivity to make sure proposals are deliverable and affordable.
- **Develop sector delivery plans (productivity and polysystems):** to make sure that the benefits of acute productivity and polysystems delivery are understood and deliverable.
- **Localise care pathways and clinical service models:** localising care pathways and agreeing a service model for the Sector. This work will be led clinicians through Clinical Working Groups focussing on complete clinical pathways (unscheduled care, planned care, specialist, maternity & newborn, children & young people, mental health, long term conditions). The Clinical Working Groups will be given clear goals and research questions, focussed on resolving the issues in the case for change. The groups will be supported by robust analysis and facilitation.
- **Enabling strategies:** people & organisational development, finance, IM&T and estates are all crucial enablers of delivery of the strategy. As clinical models emerge, separate enabling strategies will be developed for each of the areas.

Engagement and consultation (if required)

This final phase of work, if required, will be focussed on developing site-specific options for change, robust evaluation criteria, a pre-consultation business case and undertaking extensive engagement and, potentially, public consultation, if required.

- ***Site-specific options for change:*** the Clinical Strategy Group will develop options for change and public consultation (if required): This will include a consideration of potential settings of care, site options, patient flows, capacity and finance implications. The proposals will be developed in partnership with staff and the public.
- ***Evaluation criteria:*** initial evaluation criteria will be developed whilst the clinical models are being developed but detailed analysis of the site specific options will be required to allow for evaluation of the different options. Criteria would be developed with patients, the public and staff. For example, criteria might include:
 - Patient outcomes– which proposals deliver the best services and health outcomes for our patients?
 - Affordability and sustainability – are the proposals financially sound and sustainable?
 - Deliverability – can the proposals be delivered using current estates, workforce and IT capacity? How could they best be introduced?
 - Accessibility – which proposals are most accessible for residents?
 - Patient satisfaction– which proposals improve the patient experience and environment?
- ***Pre-consultation business case (and engagement):*** a robust pre-consultation business case will be developed in partnership with key stakeholders and will be subject to external clinical review before, potentially, consultation. Engagement activities will take place throughout the programme and the Joint Overview and Scrutiny Committee (JOSC) will have statutory oversight.
- ***Engagement and consultation (if required):*** formal consultation would be likely to be for at least 13 weeks and would be the opportunity for Primary Care Trusts to formally consult the public through a consultation document, website, media and a series of engagement events including with traditionally hard-to-reach groups.

The tasks, timeline and key deliverables will be monitored by the Programme Management Office with significant variations reviewed by the Strategy Board and escalated to the Joint Committee of Primary Care Trusts, if required.

Key dependencies

There are a number of key dependencies to ensure the programme is delivered:

- Delivery by Primary Care Trusts and provider organisations of the 2010/11 operating plan, especially demand management through polysystems and provider productivity savings.
- Development of the Sector role and the successful delivery of a new governance structure and the required resources for the programme.
- Set up of the Overview and Scrutiny Committees following the local elections – these will need to be in place by late June 2010 to allow public scrutiny of the case for change prior to publication.

These dependencies will be monitored through the North West London Sector Transformation Programme management arrangements.

5. Programme governance

To be successful, change in the NHS needs to be led by clinicians. Clinicians will be at the heart of the programme, working through care pathway Clinical Working Groups (which build on the work of previous Clinical Working Groups) to localise care pathways and develop high quality service models for North West London that improve healthcare for patients. The Clinical Working Groups will be set parameters around finance, estates, IM&T and workforce by a number of enabling Groups who will also work with the Clinical Working Groups to make sure that proposals are affordable and implementable. Delivery Groups based around settings of care will examine proposals to make sure they are deliverable and a Public and Patient reference group will scrutinise proposals from a patient perspective. All the groups will include people from across the sector including primary, secondary, tertiary, mental health, social services, public health, training and research. This structure is shown in Figure 6.



Figure 6: governance structure

Clinical leadership, roles and decision-making

Creating a strategy for North West London is an ambitious task, and clarity of clinical leadership, roles and decision-making between the groups will be crucial. These groups need senior and clinical leadership and will therefore be led by both clinicians and senior responsible officers (usually Chief Executives from within the sector). A robust process for appointing chairs and members of the Clinical Working Groups, building on previous Clinical Working Groups, has been developed, as shown in Figure 7.

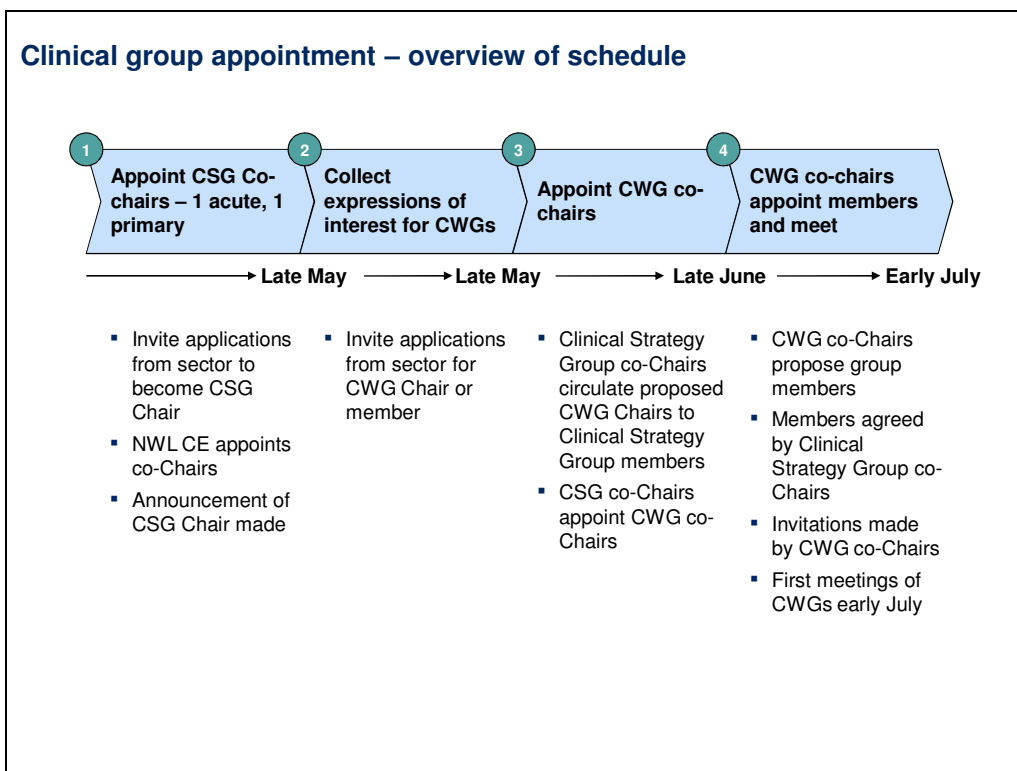


Figure 7: proposed appointment process for clinical groups

Clear roles will ensure that groups communicate effectively and do not duplicate effort. The roles of the groups are shown in Figure 8 and terms of reference for the main groups are shown in Appendix 2.



Figure 8: core responsibilities of programme groups

The groups will work together to first develop the strategy and then develop site specific options for consultation, if required. Extremely robust management by the Programme

Management Office and the Programme Steering Group will make sure that the groups communicate and work together effectively. An illustration of how this will work is shown in Figure 9 and an example of how that would be applied to unscheduled care is shown in Appendix 3.

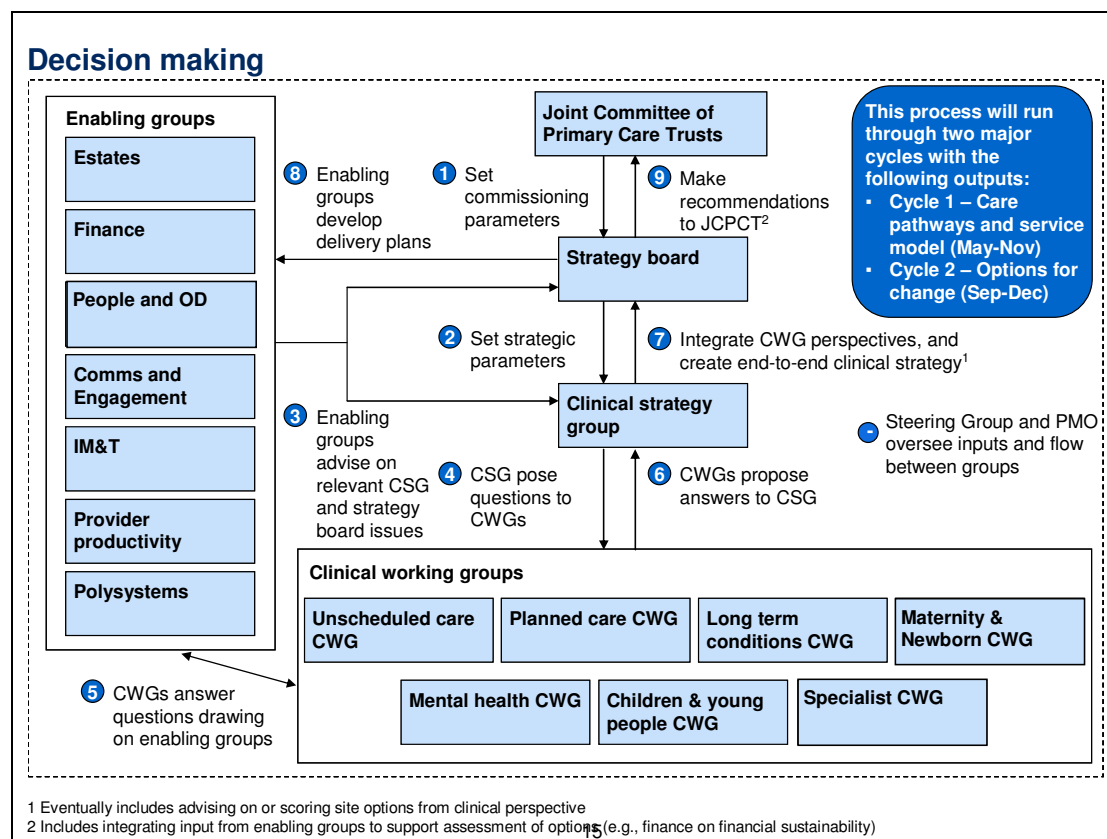


Figure 9: decision making cycle

6. Resource requirements for 2010/11

Sufficient resources would be required to ensure delivery of this ambitious programme of work, if a decision were made to proceed, as follows:

- Support for Clinical Working Groups, to ensure they can fully focus on leading the programme and put clinical expertise at the core of the decision-making process.
- Clinical engagement requiring the reimbursement of clinical sessions to make sure clinicians are able to be fully involved.
- Support for clinical leaders and their working groups, from Chief Executives, Chairs, Medical Directors and PEC Chairs from across the Sector, in their attendance and leadership of groups, their responsibilities as senior responsible officers for work streams and their leadership in engaging their staff, local public and key partners in the work.
- Providing information and effective ways of comprehensively engaging with and consulting the public, patients, staff and key partners, including relevant Overview and Scrutiny Committees, about the programme. This would be resourced from current communications resources within the sector.
- Leadership development programme, including for clinical leaders.
- External support if skills are not currently available in the Sector, particularly for example in data analysis.
- Independent impact assessments of any proposals.

If all the work in the programme were required, the total non-recurrent funding for 2010/11 totals £4m. This could potentially be split equally between providers and PCTs on the Strategy Board, based on revenue (providers) and population (PCTs).

7. Benefits and risks

Benefits

To ensure that the benefits of the programme of work are captured, new and innovative approaches to creating a strategy are proposed. By operating in this new way, the sector will create a coalition for change that will mean change is clinically led, supported by staff and the public and focused on patient care and tax payer value for money. This coalition will be able to create and deliver plans that will improve healthcare services in NWL and assure delivery of efficiency improvements. These benefits are shown in more detail in Figure 10.

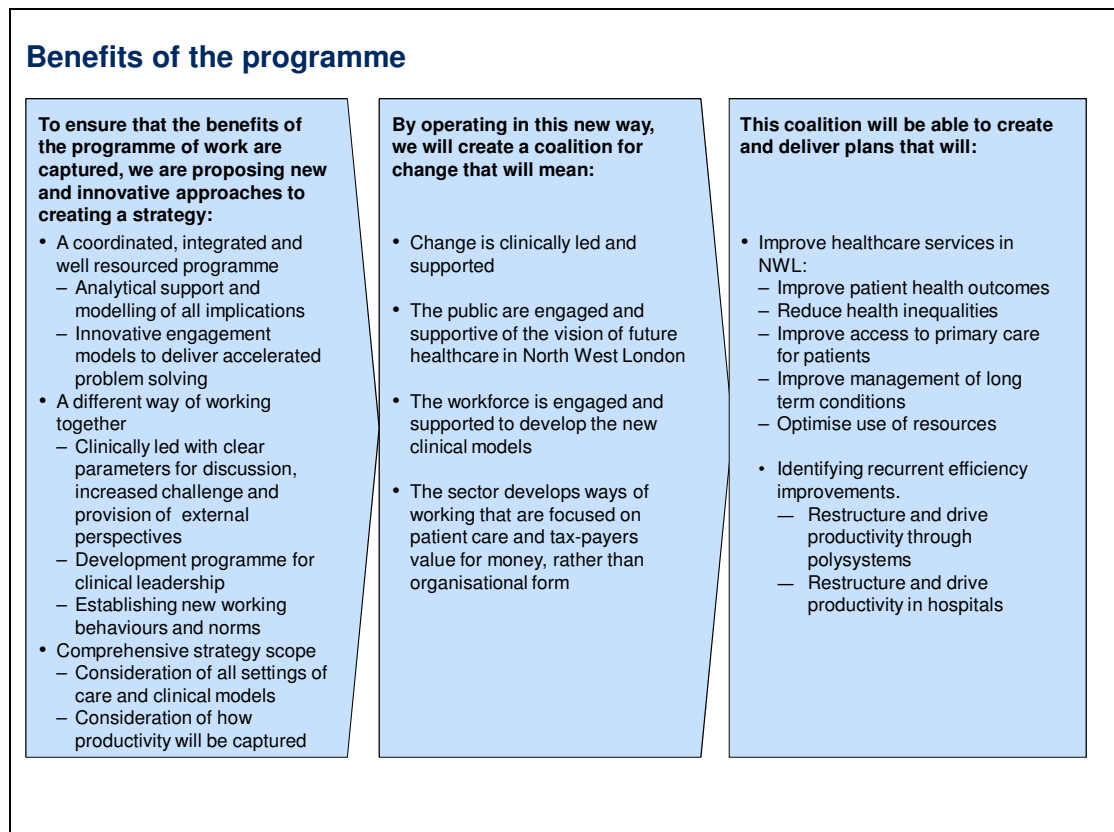


Figure 10: benefits of the programme

This programme of work, supported by a robust governance structure, would ensure that these benefits are realised.

Key success factors

The key success factors for the programme, which this paper addresses, are:

- agreeing a compelling case for change through interviews, a review of evidence and sector-wide workshops
- developing of clinical pathways across the whole health and social care system, led by the Clinical Working Groups and underpinned by robust evidence and analytical modelling
- gaining comprehensive clinical engagement and developing a clinically-led strategy, through sector wide engagement and having a clinically-led strategy development and delivery process
- developing cohesive working across the sector to develop the strategic plan through an intensive organisational development programme and robust ways of working
- gaining agreement on the potential configuration of services through a clinically-led development of options for change and a robust decision-making process

- integrating the planning and productivity agendas, led by the Clinical Working Groups and the provider and polysystems Productivity and Delivery groups
- delivering a robust implementation plan for polysystems led by clinicians and supported by robust evidence and analysis, underpinned by a delivery monitoring system.

Risks

A number of risks and mitigating strategies have been identified, many of which are the same as those identified in the Operating Plan 2010/11, as shown in Table 3.

Risk	Likelihood	Impact	Total	Mitigation	Target risk score
Unable to reach agreement from stakeholders on recommendations	4	5	20	<ul style="list-style-type: none"> ○ Stakeholder engagement and inclusiveness of decision making process 	12
Operating Plan for 2010/11 is not delivered	4	5	20	<ul style="list-style-type: none"> ○ Robust programme management processes 	12
Outcome of London-wide or other sector reviews impact on options available to North West London	4	4	16	<ul style="list-style-type: none"> ○ Undertake review of proposals and influence decision-making. ○ Close working with other sectors 	8
Clinical, management and staff engagement with the process is insufficient to develop ownership – the 'bandwidth' is not available given other priorities.	4	4	16	<ul style="list-style-type: none"> ○ Tactical engagement with critical stakeholders ○ Programming engagement with sufficient notice 	8
Potential policy change	5	3	15	<ul style="list-style-type: none"> ○ Flexible planning 	12
Programme scope is too ambitious and not able to deliver to timescales	3	4	12	<ul style="list-style-type: none"> ○ Programme management processes 	4
PCTs do not contribute sufficient funding to enable the work to be completed	3	4	12	<ul style="list-style-type: none"> ○ Robustness of business case and progress in deliverables 	4
Sector development as a result of strengthening commissioning programme significantly slows progress	3	4	12	<ul style="list-style-type: none"> ○ Robust programme management processes 	8

Table 3: risks and mitigating strategies

Robust risk management arrangements will be put in place to ensure risks are managed and mitigated by the Strategy Board and escalated to the Joint Committee of Primary Care Trusts, if required.

Appendix 1: Stock-take feedback

WORKING DRAFT
Last Modified 22/04/2010 20:12:11 GMT Standard Time
Printed

NWL stock-take

Discussion Document
23 April 2010

CONFIDENTIAL AND PROPRIETARY
Any use of this material without specific permission of McKinsey & Company is strictly prohibited

McKinsey & Company

Overview of stock-take analysis for NWL strategy development

More detail on following pages

Status of strategy development programme

CWG progress	<ul style="list-style-type: none"> ▪ Groups with traditional approach (e.g., medicine, surgery) ▪ Acute focus and little integrated care engagement ▪ Early consensus around specific Clinical Working Groups' Case for Change and major issues ▪ High-level future models of care but a number of gaps ▪ Mix of leadership skills
Acute modelling	<ul style="list-style-type: none"> ▪ KPMG activity / finance model that allows: <ul style="list-style-type: none"> – Demographic analysis – Forecasting analysis – Setting of care analysis
Polysystem planning	<ul style="list-style-type: none"> ▪ Polysystem plans at varying degrees of development ▪ Lack of consistent and coherent plans ▪ Lack of robust modelling
Estates	<ul style="list-style-type: none"> ▪ Grant Thornton estates review (Acute only)

Working Draft - Last Modified 22/04/2010 20:12:11 GMT Standard Time

Preliminary stocktake of CWG outputs

Progress to date

- Early consensus around what the case for change looks like ✓

- High-level future models of care articulated ✓

- A good sense of where the major issues lie (e.g., patient transfers, doctor training) ✓

Gaps

- Clearly articulated case for change supported by robust rationale, including:
 - Quality data
 - Acknowledgement of the need to improve productivity
 - Workforce trends (e.g., consultant-led vs. consultant-delivered services)
 - Sub-specialisation of current services
 - Changing patterns in disease (e.g., shift to an increased prevalence of long term conditions)
- Case for change that is sufficiently broad i.e., : out-of-hospital services, i.e., primary, community care and poly-systems ✗

- Clear rationale and building blocks for future models of care including
 - Understanding of the minimum clinical and economic scale driving model choice
 - Workforce implications
 - Research into the evidence behind different models of care, nationally and internationally
 - Understanding of the interfaces between each CWG and implications for out-of-hospital care

- Prioritisation of issues and identification of potential solutions ✗

SOURCE: Team analysis

McKinsey & Company | 7

Working Draft - Last Modified: 20/04/2010 20:13:11 - Printed

CWG progress to-date has faced some challenges

Key success factors for CWGs

- Have the right overall clinical leader accountable across pathways
- Have the right chair and facilitator accountable for each pathway
- Have the right membership of each pathway group
- Set clear goals for each pathway redesign group
- Set clear milestones for each pathway
- Run the meetings right
- Do the right analysis to make fact-based decisions
- Support the process with the right resources
- Track impact on outcomes
- Clinical working group structure

Observed challenges in NWL

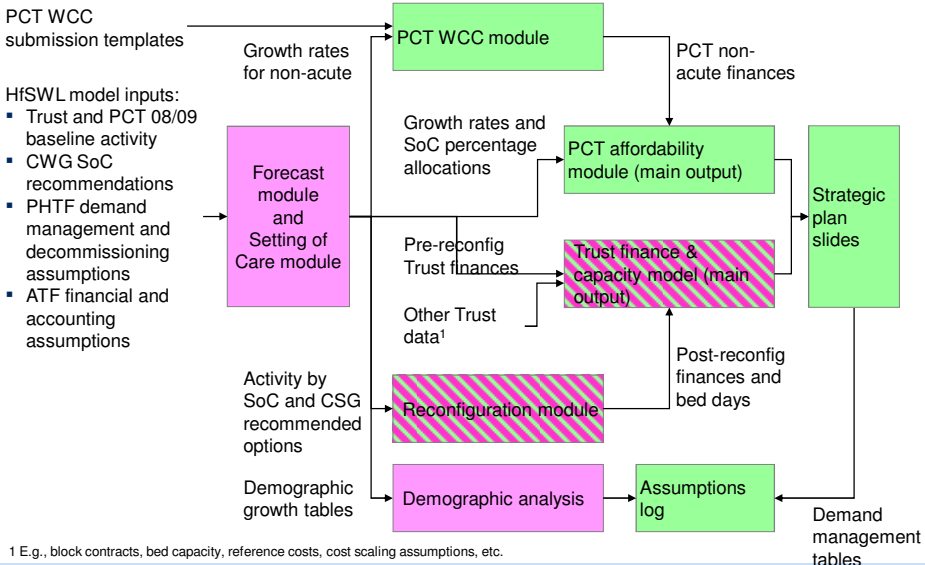
-
-
- Primary care under represented
- CWG outputs do not address whole system needs e.g., OOH, need to drive quality and improve productivity (see following pages)
- Key milestones undefined
-
- Evidence base unclear both for C4C and future models of care (see following pages)
- Analytical support has been insufficient
- Success metrics undefined
- Need to reorganise to unscheduled, planned, specialist networks, child care, maternity, mental health, LTC

Source: Team analysis

McKinsey & Company | 3

Working Draft - Last Modified: 20/04/2010 20:13:11 - Printed

HfSWL model layout compared to KPMG NWL model



SOURCE: HfSWL, team analysis

McKinsey & Company | 4

Acute reconfiguration – Model requirements

Activity forecast	Description	Illustrations
1 Project overall activity	Project activity based on the current activity level, demographic and non-demographic drivers in 10 years	Medicine 1.2%, 2.7%, 3.9% Surgery 1.2%, 0.5%, 1.7%
2 Allocate to SoC	Estimate activity by settings of care (e.g. mid-wife led unit, home, obstetrics unit etc.)	
3 Define site option	Define clinically optimal options for service provision at site level	
4 Model patient flow	For each option, calculate the patient flow for each service based on travel time and available capacity	
Capacity and finance implication		
5 Calculate required capacity	For each option, calculate required number of beds and space to support the future activity by site	
6 Estimate income	For each option, estimate the income level based on activity and tariff, as well as Trust's assumptions on nonclinical income	
7 Estimate cost	For each option, estimate how cost will change based on changes in activity, income and capacity	

SOURCE: Team analysis

McKinsey & Company | 5

Acute reconfiguration - High-level analysis of existing KPMG acute model

	Included	Needs some work	Not included
Project overall activity	<ul style="list-style-type: none"> Trust activity data HRG level – mapped to specialty Assumptions (growth, tariff changes, inflation and MFF) 	<ul style="list-style-type: none"> How confident are we trusts are able to show £ at HRG level? 	<ul style="list-style-type: none"> Not site specific
Allocate to setting of care		<ul style="list-style-type: none"> Allocates acute activity to different setting of care 	<ul style="list-style-type: none"> Detailed breakdown of SOC (e.g. PIU, MWLU, Elective Centre)
Define site option			<ul style="list-style-type: none"> Not done – model not at site level
Model patient flow	<ul style="list-style-type: none"> Patient flows manually input into model Closed borders assumed 		<ul style="list-style-type: none"> Not sure how they derived flow data Need to open the borders
Calculate required capacity	<ul style="list-style-type: none"> Activity levels in the model – not clear if capacity is calculated (i.e. (activity * LOS) / utilisation = Beds) 	<ul style="list-style-type: none"> LOS data requested from trusts – unclear whether they supplied it 	<ul style="list-style-type: none"> Capacity and LOS data doesn't factor in configuration decisions
Estimate income	<ul style="list-style-type: none"> Have activity, tariff and assumptions so can do this 		
Estimate cost	<ul style="list-style-type: none"> Costs split by fixed, variable and semi fixed 		<ul style="list-style-type: none"> No CAPEX data No Estates data No cost scaling

SOURCE: Team analysis

McKinsey & Company | 11

Elements for success of a sector strategy development programme



Case for Change

- Robust case for change evidence base (analytical & qualitative)
- Sector stakeholder agreement
- Compelling narrative

OD and leadership programme

- High performing governance bodies (e.g., Strategy Board)
- Clear narrative and story
- Sector wide leadership capabilities and capacity
- Clearly defined ways of working

CWG support and development

- Overall lead, chairs & membership of each group
- Structure which focuses practically on end-to-end clinical pathways
- Clear goals and "research questions" for each CWG, grounded in CWG C4C
- Robust support (analytics, facilitation)

Productivity requirement

- Clearly defined opportunities for PCTs and providers
- Capability and capacity to deliver

Polysystems strategy

- Clarity of plans and service assumptions with consistent and robust activity & finance modelling
- Assurance on the ability to deliver on plans
- Requirement to engage clinicians

Enabling strategies

- Estates
- Finance
- Workforce
- IM&T

Pre-consultation business case development

- Activity forecast
 - Overall activity, settings of care, site options, patient flows
- Capacity and finance implications
 - Required capacity, estimated income and cost

SOURCE: Team analysis

McKinsey & Company | 12

Overview of the readiness for success of the programme

● Low
● High

Phase	Required elements for success	What you have	Current "gap"	
Start up and programme development	OD and leadership programme	<ul style="list-style-type: none"> New organisational structures Legacy organisations Wide range of perceptions of what is required and high variation in skills 		
	<ul style="list-style-type: none"> High performing governance bodies (e.g., Strategy Board) Clear narrative and story Sector wide leadership capabilities and capacity Clearly defined ways of working 			
	Case for Change			<ul style="list-style-type: none"> Evidence base Stakeholder engagement
	<ul style="list-style-type: none"> Robust case for change evidence base (analytical & qualitative) Sector stakeholder agreement Compelling narrative 			
Strategy development	CWG support and development	<ul style="list-style-type: none"> Early consensus around CWGC4C and major issues High-level future models of care but a number of gaps Groups with traditional approach Acute focus and little IC engagement Mix of leadership skills 		
	<ul style="list-style-type: none"> Overall lead, chairs & membership of each group Structure which focuses practically on complete clinical pathways Clear goals and "research questions" for each CWG, grounded in CWG C4C Robust support (analytics, facilitation) 			
	Productivity strategy			<ul style="list-style-type: none"> None
	<ul style="list-style-type: none"> Clearly defined opportunities for PCTs and providers Capability and capacity to deliver 			
	Polysystems strategy			<ul style="list-style-type: none"> CSL support TBD
	<ul style="list-style-type: none"> Clarity of plans and service assumptions with consistent and robust activity & finance modelling Assurance on the ability to deliver on plans 			
Site option development	Enabling strategies	<ul style="list-style-type: none"> Estates review - Grant Thornton (Acute only) KPMG activity / finance model Workforce transformation strategy 		
	<ul style="list-style-type: none"> Estates Finance Workforce IM&T 			
	Pre-consultation business case development			<ul style="list-style-type: none"> KPMG activity / finance model
	<ul style="list-style-type: none"> Activity forecast <ul style="list-style-type: none"> Overall activity, settings of care, site options, patient flows Capacity and finance implications <ul style="list-style-type: none"> Required capacity, estimated income and cost 			

Working Draft - Last Modified: 25/04/2010 20:13:11 Printed

SOURCE: Team analysis

McKinsey & Company | 13

Appendix 2: Terms of reference

Shown are the terms of reference for the Strategy Board, Clinical Strategy Group and Clinical Working Groups. Terms of Reference for the other groups have been developed.

Strategy Board Terms of Reference

Title:	Strategy Board
Date approved and approving body:	JCPCT – 7 April 2010
Purpose:	<p>Role of Board</p> <ul style="list-style-type: none"> • Overall strategic leadership, direction and quality assurance of programme • Review reports from Clinical Strategy Group and Public and Patient Reference Group and make recommendations to the JCPCT <p>Programme deliverables</p> <ul style="list-style-type: none"> • Stock-take on where the Sector is with strategic planning including programme plan • Case for change • Decision making criteria, development of options and financial modelling • Pre-consultation and stakeholder engagement • Pre-consultation business case and consultation document based on final shortlist of options • Public consultation on options for service change, if required
Membership:	<ul style="list-style-type: none"> • NWL Chief Executive • NWL Primary Care Trust Chief Executives • NWL Trust Chief Executives inc. London Ambulance Service, Mental Health Trusts, Community Trusts (when formed) • Trust Chief Executives of the Royal Marsden NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust • Chairs of Patient and Public Reference Group, Clinical Strategy Group and enablers sub-groups • NWL Director of Strategy • Representative of NHS London
In attendance	<ul style="list-style-type: none"> • Strategy Lead • Others, at the request of the Strategy Board (as required for specific items)
Chair:	Sector Chief Executive

Deputy Chair:	Director of Strategy
Tenure:	N/A
Secretary:	Strategy Lead
Quorum:	<p>Matters requiring agreement (for example, when agreeing recommendations to the JCPCT) by the Strategy Board will require a majority agreement by 75% of those organisations present at the Strategy Board meeting when the agreement is reached.</p> <p>Each member has one vote.</p>
Frequency of Meetings:	Monthly with the possibility of fortnightly meetings during some phases of the programme (to be agreed by the Strategy Board if required)
Duties – operational/strategic	<ul style="list-style-type: none"> • Undertake stock-take on where the Sector is with strategic planning and produce programme plan. • Develop and agree Case for Change • Develop decision making criteria, options and financial modelling • Deliver pre-consultation process to include delivery of stakeholder engagement plan • Develop full business case and consultation document based on final shortlist of options • Deliver engagement and, potentially, consultation on options for service change, if required
Duties – decision making and advisory:	<ul style="list-style-type: none"> • Advise the JCPCT on the appropriate action to be taken at each stage in the programme of work • To review various stages of the work programme and make recommendations which allow progress to the next stage. • Advise the JCPCT on the appropriate level of engagement/consultation required for the programmes of work and lead on any formal consultation processes on behalf of the JCPCT • Consider proposals from the Clinical Strategy Group and Public and Patient Reference Group and make decisions/recommendations in response to these • Ensure appropriate representation from the NWL sector on sub-groups. • Monitor programme risks and report any significant risks to the JCPCT.
Duties – monitoring:	<ul style="list-style-type: none"> • Monitor the annual programme budget and staff resources
Subgroups:	<p>The Strategy Board is supported in delivering its objectives by the:</p> <ul style="list-style-type: none"> • The Clinical Strategy Group, which ensures recommendations

	<p>from Clinical Working Groups are sufficiently ambitious, feasible and clinically sound, reviews options and assess appraisal criteria from a clinical perspective and make recommendations to Strategy Board.</p> <ul style="list-style-type: none"> • The Public and Patient Reference Group which provides counsel to the Strategy Board on Clinical Strategy Group recommendations and issues arising from proposed options and provides advice of potential opportunities/issues not identified by Clinical Working Groups.
Accountability:	Accountable to the NWL JCPCT
Reporting responsibilities:	The group will provide regular reports and escalate issues for resolution to the JCPCT

Clinical Strategy Group

Terms of Reference

Title:	NWL Clinical Strategy Group
Date approved and approving body:	JCPCT - 5 May 2010
Purpose:	<p>The Clinical Strategy Group will provide overarching clinical leadership and engagement to the sector. It will build on the work of the current Clinical Reference Group which has previously established a good basis for clinical engagement across primary and secondary care. A greater emphasis on working across the different sectors will be adopted in the CSG, addressing the need for a more joined-up whole systems approach to transformational change. The CSG will be at the centre of the strategy development and decision-making process and will be the key conduit between the Clinical Working Groups and Strategy Board.</p> <p>It will play a pivotal role in overseeing the development of a clinically robust and sustainable sector strategy, consolidating the recommendations of the Clinical Working Groups to form a coherent set of service delivery options for public consultation, if required.</p>
Role & Responsibilities	<p>The CSG is to be responsible for driving, developing and overseeing the implementation of the following key areas of the sector strategy:</p> <p>Pathway redesign and clinical model development</p> <ul style="list-style-type: none"> • Set clinical parameters and research questions for the Clinical Working Groups • Ensure that CWGs fulfil their roles effectively, monitoring progress against agreed work programme and terms of reference for each CWG. • Provide ongoing clinical scrutiny and challenge to the CWGs as well as provide a forum for escalation of issues arising from CWGs when needed. <p>Development of options for change and consultation (if required)</p> <ul style="list-style-type: none"> • Consolidate the recommendations of the CWGs to form a coherent sector strategy, identifying key clinical interdependencies between pathways and addressing conflicting recommendations in the service models where they exist. • Develop and test site-specific options ensuring that options take into consideration shifting activity into the community; optimal clinical configurations; critical mass and outcomes and potential productivity opportunities • Develop options appraisal criteria for potential configuration scenarios (e.g. see previous point) • Develop long-list and short-list of configuration scenarios to be recommended to the Strategy Board • Commission HIAs and EQIAs on potential options as well as travel times analysis.

	<ul style="list-style-type: none"> Ensure strategic fit (at least on a clinical level) of sector plans with other sectors' plans. Where there is deviation from other sectors, ensure there is a clear fact-based rationale and consensus amongst the clinical community within the sector and where possible, support from external clinical leaders. <p>Clinical leadership and engagement</p> <ul style="list-style-type: none"> Provide clinical leadership to the sector strategy, ensuring that improved clinical quality and patient outcomes are key drivers in the strategy Ensure clinical leaders from across primary & community and secondary care are equally involved in the development of the sector strategy and the importance of a whole systems approach to engendering change is recognised and adopted Ensure the sector strategy receives the appropriate level of clinical scrutiny, drawing on external clinical leaders as appropriate Act as a coalition for change across the clinical community within the sector as well as within home organisations; develop individual members as key change leaders within the sector. <p>Oversee Operating Plan implementation</p> <ul style="list-style-type: none"> Oversee the implementation of the sector Operating Plan 10/11, including polysystem development and yielding productivity opportunities Ensure that CWGs take ownership of pathway-specific objectives within the Operating Plan, monitoring achievement of actions. Contribute to the development of the Operating Plan 11/12
Membership:	<p>Core membership:</p> <ul style="list-style-type: none"> Provider Trust Medical Directors (acute Trusts, MH, LAS and CFTs) PCT PEC Chairs DPH representative(s) Chairs of CWGs NWL Director of Strategy <p>In attendance:</p> <ul style="list-style-type: none"> Strategy Lead Others, at the request of the CSG. This may include external clinical leaders.
Chair:	Co-chairs comprising 1 x acute sector and 1 x primary care clinician
Deputy Chair:	Co-chair
Tenure:	N/A
Secretary:	Strategy Lead
Quorum:	Matters requiring agreement (for example, when agreeing recommendations to the Strategy Board) will require a majority agreement

	<p>by 75% of those organisations present at the meeting when the agreement is reached.</p> <p>Each member has one vote</p>
Frequency of Meetings:	<p>Monthly with the possibility of fortnightly meetings during some phases of the Programme (to be agreed by the Clinical Strategy Group if required)</p> <p>Additional meetings in a workshop or other format may also be necessary.</p>
Subgroups:	<p>The Clinical Strategy Group is supported in delivering its objectives by the:</p> <ul style="list-style-type: none"> • Clinical Working Groups • Public and Patient Reference Group • Provider Productivity Group • Polysystems Implementation Group • Enabling Groups
Accountability:	Accountable to the NWL Strategy Board
Reporting responsibilities:	The group will provide regular reports and escalate issues for resolution to the NWL Strategy Board

Clinical Working Groups

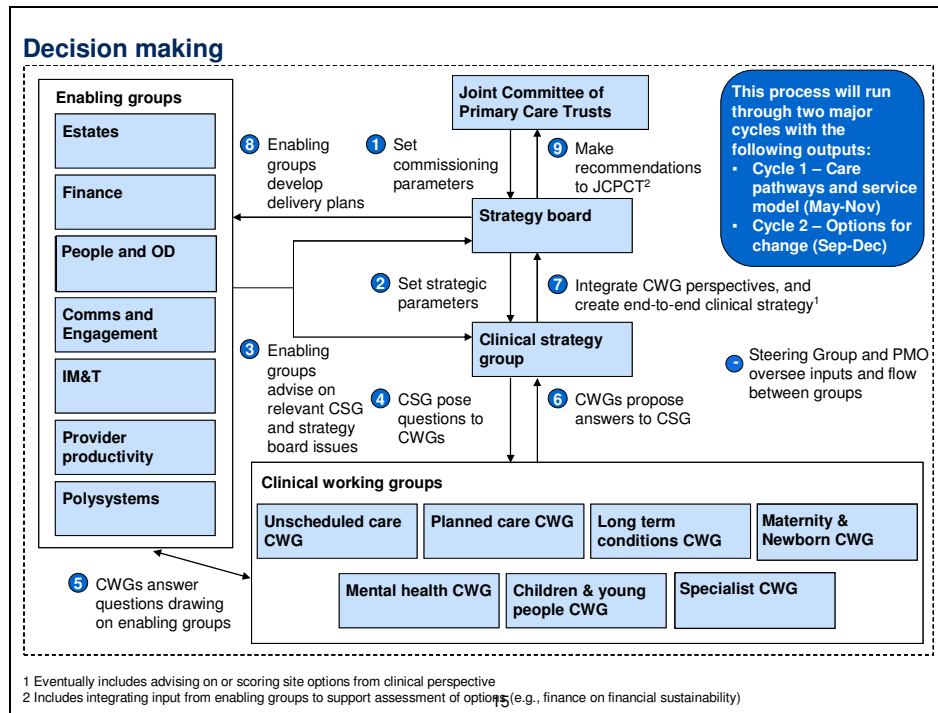
Terms of Reference

Title:	North West London Sector – Clinical Working Group
Date approved and approving body:	JCPCT - 5 May
Overall role	<p>For the pathway covered by the Clinical Working Group:</p> <ul style="list-style-type: none"> • Set the strategic direction • Support organisations/the sector in the delivery of the priorities and actions in the NWL Operating Plan 10/11 and inform the development of the NWL Operating Plan for 11/12 • Identify productivity opportunities
Purpose:	<p>Role of Clinical Working Group</p> <ul style="list-style-type: none"> • Further develop and own case for change. • Recommend changes in pathway design driving improved quality, productivity and patient experience, informed by the evidence base and aligned with London and national work • Work with productivity, polysystems, finance, workforce, estates and IM&T working groups to assess implications of delivery of new pathways, e.g. on quality, productivity, etc • Advise the Clinical Strategy Group on suitable criteria for evaluating options for delivery of the new care pathways. • Identify and agree any clinical risks and gaps in the care pathway or overall model of care • Where required, develop service specifications for parts of the care pathway • Ensure any clinical interdependencies are identified and understood as well as implications of delivering care in different care settings • To ensure close links with the North West London managed clinical networks, as required. • Support implementation of elements of the care pathway as they are agreed (and where public consultation is not necessary). • Monitor and support the implementation of the xxx section of the NWL 2010/11 Operating Plan. • Lead the development of the xxx section of the NWL 2011/12 Operating Plan, including advising the Clinical Strategy Group on how quality, productivity and patient experience can be improved as part of this plan. • Engage the wider clinical establishment in the development and implementation of care pathways. • Engage the public and patient groups in the development of care pathways. • Monitor progress against national standards and recommend improvements to ensure standards are met.
Membership:	<p>Core Membership</p> <ul style="list-style-type: none"> • Co-Chairs – clinical leads in a relevant service area (one from primary care and one from secondary care) drawn from the membership of the group • SRO who will be a CEO or equivalent in the sector supported

	<p>by a senior manager drawn from the sector</p> <ul style="list-style-type: none"> • Secondary care clinicians • Primary care clinicians • Social services • Patient & public representative
In attendance	<ul style="list-style-type: none"> • Project Team • The Clinical Working Groups may request the attendance of other staff, as appropriate (as required for specific items)
Co-Chairs:	Co-Chairs – clinical leads in a relevant service area (one from primary care and one from secondary care) drawn from the membership of the group
Resources	The group will be supported by a sector SRO and other management resources. External facilitation will also be available to support the group.
Deputy Chair:	Co-chairs
Tenure:	N/A
Secretary:	SRO
Quorum:	<p>Matters requiring agreement (for example, when agreeing recommendations to the JCPCT) by the Strategy Board will require a majority agreement by 75% of those organisations present at the Strategy Board meeting when the agreement is reached.</p> <p>Each member has one vote</p>
Frequency of Meetings:	To be determined by the co-Chairs of the Group in consultation with the SRO, as required to deliver the tasks set of it. Members will be asked to take part in workshops and events. Members will also be expected to attend wider sector events and to take part in consultation events (if required) with other clinicians, patients and the public.
Responsibilities of members	<ul style="list-style-type: none"> • Responsibilities of members of the Clinical Working Group include: <ul style="list-style-type: none"> ○ to fulfil the role of the Group as set out above ○ to inform the Clinical Working Group through a fact base of clinical evidence and data on the performance of current models of care ○ to identify and collect this fact base directly from their respective organisations ○ to help engage clinical colleagues in the sector ○ to provide relevant data, whether public or internal data to inform the Clinical Strategy Group optimal service configuration options ○ to endorse a sector-wide view and not an organisation-specific view of the task at hand ○ to promote and endorse the vision and objectives of the Sector and strategy to stakeholders where necessary ○ to keep papers and discussions confidential unless agreed otherwise

	<ul style="list-style-type: none"> ○ to adhere to the Sector’s communications strategy.
Supporting Groups:	<p>The Clinical Working Group is supported in delivering its objectives by the:</p> <ul style="list-style-type: none"> • Provider Productivity Groups and Polysystems Implementation Group – will advise on the delivery of the 2010/11 operating plan and support the Clinical Working Group on the productivity and polysystems aspects of delivering its agenda. Support might include reviewing opportunities for productivity savings and modelling the impact of polysystems delivery. • Enabling Groups (people & organisational development , IM&T, finance and estates) – to support the Clinical Working Groups to develop pathway changes and review the gains from these changes. Support will include activity, financial and workforce modelling, providing advice on workforce development and developing communications literature. The communications and engagement enabling group will support all the groups in communicating and engaging wider stakeholders. • Patient and Public Reference Group will provide input and advice on the patient and public perspective.
Accountability:	Accountable to the North West London Clinical Strategy Group
Reporting responsibilities:	The group will provide regular reports and escalate issues for resolution to the NW London Clinical Strategy Group

Appendix 3: Example of decision making for unscheduled care



Developing care pathways – unscheduled care example

- | Stage | Detailed illustrative responsibilities |
|-------|---|
| 1 | • Strategy Board set overarching planning constraints and parameters (with support of enabling groups) |
| 2 | • CSG set clinical planning parameters, ensuring consistency across CWGs on key issues (i.e., specialist coverage expectation) |
| 5 | • CWG develop detailed proposal for best practice unscheduled care to meet quality, productivity and patient experience parameters
• CWG make allocation of pathway activity to settings of care assumptions |
| 5 | • CWG work with other groups to check assumptions <ul style="list-style-type: none"> – LTC group on assumed prevention assumptions – Polysystems group on expected urgent care model assumptions – Acute productivity group on admission and discharge assumptions |
| 6 | • CWG identify key changes along pathway to improve diagnostics and administration productivity |
| 6 | • CSG review implications of unscheduled care proposal in context of all proposals and allocate implications to delivery working groups |
| 8 | • Delivery groups, supported by enabling groups, develop sector recommendations on specific implementation assumptions <ul style="list-style-type: none"> – Polysystem team <ul style="list-style-type: none"> • Propose how polysystem resources should be configured to meet activity load • Develop admission and discharge processes for OOH care across sector • Develop diagnostics profile OOH between primary, community and social care – Provider productivity team (acute) <ul style="list-style-type: none"> • Design most effective MAU, IP ward, consultant job plan • Share best practices in delivery • Improve admission and discharge protocols in hospitals • "Drive" labour productivity |
| 9 | • Strategy board review full proposals and feasibility assessment and challenge / sign off for JCPCT review |
| - | • Steering group and Programme Management Office (PMO) oversee inputs and flow between groups |