Health for North East London

Pre-consultation business case

November 2009

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A FOREWORD FROM OUR JOINT CLINICAL DIRECTORS

Providing high-quality health services in north east London is one of the most challenging jobs in the NHS. When asked, patients and the public have expressed their discontent with current services and we know that care could be improved. We do not meet the needs of a very diverse, often unhealthy population. Life expectancy is low and quality of life is poor compared to other parts of London and the rest of England and we need to organise services better to make improvements.

The evidence presented by *Healthcare for London* showed that a great many lives can be saved by NHS organisations working in partnership, concentrating complex services on fewer sites, and providing more services in the community, closer to home. Our aim is to use the knowledge and evidence that we now have to improve the health of local residents. We must ensure that if people are ill, they get the right services at the right location from the best clinical teams.

The development of proposals for reconfiguration in north east London has been clinically led from the outset. In our roles as joint clinical directors we have led the process of examining the clinical evidence base, developing a compelling case for change, identifying clinically viable options for change, and undertaking an assessment of these options to form recommendations. Through our six Clinical Working Groups we have been guided by clinical experts for individual service areas, and greatly assisted by our north east London Medical Director, Professional Executive Committee chair, and Clinical Reference Group colleagues.

We believe that the proposals set out in this pre-consultation business case will help to transform the healthcare available in north east London and patients will benefit from better, safer, more convenient care. What will this transformation feel like to patients?

- **Improvements in urgent care and A&E services**. We want to improve access to primary care-led urgent care services in polyclinics and at the 'front doors' of A&E departments. This will ensure that A&E doctors and nurses can use their skills and training to focus on the most severely ill or injured patients. We want patients arriving at urgent care services or A&E to be assessed by a senior clinician in less than an hour. All patients who are admitted to hospital should be seen quickly by a senior clinician who will take charge of their care and make sure they can access all the tests and treatments needed to help them recover quickly.

- **Offer women the choice and better quality maternity services that they have told us they would like.** This includes the choice to give birth at home or in a community midwife-led unit. Women who need a higher level of care will have better and earlier access to consultants and senior clinicians. We expect this will lead to fewer complications at birth for women and their babies. We also want to see antenatal and postnatal care available in polyclinics, closer to people's homes, and to provide advocacy services to pregnant women, such as language advocates and access to legal advice and social care services.

- **Improve services for children and young people**. North east London has a very young population and right now we are not always providing the best quality children's services consistently across the sector. We want to see improved assessment and treatment of children in A&E – provided 24 hours a day, seven days a week. Some children with more complex needs will benefit from improved inpatient care at specialist children's wards. We also want to see children's health services better integrated with other services provided closer to home.

- **Reduce the number of planned operations that are cancelled at short notice**. In 2009, over 1,000 patients in north east London are likely to have their surgery cancelled on the day. Our proposals to separate planned surgery from emergency surgery will help us to reduce this number by half.

In particular, we want to know that patients are really feeling a positive impact from the changes we will put in place. Patient surveys provide an insight into how patients feel about their health services. Surveys will ask patients questions such as: Did staff do everything they could to help control pain? Were you involved as much as you wanted to be in decisions about your care? We will continue to use patient surveys, as well as developing new ways to help us understand what patients experience when accessing health services, and to act on this information to make continuous improvements for patients.

We have worked with many clinicians – doctors and other health professionals – to look at how we can provide the best quality care for our communities. We would like to thank our colleagues in all the north east London hospitals and primary care trusts for the time, energy and commitment that they have given in helping us to develop these proposals for change.

Dr John Coakley MD FRCP, Medical Director and Consultant in Intensive Care Medicine at Homerton University Hospital NHS Foundation Trust

Dr Michael Gill FRCP, Medical Director and Consultant Geriatrician at Newham University Hospital NHS Trust

A FOREWORD FROM OUR JOINT SENIOR RESPONSIBLE OWNERS

Our central objective for north east London is to improve the health and well-being of our community, proactively investing in people's health and responding to their healthcare needs. We aspire for north east London healthcare services to be recognised as being amongst the best – high performing providers who deliver good health outcomes, are innovative, efficient and provide a positive user experience.

Achieving this objective will require a concerted effort across all NHS organisations within the sector. Some activities have already been agreed and are underway, such as the development of polysystems, an increase in the amount of healthcare services outside hospital, and improvements to the quality and productivity of services delivered by all healthcare providers.

Each primary care trust in north east London has been investing in and developing plans to provide more care in local communities. Thousands of people will be able to walk or take a short journey to urgent care services in polyclinics 12 hours a day, seven days a week. We plan to develop more polyclinics offering a wide range of tests, and care and advice from health professionals including local GPs and local authority social care staff. Polyclinics will complement existing health and social care services working in partnership to improve the health of local people.

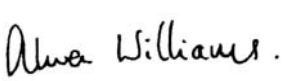
The remaining part of this picture is to improve clinical outcomes and patient experience for those people who need to access acute healthcare services from our hospitals through positive changes to the configuration of some services at our hospital sites. We want to ensure children and adults receive high-quality hospital care, to complement the increasing amount of care available close to people's homes; in health centres, polyclinics, GP surgeries, pharmacies and other local centres.

We believe we should provide more services close to where people live whenever possible – while providing some very specialist services in centres of real expertise. This is so we can ensure that people needing specialist care receive the best possible support from the right people in the right place at the right time.

This pre-consultation business case summarises the proposed changes as they relate to acute reconfiguration and describes the clinical benefits that this change can bring about – both directly, and as a catalyst to the shift of services to the community and delivery of quality and productivity improvements. We are therefore pleased to recommend this pre-consultation business case to the JCPCTs and NHS London with the full support of the *Health for North East London* Programme Board and Clinical Reference Group.

Heather O'Meara

Senior Responsible Owner (SRO) and Sector Chief Executive for outer north east London



Alwen Williams

Senior Responsible Owner (SRO) and Sector Chief Executive for inner north east London

EXECUTIVE SUMMARY

Introduction

This pre-consultation business case (PCBC) summarises the proposals being developed as part of the *Health for North East London* programme. The document has been developed, for the Joint Committees of Primary Care Trusts (JCPCTs) of inner north east London and outer north east London to approve, allowing the proposed public consultation to proceed. Approval of the PCBC is a prerequisite for consultation to proceed.

The work undertaken to determine the proposals contained in this business case has been led by the seven PCTs in north east London: NHS Barking and Dagenham; NHS City and Hackney; NHS Havering; NHS Newham; NHS Redbridge; NHS Tower Hamlets; and NHS Waltham Forest. The acute providers directly affected are: Barking, Havering and Redbridge Hospitals NHS Trusts (BHRT), which has two acute hospital sites: King George and Queen's; Barts and the Royal London NHS Trust (BLT). BLT has two acute hospital sites: St Bartholomew's (Barts) and the Royal London – only the Royal London is in scope for this work; Homerton University Hospital NHS Foundation Trust; Newham University Hospital NHS Trust; and Whipps Cross University Hospital NHS Trust.

The development of reconfiguration proposals has been clinically led; with two Joint Clinical Directors, over 45 clinicians actively and closely involved in the review of local health services and developing the recommendations for the future; and a further 200 clinicians involved as part of wider stakeholder engagement activities. The *Health for North East London* programme has also drawn upon external bodies of expertise to review the work of the programme, and the developing proposals, including the National Clinical Advisory Team (NCAT), *Healthcare for London* Clinical Advisory Group and a specialist consultancy to undertake the health impact assessment.

Engagement undertaken for *Health for North East London* builds on previous pan-London and local consultation exercises, namely, *Healthcare for London* which consulted across the capital and *Fit for the Future*, an engagement exercise covering the PCTs of Barking and Dagenham, Havering, Redbridge and Waltham Forest. During 2009 a number of engagement events have been held across north east London involving members of the public, representatives from Local Involvement Networks (LINks) and key stakeholders including local clinicians, Overview and Scrutiny members and representatives from local authorities. Individual PCTs have also held engagement events on the content of Health for North East London for their population, with a focus on the local impact of the developing proposals.

The case for change

The *Health for North East London* programme takes *Healthcare for London* as its cue and refines the five key principles and seven settings of care for the specific needs and requirements of north east London.

The rationale for 'changing now' is to ensure both the immediate and longer-term clinical viability of health services in north east London. Whilst there have been considerable achievements in the last few years, most notably in reducing waiting lists and increasing survival rates for cancer and coronary heart disease, health indicators still show that north east London is worse off than other areas in London, and England.

There are six key reasons for making significant changes in the way we deliver healthcare in the sector:

1. **Reason one**: we need to improve the health of people in north east London and ensure healthcare services are meeting public expectations.
2. **Reason two**: the population of north east London is rising rapidly leading to greater demand on health services.
3. **Reason three:** hospital is not always the answer; more care can be delivered in community settings than ever before and patients benefit from care closer to home.
4. **Reason four**: there are workforce challenges which currently prevent delivery of the best quality care and optimal patient outcomes.
5. **Reason five:** the need to adopt new models of care and best practice which can deliver better outcomes for patients.
6. **Reason six:** the need to make best use of taxpayers' money.

The case for change is primarily clinically-driven rather than financially-driven; improving the quality of healthcare services and delivering improved outcomes for the local population is the key reason for change. However, it is important to take into account the move from a ten year period of expansionary growth to a 'steady state' of lower annual growth, and the challenge this will give to trusts. There will be a greater need for hospitals to operate at or below tariff price to maintain financial viability. Projections show that hospital costs are increasing faster than tariff prices which means the future financial situation is looking worse not better.

Development of the reconfiguration proposals

The selection of options for consultation was led by the Clinical Reference Group (CRG), with expert input from six Clinical Working Groups (CWGs). The context for this consideration of options was *Healthcare for London* and the need to provide more care closer to home. Clinical recommendations from the CWGs were drawn together, and the CRG used these as the basis for consideration, on a non site specific basis, of the most clinically beneficial configuration model for north east London. The CRG non site specific recommendations were:

- Two major acute hospitals providing local hospital services and additional specialist services.
- Two or three hospitals with A&E, urgent medicine and surgery and critical care.
- One or two hospitals would no longer be required to provide A&E, urgent medicine and surgery and critical care. These hospitals could instead focus on providing higher

quality services the cast majority of patients who need urgent care, diagnostics, outpatient appointments, minor surgery, and rehabilitation rather than an A&E service.

- In addition to a range of midwifery-led units, a minimum of four, preferably five, obstetric maternity unit are required. The CRG preferred co-location with A&E, acute medicine and surgery provision where possible.

To develop this recommendation into a site specific recommendation, an appraisal process for was undertaken with three key steps:

1. Using a decision-tree to identify all possible reconfiguration options.
2. Developing and applying criteria (relating to clinical quality, safety and workforce; capacity; access; and deliverability) on which to score and rank options.

   Applying weightings to each criteria and sensitivity testing to ensure robustness of weightings.

Recommendations from the options appraisal

Following the options appraisal the following recommendations were made:

1. That the major acute hospital model set out by *Healthcare for London* should be developed in north east London with specialist services, currently being provided by many hospitals in the sector, being consolidated at the two proposed major acute hospitals – the Royal London Hospital and Queen's Hospital.

2. That, in addition to the two major acute hospitals, there will continue to be four hospitals with three (Homerton, Newham and Whipps Cross) providing A&E, critical care, obstetric and gynaecology and other acute services.

3. That King George Hospital will be re-shaped to provide urgent and planned care services. There are two proposed options for service configuration at King George, plus a set of additional services that could be located at King George with either reconfiguration option. These are summarised below

   - '**Core' service configuration ~** services would comprise round the clock urgent care services, an on-site polyclinic, outpatient services and diagnostics, planned surgery[1], stroke rehabilitation and other rehabilitation and intermediate care beds, community services for children, adults and older people. It is expected that this model would enable the UCS to undertake a minimum of 40% of current A&E activity.

   - **'Enhanced' service configuration ~** services would comprise the 'core' configuration plus next-day outpatient clinics for urgent specialist assessment and treatment, increased planned surgery activity including transfer of non-complex activity from Queen's. It is expected that this model would enable the UCS to undertake between 60% and 75% of current A&E activity as a result of rapid access to specialist advice and enhanced diagnostics.

[1] Planned surgery comprises activity currently undertaken on the King George site including the Independent Sector Treatment Centre (ISTC)

- **Other services located at King George ~** compatible with either the 'core' or 'enhanced' configuration, is the proposal to relocate services from elsewhere to the King George site. These services could include renal dialysis and child health development services.

4. That, across north east London, planned care pathways should be separated as far as is possible from urgent care pathways to realise the benefits that this can deliver – in terms of reductions in cancelled operations/ procedures and reductions in the rates of healthcare-acquired infections.

Financial analysis of the reconfiguration proposals

As the selection of recommended options has been clinically, rather than financially, driven, the proposals described above are recommended on the basis of being the highest-scoring option from the non-financial appraisal process. However, following non-financial option appraisal, a number of high-scoring options were subsequently modelled for their financial impact on the whole health economy of north east London.

Financial analysis shows that the preferred option provides financial benefit to the overall health economy of north east London, and especially to BHRUT – the trust currently experiencing most severe financial challenges. This therefore makes the proposals a particularly strong recommendation.

Modelling shows that one high-scoring option (two major acute hospitals, three hospitals with A&E and Newham a hospital with UCS), can deliver greater savings than the proposals outlined above - £27million compared to £19 million that can be delivered if King George is a hospital with UCS. However, the view of the CRG was that the additional £8million savings does not outweigh the benefits that the recommended proposals can deliver in terms of clinical quality, safety and workforce; capacity; access; and deliverability.

Transition and implementation

Implementation of either the 'core' or 'enhanced' configuration options for King George would be phased over a period of three years; high-level identification of milestones and initial planning to phase implementation of these milestones has been undertaken in conjunction with BHRUT- the trust for whom most impact is felt.

The benefits anticipated from Health for North East London

We believe that the proposals set out in this pre-consultation business case will help to transform the healthcare available in north east London and patients will benefit from better, safer, more convenient care. What will this transformation feel like to patients?

- **Improvements in urgent care and A&E services**. We want to improve access to primary care-led urgent care services in polyclinics and at the 'front doors' of A&E departments. This will ensure that A&E doctors and nurses can use their skills and training to focus on the most severely ill or injured patients. We want patients arriving at urgent care services or A&E to be assessed by a senior clinician in less than an hour. All patients who are admitted to hospital should be seen quickly by a senior

clinician who will take charge of their care and make sure they can access all the tests and treatments needed to help them recover quickly.

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In particular, we want to know that patients are really feeling a positive impact from the changes we will put in place. Patient surveys provide an insight into how patients feel about their health services. Surveys will ask patients questions such as: Did staff do everything they could to help control pain? Were you involved as much as you wanted to be in decisions about your care? We will continue to use patient surveys, as well as developing new ways to help us understand what patients experience when accessing health services, and to act on this information to make continuous improvements for patients.

Conclusion

This pre-consultation business case sets out a compelling case for change with clear options for the future, and provides a robust evidence-base to proceed to consultation. The feedback from consultation will inform the final set of recommendations for approval by the JCPCTs.

TABLE OF CONTENTS

A Foreword from our joint clinical directors 1

A Foreword from our joint senior responsible owners 3

Executive summary 4

TABLE OF CONTENTS 9

1. Introduction 12
- 1.1 Programme activity 12
- 1.2 Purpose of the pre-consultation business case 13
- 1.3 The development of the programme and pre-consultation business case 13
- 1.4 The context for *Health for North East London* 14
- 1.5 Scope of the pre-consultation business case 17
- 1.6 Current acute health landscape 20
- 1.7 Programme leadership and governance 22
- 1.8 Stakeholder engagement to date 28
- 1.9 Integrated impact assessment 32
- 1.10 The structure of the pre-consultation business case 32
- 1.11 Financial Analysis Contained within this Business Case 33
- 1.12 Further supporting information 34

2. The clinical case for change and vision for the future 35
- *2.1* From *Healthcare for London* to *Health for North East London* 35
- 2.2 The six key reasons for change and the vision for north east London 36
- 2.3 The vision for healthcare in north east London 44
- 2.4 The case for change for six clinical areas 47
- 2.5 From vision to reality 62

3. Benefits realisation from the reconfiguration proposals 65
- 3.1 A comprehensive benefits framework 65
- 3.2 The clinical benefits of reconfiguration 66

4. The financial context for north east London 78
- 4.1 The commissioners' perspective 78
- 4.2 The providers' perspective 88

5. Non-financial options appraisal 94
- 5.1 Principles that underpin the work of the programme 94
- 5.2 Criteria for non-financial options appraisal 97
- 5.3 Phase one: a decision-tree to identify a list of potential options for acute services 98
- 5.4 Phase two: scoring against the decision-making criteria 103
- 5.5 Conclusions from the non-financial options appraisal process 120

6. Financial assessment of options 125
- 6.1 The savings accruing from all options 125
- 6.2 The savings accruing from the three selected options 126

6.3 Conclusions 127

7. Recommendations from the options appraisal 128
7.1 Summary of the non-financial option appraisal 128
7.2 Summary of the financial analysis 128
7.3 Conclusion 128
7.4 The recommendation 129

8. The clinical proposals for change 130
8.1 Summary of changes 130
8.2 The current configuration of services 131
8.3 Proposed service configuration 133
8.4 Development of the major acute model in north east London 135
8.5 Providing hospital services at Homerton, Newham, and Whipps Cross 137
8.6 Planned care services 139
8.7 Clinical services to be provided at King George 140
8.8 Benefits of the clinical proposals for change 143

9. Financial analysis of the clinical proposals for change 146
9.1 Revenue consequences to providers 146
9.2 Space utilisation on the King George site 149
9.3 Enhanced configuration of services at King George 151
9.4 Transitional costs of reconfiguration 151
9.5 Capital costs 152

10. Activity Analysis of the clinical proposals for change 156
10.1 Forecasts of movements of activity 156
10.2 Inpatient activity 157
10.3 Maternity 159
10.4 A&E and urgent care service activity 160
10.5 Outpatient activity 162
10.6 Volumes of activity for King George 162
10.7 Volumes of activity for Queens Hospital 163
10.8 Volumes of activity for Whipps Cross Hospital 164
10.9 Volumes of activity for Newham Hospital 164
10.10 Volumes of activity for Barts and the London 165
10.11 Volumes of activity for Homerton Hospital 165
10.12 Bed capacity 166

11. Transition and implementation 170
11.1 Decision-making process following consultation 170
11.2 Milestones for implementation 172
11.3 Dependencies 174
11.4 High-level implementation plan 175
11.5 Implementation planning 175
11.6 Benefits realisation 177

12. Approval process 179
12.1 Recommendations made by Clinical Reference Group (CRG) 179
12.2 Recommendation made by Programme Board 179
12.3 Approval by the Joint Committees of PCTs 179

13. Preparing for consultation and engagement 181
13.1 Purpose of undertaking consultation and engagement 181

13.2 Requirements to consult and accountability for consultation 182
13.3 Consultation questions 183
13.4 Engaging with stakeholders 184
13.5 Consultation and materials 187
13.6 Schedule of activities for the consultation period 189

1. INTRODUCTION

In July 2007 *Healthcare for London* published *A Framework for Action* written by Professor Lord Ara Darzi. This document was a result of patient, public, staff and partner organisation engagement. The purpose was to determine how to deliver healthcare that is better, safer, more accessible and helps people stay healthier.

A Framework for Action led to a pan-London consultation by London PCTs in 2008/09 *Healthcare for London: Consulting the Capital*. The response from the public was that they wanted real change and to have responsive, safe, accessible and high quality healthcare. Following the consultation the London JCPCT made a set of decisions to implement the vision set out in these documents. The challenge for north east London now is how to implement the *Healthcare for London* vision locally.

In December 2008 the Chief Executives and Chairs of all NHS Trusts in the sector met and agreed to establish a sector wide change programme Health for North East London. This is a whole-system change programme designed to drive improvements in the quality, productivity and sustainability of health care in north east London. It aims to:

- Improve the health of the whole population, reducing inequalities;
- Improve service quality as measured by safety, patient experience, access and quality standards;
- Ensure ongoing financial sustainability.

Local NHS organisations are committed to working together to deliver these aims. We recognise the importance of engaging clinicians, patients and local residents in the change programme, as well as the importance of integrated working with local authorities and other local partner organisations. As such we will actively seek ways to:

- Enable clinicians to drive the changes required
- Develop meaningful partnerships with patients and local residents in the development and delivery of their local health services
- Ensure the work of the programme is effectively linked to the work of local strategic partnerships.

1.1 PROGRAMME ACTIVITY

Whilst the pre-consultation business case focuses primarily on the reconfiguration of acute services, reconfiguration is only one part of a wider programme of improvement activity. The *Health for North East London* programme has three broad approaches to improving the quality and financial viability of local health services:

- *"local where possible":* in line with the clear recommendations from *Healthcare for London,* local clinicians agreed that a substantial proportion of clinical activity currently being delivered in acute hospital settings in north east London could be delivered in alternative care settings, closer to home (including polyclinics);

- *"centralise where necessary"* ~ some services need to be provided from fewer locations (i.e. bigger catchment populations) to provide critical mass for the clinical procedures and ensure best use of clinical skills;

- *"making best practice, common practice"* ~ clinicians have identified a range of ways in which existing services could provide improved clinical quality and productivity through ensuring the consistent application of best practice across the sector. For example, by ensuring early consultant review for all patients admitted to hospital for unscheduled care, or by strictly limiting night time operating.

The reconfiguration of acute hospital services focuses on the second of these approaches, "centralise where necessary", and is dependent on the first of these approaches, "local where possible". Whilst the third approach "making best practice, common practice" is relevant to the reconfiguration proposals, it is not wholly dependent on reconfiguration to achieve it.

1.2 PURPOSE OF THE PRE-CONSULTATION BUSINESS CASE

The pre-consultation business case (PCBC) focuses on the reconfiguration of acute hospital services.

The PCBC demonstrates a robust, evidence-based, clinical case for change; a description of the clinical proposals for change; and a framework for the planning and management of the reconfiguration. The PCBC uses information available at the time of writing to analyse each option in terms of its suitability; the extent to which it will deliver the vision for north east London, its impact on patients and its impact on the local health economy.

The remainder of this chapter comprises:

- **Section 1.3** explains the background to the development of the programme and the PCBC;

- **Section 1.4** provides the context for the programme;

- **Section 1.5** describes the scope of the PCBC;

- **Section 1.6** sets out the current acute services landscape;

- **Section 1.7** gives an overview of the programme's leadership and governance;

- **Section 1.8** describes the stakeholder engagement to date;

- **Section 1.9** explains the process for the integrated impact assessment

1.3 THE DEVELOPMENT OF THE PROGRAMME AND PRE-CONSULTATION BUSINESS CASE

The *Health for North East London* programme commenced in December 2008. The leaders of the NHS in north east London recognised that implementation of *Healthcare for London* into the local healthcare context required considerable planning to overcome specific local challenges and ensure clinical and financial sustainability. Locally, there was

a history of clinicians and health service leaders working together to improve the quality and delivery of services, and this basis for joint working was built upon to form *Health for North East London.*

The PCBC process described below outlines the key steps and milestones achieved by the project since its initiation, enabling the production of the PCBC.

1	December 2008	*Project initiated*	Recognition of the challenge of implementation of Healthcare for London in north East London.
2	March 2009	*Case for change published*	Identification of the reasons why change is needed. Baseline analysis and modelling to substantiate case for change.
3	March – June 2009	*CWGs develop clinical visions*	Clinical working groups review clinical services, identifying the vision for the future and make recommendations.
4	March 2009	*Public involvement in the case for change*	Stakeholder briefings and engagement events on the case for change and next steps of the programme
5	April – October 2009	*Commissioning context*	PCTs develop plans for enabling the shift of services out of hospitals
6	April-July 2009	*Benefits modelling*	Identification of the benefits for patients and benefits for staff to be achieved through reconfiguration for each CWG area
7	April 2009	*Public involvement in criteria development*	Public and stakeholders participate in identifying how to make decisions about possible options
8	May 2009	*Quality assurance*	NCAT review: clinical assurance of the case for change and emerging CWG visions. OGC Gateway review: quality assurance of programme and progress to date .
9	June 2009	*Development of a vision for north east London*	CRG synthesises the work o the CWGs into an overall set of recommendations for the whole health economy
10	July – August 2009	*Options development*	Identification of the range of clinical options for delivering change
11	August 2009	*Public involvement in criteria 'weighting'*	*"What matters to you?"* event held involving members of the public to determine a system of 'weighting' the decision-making criteria, later used for short listing options.
12	August 2009	*Short listing of options*	Evaluation and assessment process of the identified clinical options using the decision-making criteria
13	August – October 2009	*Preparation of PCBC*	Further development of the clinical proposals for change, and engagement with the public.
14	October 2009	*Clinical advice on proposals for change*	Clinical review of the proposals for change by the National Clinical Advisory Team
15	November 2009	*Quality assurance of PCBC*	Quality assurance of the PCBC by NHS London and Capsticks Solicitors

1.4 THE CONTEXT FOR *HEALTH FOR NORTH EAST LONDON*

There are four key aspects to the context to the *Health for North East London* programme.

1. Health challenges in north east London
2. Health service performance in north east London
3. Applying the principles of *Healthcare for London*
4. Adopting best practice and new models of care

1.4.1 Health challenges in north east London

North east London is facing a bigger health challenge than any other London sector. Key health indicators are poor; the local population has a lower life expectancy, higher rates of infant death and higher mortality rates from cancer and cardiovascular disease than other London sectors.

The coupling of high incidence of health need and a fast growing population means demand for health services in north east London is set to increase in volume and complexity. Commissioners of health services must ensure that the response to this need is to provide the most appropriate services in the most appropriate settings, ensuring they are high quality and patient-focused. The high incidence of illness and below-average health indicators in north east London tells us that continued provision of the same type of services is not the answer for the future.

1.4.2 Health service performance in north east London

We know that health services in north east London are not performing as well as we should expect in terms of quality or productivity. There are some examples of excellent practice and performance in the local NHS, but there is too much variation, meaning some patients do not receive the best possible care that others benefit from. Overall, the NHS in north east London under-performs on mortality rates, patient satisfaction and performance targets such as waiting times. High levels of vacancies and staff turnover are key factors in this variation of standards.

North east London currently underperforms against some key national targets and there is significant variation between NHS organisations – this is shown in the figure that follows. For this reason, one of the key objectives of the work of Health for North East London is to ensure all key national targets are achieved.

The figure below shows acute trust performance for the five north east London trusts for the following national targets:

- Rates of MRSA infection;
- Rates of C. difficile infection;
- A&E 4-hour waiting times;
- Cancer 2-week waiting times;
- 18 week waiting times for *admitted* patients;
- 18 week waiting times for *non-admitted* patients;

The figure illustrates whether each trust performs better than the England average, or worse than the England average. Where performance is in the top decile for England, this is also shown. The key findings are:

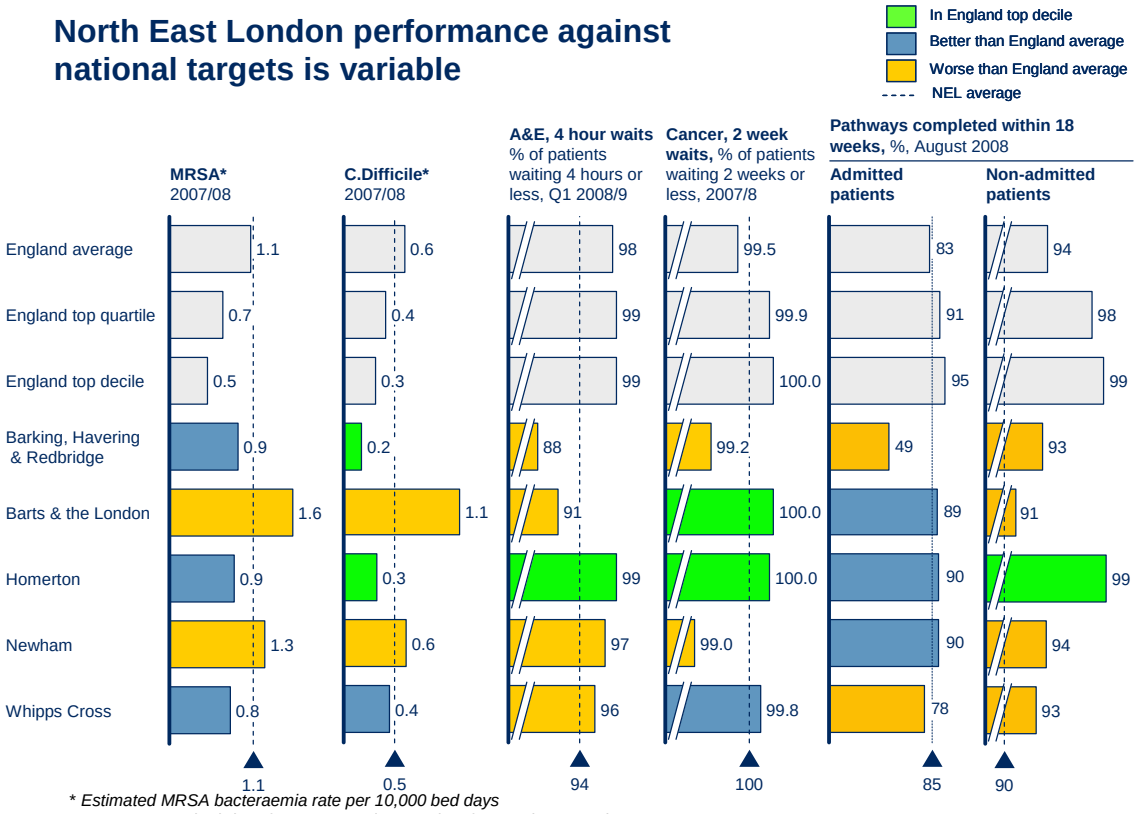
- There is evidence of some very good practice in the sector; the Homerton performs in the top England decile for A&E waiting times, cancer waiting times, the 18 week wait for non-admitted patients and infection rates for C. Difficile.

- There is considerable variation between trusts. For example, for cancer waiting times, three trusts perform higher than the England average, in fact two of these three are in the England top decile, yet two trusts underperform against the England average.

- There is variation of performance within all trusts against different measures. For example, Barking, Havering and Redbridge does well for infection control but is below the England average for all waiting time targets.

- All trusts, except Homerton, are underperforming against A&E waiting times.

North East London performance against national targets is variable



** Estimated MRSA bacteraemia rate per 10,000 bed days*
*** Rate per 1000 bed-days for acute specimens taken from patients aged 2-64 years*
Source: HCAI Data Capture System, July 2008; Department of Health monthly report, Healthcare commission, Department of Health dataset QMAE , Department of Health monthly report, Healthcare commission

1.4.3 Applying the principles of Healthcare for London

Health for North East London takes its cue from *Healthcare for London*. There are four key areas of focus explored in *Healthcare for London: a Framework for Action* that are of particular relevance for north east London:

1. **Localise where possible, centralise where necessary ~** routine healthcare should take place as close to home as possible. More complex care should be centralised to ensure it is carried out by the most skilled professionals with the most cutting-edge equipment.

2. **Better use of the workforce ~** the NHS' staff are its greatest asset, but their abilities are not always fully utilised. For instance, doctors in a large acute hospital in London see 24 per cent fewer patients than their counterparts in comparable hospitals elsewhere in England and nurses also see relatively fewer patients.

3. **Better use of the NHS estate ~** the NHS in London has a huge and under-utilised estate. A comprehensive estates strategy is required to explore how surplus or underused estate can be used to finance new developments.

4. **Models of healthcare provision ~** at present London does not have the infrastructure and facilities to provide ideal care. New models of provision are described that will be needed to deliver high-quality care. These new models include polysystems.

Health for North East London is the sector's response to *Healthcare for London*. This PCBC focuses on the changes that are needed to enable the key areas of focus of *A Framework for Action* to be adopted locally.

1.4.4 New models of care

There is increasing evidence of new clinical models and ways of working that can deliver significant benefits to both patients and staff.

Many of the Royal Colleges recommend a consultant-delivered model of care, often on a round the clock basis, to deliver improved clinical outcomes and reductions in patient length of stay. Sub-specialisation of clinical staff and services brings benefits for patients, but requires a threshold and richness of patient case-mix to sustain. It is also evidenced that separation of planned and emergency care pathways leads to better outcomes for patients, particularly the incidence of healthcare acquired infections.

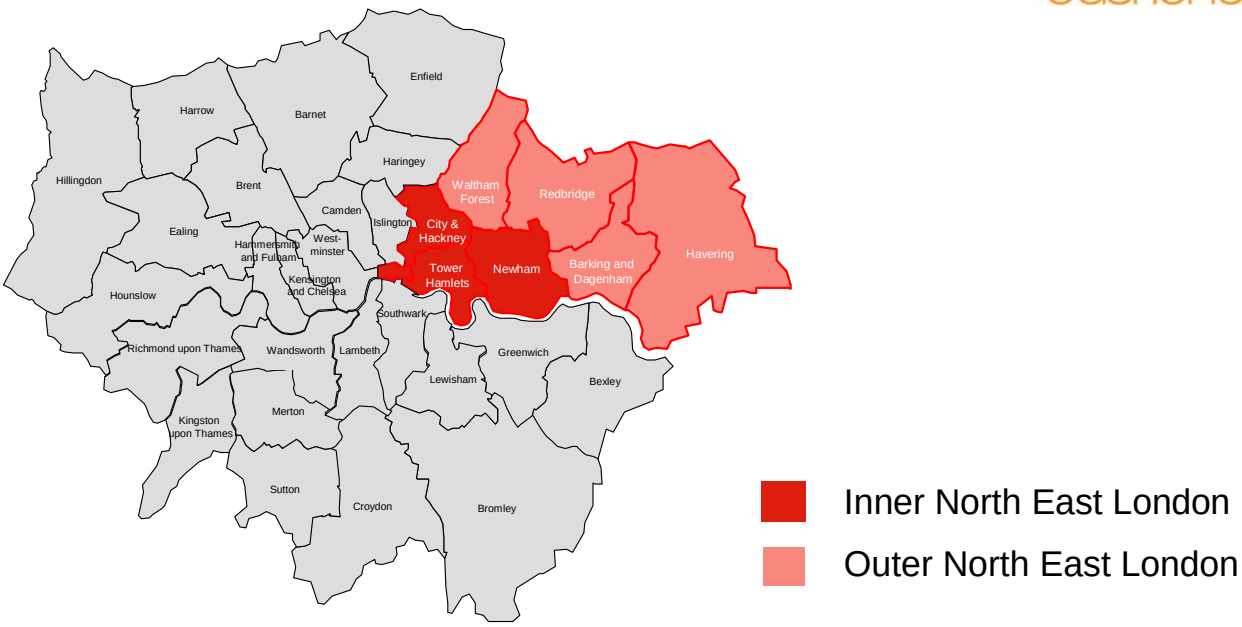
Considerable change is required to enable the NHS in north east London to adopt these new ways of working.

1.5 SCOPE OF THE PRE-CONSULTATION BUSINESS CASE

1.5.1 Geography

Primary Care Trusts (PCTs) in London are grouped into six sectors. The north east London region covers two of these sectors: 'outer north east London' and 'inner north east London'. The scope of the PCBC includes all patients who access healthcare services in north east London, and therefore the significant in-flows from out of area, in particular fro Essex, should be noted.

The map that follows shows the PCT and sector boundaries for the region.



The health economy of north east London comprises seven PCTs:

- *Inner north east London*: City and Hackney, Newham, Tower Hamlets
- *Outer north east London*: Barking and Dagenham, Havering, Redbridge, Waltham Forest.

Each sector has a Joint Committee of PCTs (JCPCT) which has delegated authority from its constituent PCTs to make decisions in relation to the *Health for North East London* programme.

The scope of the PCBC covers all residents of north east London and users of the relevant services within the sector.

1.5.2 Acute hospital sites in north east London

The PCTs are responsible for commissioning acute health services for the local population. The majority of those services are commissioned from the five local acute trusts in north east London. Some specialised services are commissioned from hospitals outside of north east London, often in central London.

The five north east London acute trusts are:

- Barking, Havering and Redbridge Hospitals NHS Trusts (BHRT). BHRT has two acute hospital sites: King George and Queen's.
- Barts and the Royal London NHS Trust (BLT). BLT has two acute hospital sites: St Bartholomew's (Barts) and the Royal London;
- Homerton University Hospital NHS Foundation Trust;
- Newham University Hospital NHS Trust;
- Whipps Cross University Hospital NHS Trust;

1.5.3 Acute services under review

Clinical working groups (CWGs) were formed to undertake a detailed review of six key clinical specialty areas. CWGs were tasked with defining and articulating the case for change and the vision for their service, and the changes required in north east London to deliver this vision. The six CWGs were:

- **Children's and young people's services ~** the group reviewed acute services for patients under 19, specifically focusing on urgent care, specialist care, surgery and planned care

- **Urgent medicine ~** the group's focus was on acute services for people who need urgent advice, care, treatment or diagnosis. 'Urgent care' is an umbrella term to include *unscheduled care*, *unplanned care* and *emergency care*.

- **Urgent surgery ~** the CWG defined urgent surgery as that which cannot be planned, and has to be performed within a defined timescale.

- **Maternity and newborn care ~** the group reviewed and made recommendations for the care of pregnant women from pre-conception to delivery and the care of neonates (newborns).

- **Specialist services ~** the CWG covered highly specialised services including cancer and cardiac services, vascular surgery and neurosurgery.

- **Planned care services ~** care that is pre-arranged and includes elective medical admission, elective surgery, outpatient attendances and diagnostic services.

The CWGs have been reshaped with a current focus on improving quality and productivity of acute services to deliver their service visions.

In addition to the six CWGs, PCT commissioners are also working to define their plans for creating capacity and capability in the community to enable the shift of services from hospital settings.

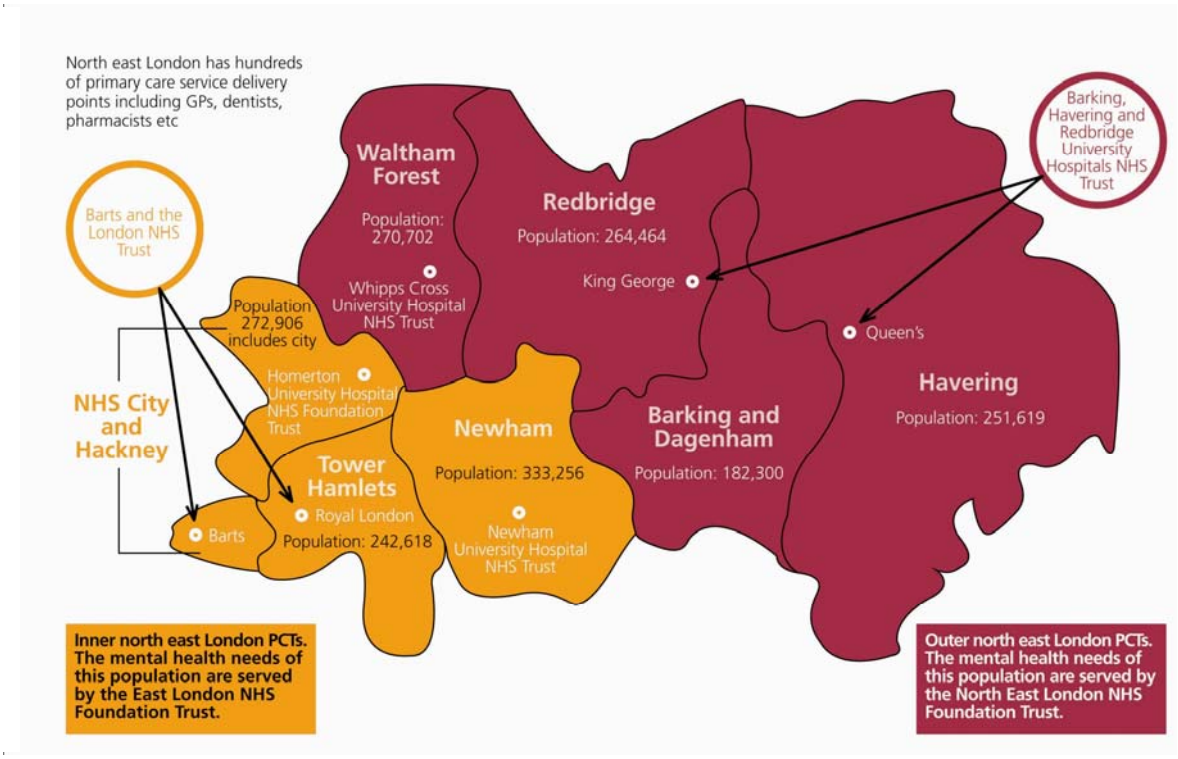
1.5.4 Out of scope

- East London and the City Mental Health Foundation Trust and North East London NHS Foundation Trust cover this area as well, but are not included in the proposals for reconfiguration. The location of mental health services is not identified as a key issue to delivering overall quality improvements; rather the need for better integration between mental health and other services is the priority. This is set to be a key focus for the *Health for North East London* programme once the configuration of acute services is agreed.

- Barts Hospital – the pan-London review of cardiac services is underway and its outcome may have implications for Barts Hospital. Given the review, Barts has been excluded from the *Health for North East London* work. However, the work will need to consider the outcomes of the review in deciding the final picture of service configuration for north east London.

1.6 CURRENT ACUTE HEALTH LANDSCAPE

The map that follows shows the PCT catchment areas of north east London and the location of the acute hospitals

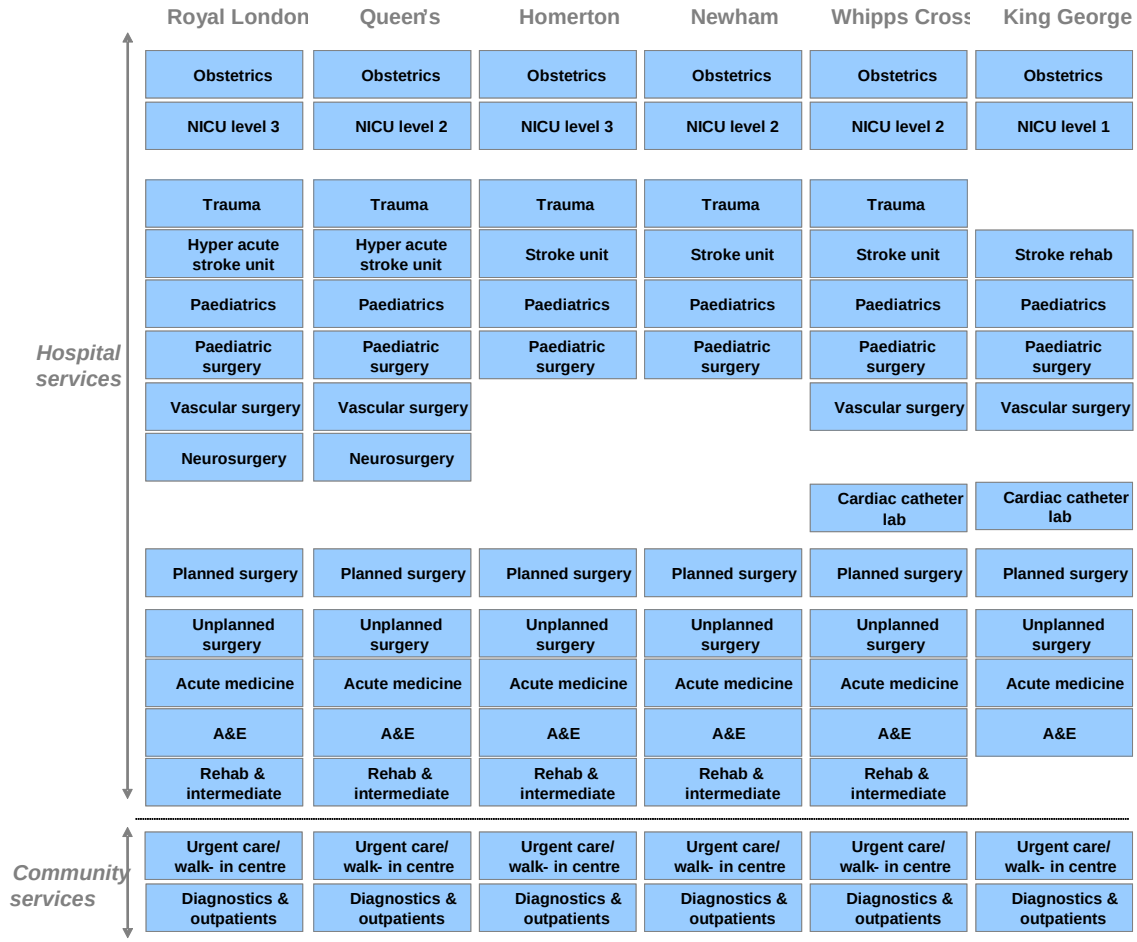


The table below contains 2007 activity levels for the six acute hospitals within the scope of the review.

	A&E activity	Inpatient activity	Outpatient activity	Births	Inpatient beds
Barts and the London	134,344	77,477	479,564	4,137	1,134
Queen's	148,889	57,582	345,780	5,476	837
Homerton	91,629	30,665	183,027	4801	493
Newham	100,571	34,403	193,464	5,246	384
King George	94,792	38,333	182,868	3,186	488
Whipps Cross	111,805	57,598	251,326	4,878	787

1.6.1 Current provision of services

The figure that follows shows which acute and community clinical services are currently provided at each of the hospital sites in the review.



As Barts is out of scope for Health for North East London, it is not included in the diagram above. It is noteworthy that there is a cardiac catheter lab located the London Chest Hospital, Mile End, which is part of Barts and the London NHS Trust. The pan-London review of cardiac services is expected to conclude that this service should continue to be provided by Barts and the London NHS Trust but may be relocated to the Royal London Hospital.

1.6.2 Distances between hospital sites

There are six acute hospital sites 'in scope' for the core reconfiguration proposals. These hospitals are located within relatively close proximity to one another. Distances between each are set out in the table below. This shows that the longest distance is 15.6 miles between the Royal London, Whitechapel and Queen's hospital, Romford and the shortest distance is three miles from the Royal London to the Homerton[2].

[2] Information was obtained from the AA route planner, using the most direct route possible in each case.

	Royal London	Newham	Queen's	King George	Whipps Cross	Homerton
Royal London		5.1 miles	15.6 miles	12.3 miles	7.9 miles	3.0 miles
Newham	5.1 miles		8.9 miles	7.1 miles	5.3 miles	5.6 miles
Queen's	15.6 miles	8.9 miles		4.5 miles	9.5 miles	12.4 miles
King George	12.3 miles	7.1 miles	4.5 miles		6.3 miles	9.2 miles
Whipps Cross	7.9 miles	5.3 miles	9.5 miles	6.3 miles		4.3 miles
Homerton	3.0 miles	5.6 miles	12.4 miles	9.2 miles	4.3 miles	

The scope of work of the Integrated Impact Assessment (IIA) includes further work on the impact of any changes to distances and travel times. This work will take place during consultation and will be made available via the Health for North East London website www.healthfornel.nhs.uk.

1.7 PROGRAMME LEADERSHIP AND GOVERNANCE

1.7.1 Clinical leadership

The *Health for North East London* programme is a clinically-led programme of work. Over 45 clinicians have been actively and closely involved in the review of local health services and development of recommendations for the future, and a further 200 clinicians have been involved as part of the wider stakeholder engagement activities.

Clinical leadership of the programme can be evidenced through the following governance mechanisms:

- Two joint **clinical directors** were appointed at the outset to provide clinical leadership for the review. They are Dr Mike Gill, Medical Director of Newham University Hospital NHS Trust and Dr John Coakley, Medical Director of Homerton University Hospital NHS Foundation Trust.

- The **Clinical Reference Group** brings together provider trust medical directors, PCT Professional Executive Committee chairs and leads of the clinical working groups. The CRG is jointly chaired by the clinical directors. A key role of this group is the synthesis of the work of the six CWGs into an overall set of recommendations.

- Six **clinical working groups (CWGs)**, representing key clinical service areas, were established to make recommendations for change in the way local health services are delivered. The CWGs advise the CRG on the detailed clinical visions and solutions that are proposed.

- The review of **out of hospital care** is led by each PCT, with primary and community clinical leads working to ensure that thinking and delivery is integrated across the whole health system.

- **External clinical review** of the programme's work has been overseen by Dr Chris Clough of the National Clinical Assessment Team (NCAT). Two reviews have taken place. The first, in May 2009 assessed the case for change and developing proposals for change, and the second, in October 2009 examined the detail of the proposals

prior to consultation. Reports following each review have expressed NCAT's support of the case for change and the clinical proposals for change (these reports are available separately).

- **Wider clinical engagement** through stakeholder events, including a clinical engagement event aimed specifically at clinicians, has helped to secure the involvement of over 200 local clinicians in the work of the programme (a summary of this event is available separately).

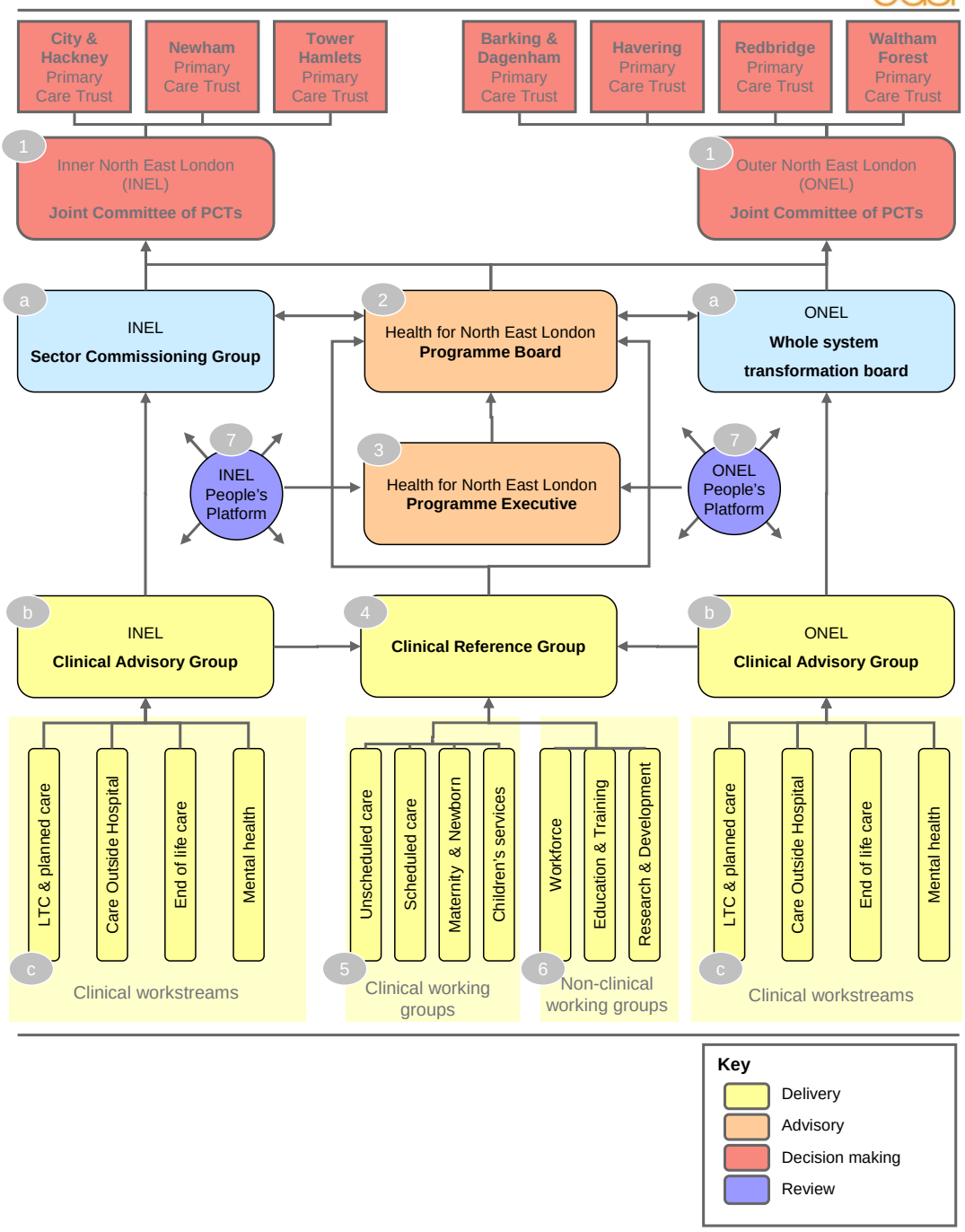
1.7.2 Programme governance

An overview of the programme's current governance structure is provided in the diagram overleaf, followed by a description of the role and responsibility of each. There is a separate paper that provides further detail on the programme's governance arrangements.

The governance structure shown is for the full *Health for North East London* programme, not just the elements that relate to reconfiguration. The diagram identifies the governance elements relating to reconfiguration in numbers 1-7, and the elements that relate to the wider aspects of the programme are in letters a-c.

The governance structure diagram shows that the two JCPCTs are the decision-making bodies for the programme. The JCPCTs are advised by the Programme Board, which in turn is supported by the Programme Executive and Clinical Reference Group.

In addition to the governance structure detailed in the diagram, there are six external groups that play a role in reviewing the work of the programme and strengthening its recommendations through expert advice and challenge. These are detailed in the descriptions that follow.



This governance structure is current as of 6 November 2009 but is likely to change as the programme moves through different stages.

a. GOVERNANCE ELEMENTS RELATING TO RECONFIGURATION

1 Joint Committee of Primary Care Trusts (JCPCTs)

There are two Joint Committees of Primary Care Trusts; one for each of the two sectors of inner north east London and outer north east London. The JCPCTs are bodies that already exist with certain delegated authorities from their constituent PCTs to take decisions which affect the whole sector.

Specifically for *Health for North East London* the JCPCTs hold ultimate and statutory responsibility for agreeing the PCBC and consultation materials, and for the decision to go forward into public consultation on behalf of its constituent PCTs. The two committees will also receive the responses to consultation and make decisions in light of this in relation to the shape of healthcare in north east London.

2 Programme Board

The Programme Board's role is advisory. It advises the joint senior responsible owners (SROs) to make recommendations to the JCPCTs. It supports the joint SROs in delivery of the *Health for North East London* programme plan, endorses the pre-consultation business case and supports the development of pre-consultation materials.

The Programme Board is chaired jointly by the two SROs. Its membership comprises the joint clinical directors, the chief executives of the five acute trusts, the *Health for North East London* programme director and senior representatives from NHS London.

The joint SROs are Alwen Williams, sector chief executive for inner north east London and Heather O'Meara, sector chief executive for outer north east London. The role of the joint SROs is to ensure there are clear objectives for the programme; focus is maintained; the programme has clear authority; the context (including risks) is actively managed and that the projected benefits are delivered.

3 Programme Executive

The Programme Executive's role is to focus on delivery. It is held to account by the Programme Board for delivery of the programme. Its responsibilities include overall programme management of *Health for North East London*; delivery of the programme objectives and its resourcing; engagement with provider trusts and consultation with staff, patients, public, media and other stakeholders.

Its membership comprises the SROs, the joint clinical directors, the programme director and members of the *Health for North East London* programme team, finance leads for inner north east London and outer north east London, managing directors of the two sector acute commissioning units, representatives from NHS London and *Healthcare for London.*

4 Clinical Reference Group (CRG)

The role of the Clinical Reference Group (CRG) is to provide clinical leadership and support to the Programme Executive and Programme Board, particularly in assessing alternative service configurations and making clinical recommendations for change. It provides expert clinical advice across the range of health issues affecting the population in north east London, and considers analyses and proposals from the clinical working groups, advising on any additional factors for consideration. The CRG advises the SROs on the clinical safety of options proposed. This group has the role of synthesising the work of the six groups into an overall set of recommendations.

Its membership comprises the joint clinical directors, clinical working group leads, acute trust medical directors and PCT PEC chairs.

5 Clinical working groups (CWGs)

Covering four clinical service areas associated with the reconfiguration review, the CWGs lead discussion and analysis of 'best practice' clinical service provision, evaluate service

demand and capacity, identifying strengths and weaknesses of existing services, and describing the potential impact of demographic, economic, regulatory, technological and health policy trends on future health service demand and delivery. Each CWG has one or more clinical leads appointed to provide leadership for the group. *The CWGs have recently changed their grouping - previously there were six CWGs covering urgent medicine; urgent surgery; maternity; children's services; specialist services; and planned care. Under the current governance structure there are four groups: unscheduled care (comprising urgent medicine and urgent surgery); scheduled care (comprising the former CWGs of planned care and specialist services); maternity (no change); and children's services (no change).*

6 **Non-clinical working groups**

The three non-clinical workstreams are responsible for delivering the non-clinical elements of the programme plan, developing and endorsing aspects of the pre-consultation business case, engagement and consultation materials and processes. Each workstream has a named lead responsible for delivery.

7 **The People's Platform**

Two advisory groups, to represent inner north east and outer north east London, have been formed to advise the *Health for North East London* programme on pre-consultation activity, consultation methods and materials, as well as formally considering the proposals and making recommendations to the programme. Each group's membership comprises LINks members and members of the general public.

b. GOVERNANCE ELEMENTS RELATING TO THE WIDER HEALTH FOR NORTH EAST LONDON PROGRAMME

a **Sector commissioning arrangements**

Both inner north east London and outer north east London have sector-wide arrangements in place for acute commissioning, including sector acute commissioning units. The boards responsible for these arrangements are: for inner north east London; the Sector Commissioning Group and for outer north east London; the Whole System Transformation Board.

b **Clinical Advisory Groups**

The Clinical Advisory Group (CAG) provides clinical leadership and support to the Programme Executive and Programme Board, for the breadth of the programme. It provides expert clinical advice across the range of health issues affecting the population in north east London, and considers analyses and proposals from the clinical working groups, advising on any additional factors for consideration. Its focus is on the areas covered by the clinical workstreams, namely long term conditions and planned care; care outside hospital; end of life care; and mental health.

c **Clinical workstreams**

Covering four clinical service areas, the clinical workstreams lead discussion and analysis of 'best practice' clinical service provision, evaluate service demand and capacity, and identifying strengths and weaknesses of existing services. The four clinical

workstreams are: long term conditions and planned care; care outside hospital; end of life care; and mental health.

c. EXTERNAL REVIEW GROUPS

- **Joint health overview and scrutiny committees ~** Overview and Scrutiny committees (OSC) have a responsibility to scrutinise proposed changes to health provision on behalf of local residents. For north east London the OSC committees have formed into two joint committees – for inner north east London, and for outer north east London.

- **NHS London ~** as the Strategic Health Authority for London its role is to ensure that the programme develops proposals that are robust and fit for purpose and that public consultation is carried out appropriately. NHS London has reviewed the PCBC as part of this process.

- ***Healthcare for London*** **Clinical Advisory Group (CAG) ~** the CAG is a pool of expert clinicians from a range of clinical specialties, which informs the development of the *Healthcare for London* programme and supports the *Healthcare for London* programme team and London PCTs in the development of local plans for implementing the vision of *Healthcare for London.*

- **National Clinical Advisory Team (NCAT) ~** NCAT was invited by the programme team to undertake a review of the clinical case for change and proposed options for change. They report independently on their assessment of readiness for consultation on the clinical aspects. NCAT provides a pool of clinical experts to support and guide the local NHS on service change proposals to ensure they are safe and accessible by patients. A review was undertaken by NCAT in May 2009 of the case for change and a further visit in October 2009 assessed the detailed proposals for change.

- **Office of Government Commerce (OGC) Health Gateway review ~** OGC Gateway reviews examines the robustness of the outcomes and objectives for the programme and confirms they make the necessary contribution to NHS strategy. A Gateway *Stage 0* review was undertaken in May 2009.

- **Legal assurance ~** Capsticks Solicitors are working with the programme team to give legal advice and assurance.

d. GOVERNANCE OF THE INTEGRATED IMPACT ASSESSMENT

Mott MacDonald has been awarded the contract to undertake the integrated impact assessment and a steering group has been established to oversee this work. The steering group is chaired by Professor Sir Cyril Chantler and is comprised public health expertise and representatives of NHS London and London Travelwatch (London transport users committee). The first meeting of the body was held on 28 September 2009 and it is expected that the integrated impact assessment steering group will meet on at least four further occasions through to March 2010.

1.8 STAKEHOLDER ENGAGEMENT TO DATE

Health for North East London published and distributed its Case for Change document in March 2009 (available separately). This document set out the ambition to make *Healthcare for London* happen in north east London and looks at the key reasons why changes are needed to the local NHS. The Case for Change was intended as a platform from which to build patient, public and stakeholder engagement and ensure meaningful involvement in the development of the clinical vision and proposals for change.

Engagement with patients, the public and stakeholders has been formed around four key areas:

- Building on previous consultations and engagement work
- Events open to the public
- Work with the engaged public using mechanisms such as LINks and the People's Platform
- Engagement with Overview and Scrutiny Committees

A detailed account of all pre-consultation engagement activity undertaken can be found on the *Health for North East London* website www.healthfornel.nhs.uk.

1.8.1 Stakeholder engagement builds on previous consultations

Engagement undertaken for *Health for North East London* builds on previous pan-London and local consultation exercises, namely, *Healthcare for London* which consulted across the capital and *Fit for the Future*, an engagement exercise covering the PCTs of Barking and Dagenham, Havering, Redbridge and Waltham Forest.

7.1.1 Healthcare for London

Residents of north east London were part of the London-wide *Healthcare for London* consultations. These comprised:

- *Healthcare for London: Consulting the Capital* ~ during January to March 2009 Healthcare for London held a public consultation on the contents of *A Framework for Action*. The document set out proposals for improving care from birth through to end-of life.
- *Healthcare for London: the Shape of Things to Come* ~ during January to May 2009 a public consultation was held regarding plans to improve stroke and major trauma services. This programme reported in July 2009 and confirmed that for north east London, major trauma services will be provided at the Royal London hospital, with hyper-acute stroke units at the Royal London and Queen's hospital.

NHS organisations in north east London took an active role in bringing these pan-London consultations to local residents, NHS staff and wider stakeholders. PCTs took a lead in the consultation and acute trusts were key stakeholders; each PCT undertook road shows throughout their locality and held a series of public meetings.

The pan-London consultations showed significant support for the principles contained in *A Framework for Action*. In July 2009 north east London commissioned an analysis of consultation responses in north east London PCTs which identified key points of difference and similarity in the pattern of responses from individuals living in north east London compared to the London wide picture. This report is available on the *Health for North East London* website.

7.1.2 Fit for the Future

During 2007 outer north east London PCTs established a programme, *Fit for the Future*, as the vehicle for initiating a review of acute hospital services to ensure clinical and financial sustainability in the outer sector into the future. As part of the external review process the programme received advice from the National Clinical Advisory Team (NCAT) at an early stage. NCAT commended the sector on the work it had done in developing a robust out of hospital strategy but advised that a range of these services needed to be in place to improve the service pathways. NCAT also advised that greater clinical leadership should be embedded into the governance of the programme.

In discussions between PCTs to address these points, and in light of pan-London developments including *Healthcare for London* and changes to the organisational landscape for primary care trusts and their influence on acute commissioning, it was decided that the timing of the review was no longer appropriate. The sector did however continue to implement the recommendations relating to care outside of hospital as part of their collaborative commissioning initiatives. These plans have been revised to take into account the polyclinic vision described in *Healthcare for London's A Framework for Action*. Three of the first seven polyclinics in London have been opened in north east London: Loxford in Redbridge, Oliver Road in Waltham Forest and the Barkantine, in Tower Hamlets.

In 2008 it was agreed that a new programme should be established to take forward a whole system transformation covering the whole of north east London, *Health for North East London*. As part of the set-up of *Health for North East London* as a new programme, the lessons learned from Fit for the Future were integrated into the programme arrangements and plan.

1.8.2 Other public engagement

a. ENGAGEMENT EVENTS

During the early part of the programme set-up, engagement events have generally been co-ordinated by the *Health for North East London* programme team on a pan north east London basis. As the programme has reached the stage of forming proposals and nearing consultation, much of the responsibility for engagement events has been taken on by individual PCTs with a more local focus.

The following five engagement events were co-ordinated by the *Health for North East London* programme team on a pan north east London basis:

- **April 23-26th: four workshops to develop a set of criteria for the non-financial options appraisal process.** A total of 119 people took part in the four workshops, including members of the public, managers, engaged public (such as LINks) and clinicians from across the sector. The aim of these workshops was to help develop a series of criteria that were later used to differentiate options for change and determine

the proposals to be tested during public consultation. These workshops were independently facilitated by Opinion Leader.

- **May 6th: an event aimed at local clinicians to raise awareness and clinical involvement in the programme.** There were over 200 participants including acute care consultants, GPs, midwives, nurses and managers. There was also representation from NHS London, local mental health trusts and community healthcare providers.

- **June 1st – 10th: a series of public meetings to share information about the programme and widen participation.** Meetings were advertised through local press and PCT and acute trust communications cascades. Information was shared on the principles of *Healthcare for London*, such as *local where possible; centralise where necessary* as they applied to north east London. Attendees confirmed their support for these principles and support for a subsequent consultation on the detailed proposals. They also expressed their wish to have further information on proposals for change.

- **June 2nd: a full day event for NHS organisations and key local stakeholders.** North east London NHS organisations were invited to attend, along with representatives from each Overview and Scrutiny Committee and LINks group and some local authorities also attended. Attendees were provided with information on possible options for change on a non-site specific basis i.e. three-site, four-site, five-site and six-site options for acute service configurations.

- **August 18th: public and stakeholder involvement in weighting the decision-criteria.** The general public, engaged public, clinicians and managers were involved. The objective was to understand attendees' priorities in relation to the decision criteria and weight these accordingly when short listing the options for change.

- **November 23rd: Joint JCPCT meeting held in public.** The meeting at which the two JCPCTs will consider the recommendations for consultation contained in the PCBC is to be open to the public. Advertisements have been placed in the local media inviting the public to attend and invitations have issued via LINks and the People's Platform.

In addition to the events described above, individual PCTs have also held engagement events. For instance, NHS Havering held an open meeting for community and voluntary groups on 28th October 2009, NHS Barking and Dagenham's co-ordinated an event, facilitated by the local LINk on 29th October 2009, and NHS Redbridge have involved their primary care and community clinicians via presentations to all polysystems within their PCT area.

b. LOCAL INVOLVEMENT NETWORKS (LINKS)

Health for North East London is working in partnership with eight LINks groups; coterminous with PCTs with the exception of two groups for City and Hackney. Formal engagement with all LINks groups working together commenced 21 May 2009, with ongoing engagement since this time. The LINks have formed their own *Health for North East London* working group which has since met on a monthly basis and includes attendance from the *Health for North East London* programme team.

A series of engagement meetings have taken place between the programme team and LINks groups as well as the programme being part of wider discussions within the ongoing relationship between PCTs and LINks groups. LINks' involvement in engagement events has been encouraged and attendance has been good.

c. THE PEOPLE'S PLATFORM

In consultation with LINk members and Overview and Scrutiny Committee officers, two People's Platform's, to represent inner north east and outer north east London, have been formed. These will:

- advise on the scope and inclusivity of public consultation and engagement, and on consultation material
- represent patient and public interests in discussions on the development of services
- challenge the programme to ensure that recommendations arising from consultations fully represent the interests expressed by patients and the public
- advise the programme on pre-consultation activity, consultation methods and materials, as well as formally considering the proposals and making recommendations to the programme.

Each group's membership comprises LINks members and members of the public. Members of the public were recruited by public advertisements in newspapers and PCT / hospital / LINks cascades. At a recruitment event on 21 October independent assessors selected the public members of the group from those that had applied. People's Platform members have subsequently met to discuss and comment on the proposed consultation questions (a summary of this event is available separately).

d. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEES

There are eight Overview and Scrutiny Committees (OSCs) in north east London, co-terminus with PCT areas, with the exception of two groups for City and Hackney. As part of *Fit for the Future* outer north east London OSCs had already formed a Joint Health Overview and Scrutiny Committee (JHOSC) which was continued for *Health for North East London.* Inner north east London OSCs subsequently agreed to form a JHOSC for the inner sector for this purpose.

Formal engagement began in March 2009 when the Senior Responsible Owners presented to their respective OSCs about the *Health for North East London* programme scope and objectives. A subsequent meeting on 30 July 2009 brought together the eight OSCs. It was at this meeting that a formal agreement was made of a two JHOSC structure for *Health for north east London.* In addition to formal engagement via the programme team, individual PCTs have maintained a dialogue with their local OSC about the *Health for North East London* programme via their usual channels.

Each JHOSC has nominated an officer to service the JHOSC in conjunction with the appointed OSC officers and to work with the programme team. The JHOSC officers have been in regular contact with the programme team and were invited to the full day engagement event held 2 June 2009. They have also attended the LINks working group meeting where decisions were taken on the formation of the People's Platforms and the process for delivering the consultation in partnership with LINks.

1.9 INTEGRATED IMPACT ASSESSMENT

An impact assessment is a statutory requirement intended to support NHS bodies in the consideration of environmental, equality and diversity issues in the design, development and delivery of policies and services across the health sector.

For the purpose of the *Health for North East London* programme, an integrated impact assessment has been commissioned to analyse the effects on health inequalities and equalities, travel access, and carbon footprint expected to result from *Health for North East London's* proposals in respect to the community in and around the seven boroughs of north east London.

The integrated impact assessment will consist of three key phases:

- A pre-consultation initial assessment report;
- A focused assessment and draft output report, to be undertaken in parallel with the broader consultation piece; and
- A post-consultation final output report, including recommendations.

The results of the integrated impact assessment will support the JCPCTs to make an informed decision on the proposed changes, alongside the response from public consultation and the final business case.

1.10 THE STRUCTURE OF THE PRE-CONSULTATION BUSINESS CASE

The remainder of the PCBC is structured as follows:

- **Chapter 2** sets out the clinical case for change and the vision for the future of acute healthcare delivery in north east London;
- **Chapter 3** outlines the benefits realisation expected from the reconfiguration proposals, with particular emphasis on benefits for patients and staff;
- **Chapter 4** provides information on the financial context of north east London from the commissioner and the provider perspective;
- **Chapter 5** describes the non-financial options appraisal process to identify the shortlist of reconfiguration options;
- **Chapter 6** details the financial assessment of each of the shortlisted process;
- **Chapter 7** sets out the recommendation of the clinical proposals for change by *Health for North East London* Programme Board for consideration by the JCPCTs;
- **Chapter 8** describes the detail of the clinical proposals for change and the changes required to realise the vision of this option;
- **Chapter 9** considers the impact of the proposals for change on the financial position of acute trusts, PCTs and the health economy as a whole;
- **Chapter 10** reviews the re-distribution of activity at each hospital as a result of the proposals for change;

- **Chapter 11** outlines plans for transition and implementation of the proposals for change.

- **Chapter 12** details the approval process required by the JCPCTs with regard to the clinical proposals for change;

- **Chapter 13** details the next stages of work for public consultation on the proposals.

1.11 FINANCIAL ANALYSIS CONTAINED WITHIN THIS BUSINESS CASE

Financial analysis to support this business case is contained throughout this document:

- Chapter 4, *Financial Context Across North East London*, describes the financial landscape across the health economy until 2016/17 for both commissioners and acute providers. For the PCTs there will be period when allocations will, at best, keep up with inflation. For PCTs to maintain financial balance at a time when demand for services is increasing there will have to be a material change to the way that services are delivered that will include decommissioning some services and changing the settings from which care is delivered. For acute providers there will be a significant reduction in their income that will mean that there will have to be reductions to spending of the order of 32% of current costs.

  The supporting appendix D gives the assumptions that went into the financial modelling. Appendix E contains income and expenditure forecasts for the five acute providers before and after productivity gains.

- Chapter 6, *Financial Assessment of Options*, contrasts the financial effect of each of the options selected. The financial tests that are being applied to the options are:

  - Would the changes proposed in any of the options increase the cost of operating any provider following reconfiguration?

  - Is the financial viability of any provider put at risk as a result of the reconfiguration?

  The selection of the options is based on non-financial criteria and has not been financially driven. The conclusion reached is that all three of the shortlisted options meet the financial tests.

  The supporting appendix K shows the projected income and expenditure of the five providers under each of the shortlisted options.

- Chapter 9, *Financial Analysis of the Clinical Proposals for Change*, provides detailed financial information about the preferred option. This includes the changes to income and expenditure forecast for each of the providers, the capital investment that will be required and the transition costs.

  The conclusion reached is that the preferred option will improve the financial viability of BHRUHT, Newham and Whipps Cross Trusts. The transitional costs, £24m, will be absorbed into the running costs of the trusts. The Capital costs, £19.6m, will be met either as a new PFI contract at Queen's Hospital or will be met by a capital receipts on the sale of part of the King George site.

The supporting appendix L gives full income and expenditure forecasts for the five acute providers.

1.12 FURTHER SUPPORTING INFORMATION

Whilst the documents which relate directly to the PCBC are included as appendices, there are a number of relevant documents which can be accessed separately and are available on the *Health for North East London* website at www.healthfornel.nhs.uk

These documents are;

1. **Clinical Working Group (CWG) reports ~** a summary of the deliberations of each of the six CWGs including the case for change, vision and detailed recommendations for each clinical service area.

2. **National Clinical Advisory groups (NCAT) reports** ~ written reports following the two NCAT reviews.

3. **PCT plans for transforming primary and community care ~** the detailed plans for development of polysystems and other improvements to out of hospital care. *Available December 2009.*

4. **Non-financial options appraisal supporting information ~** several documents are available which provide further detail on specific aspects of the appraisal process, such as scoring of options for maternity services.

5. **PCT consultation and engagement plans ~** PCT plans events, engagement and other activities to be undertaken during the public consultation period.

2. THE CLINICAL CASE FOR CHANGE AND VISION FOR THE FUTURE

This chapter considers the factors that are driving the need for change and sets out the vision of how services will look, and what benefits will be delivered to patients, once change is achieved. The chapter is structured into four sections, comprising:

- **Section 2.1** describes how *Health for North East London* leads on from the principles set out in *Healthcare for London: A Framework for Action*;
- **Section 2.2** examines the six key reasons that change is needed and the overall vision of health services in north east London;
- **Section 2.3** identifies the vision for the future
- **Section 2.4** reviews six clinical areas of focus, articulates the case for change for each area and;
- **Section 2.4** describes the process of moving from the vision contained in this document to implementation.

2.1 FROM *HEALTHCARE FOR LONDON* TO *HEALTH FOR NORTH EAST LONDON*

The case for change stems from *Healthcare for London: a Framework for Action* and the *Next Stage Review* which together set the vision for the future of healthcare in terms of clinical quality, patient satisfaction and sustainability. The aspirations for healthcare described by these documents, as well as the mechanisms for achieving the aspirations, have been formally consulted on and have gained significant clinical and public support.

Analysis of the responses to *Healthcare for London: a Framework for Action* from residents of north east London gives us valuable insight into what local people want and value from their health services. In particular, we know that:

- Over 50% of those expressing a view supported the concentration of specialist care of children in fewer hospitals – even though this could be further from their home. A safer, higher quality, service was more important to them. Support was even stronger (over 60%) for concentration of complex emergency surgery.
- Over two thirds of respondents wanted to see a greater proportion of the money currently spent on hospital care for people with long-term conditions spent on supporting people in the community.
- People wanted to see treatment of some conditions moved to specialist hospitals and more outpatient care, minor procedures and tests in the community. Only 20% of respondents wanted the NHS to continue to provide services in the same way as now, with most hospitals providing most services.

North east London clinicians have expressed their support for the principles of *Healthcare for London* and PCTs are committed to delivering the ambition of *Healthcare for London* and applying the principles for change to the north east London context to achieve real improvements for patients.

The key principles of *Healthcare for London: a Framework for Action* are:

1. Services focused on individual needs and choices

2. Localise where possible, centralise where necessary

3. Truly integrated care and partnership working, maximising the contribution of the entire workforce

4. Prevention is better than cure

5. A focus on health inequalities and diversity

Healthcare for London also sets out seven models of healthcare provision for the future:

- More healthcare should be provided at **home**
- New facilities – **polyclinics** – should be developed that can offer a far greater range of services than currently offered in GP practices, whilst being more accessible and less medicalised than hospitals
- **Local hospitals** should provide the majority of inpatient care
- Most high-throughput elective surgery should be provided in **elective centres**
- Some hospitals should be designated as **major acute hospitals**, handling the most complex treatments
- Existing **specialist hospitals** should be valued and other hospitals should be encouraged to specialise
- **Academic Health Science Centres** should be developed in London to be centres of clinical and research excellence

The *Health for North East London* programme takes *Healthcare for London* as its cue and refines the five key principles and seven settings of care for the specific needs and requirements of north east London.

2.2 THE SIX KEY REASONS FOR CHANGE AND THE VISION FOR NORTH EAST LONDON

The rationale for changing now is to ensure the immediate and longer-term clinical viability of health services in north east London. Whilst there have been considerable achievements in the last few years, most notably in reducing waiting lists and increasing survival rates for cancer and coronary heart disease, health indicators still show that north east London is worse off than other areas in London and England.

There are six key reasons for making significant changes in the way we deliver healthcare in the sector:

7. **Reason one**: we need to improve the health of people in north east London and ensure healthcare services are meeting public expectations

8. **Reason two**: the population of north east London is rising rapidly leading to greater demand on health services

9. **Reason three:** hospital is not always the answer; more care can be delivered in community settings than ever before and patients benefit from care closer to home

10. **Reason four**: there are workforce challenges which currently prevent delivery of the best quality care and optimal patient outcomes

11. **Reason five:** the need to adopt new models of care and best practice which can deliver better outcomes for patients

12. **Reason six:** the need to make best use of taxpayers' money

2.2.1 Reason one: we need to improve the health of people in north east London and ensure healthcare services are meeting their expectations

North east London is facing a bigger health challenge than any other London sector. Key health indicators are poor; the local population has a lower life expectancy, higher rates of infant death and higher mortality rates from cancer and cardiovascular disease than other London sectors. There is a high incidence of long term conditions such as diabetes, chronic obstructive pulmonary disease (COPD), hypertension and cardiovascular disease as well as high rates of mental illness and infections such as tuberculosis (TB) and HIV. Social, environmental and lifestyle are all contributing factors to the health of the population and all can play a critical role in making positive change. Local people need more help to adopt healthy lifestyles and prevent ill health.

We know that health services in north east London are not performing as well as we should expect in terms of quality or productivity. There are some examples of excellent practice and performance in the local NHS, but there is too much variation, meaning some patients do not receive the best possible care that others benefit from. Overall, the NHS in north east London performs too low on mortality rates, patient satisfaction and performance targets such as waiting times. The table that follows shows the ratings given to acute trusts in north east London in October 2009 by the Care Quality Commission.

Care Quality Commission hospital performance data

	Overall quality mark	Use of resources	Children's services	Maternity services	Patient satisfaction	Mortality ratio
Homerton	Excellent	Excellent	Good	Weak	Worse than average	Average
Whipps Cross	Good	Weak	Fair	Fair	Worse than average	Average
Barts and the London	Weak	Fair	Good	Weak	Average	Better than average
Newham	Good	Fair	Good	Weak	Average	Worse than average
Barking, Havering, Redbridge	Weak	Weak	Fair	Weak	Worse than average	Worse than average

There is much public support for the work done by the NHS; however, health services in north east London are not meeting the expectations of the local population. Levels of patient satisfaction are lower locally than the average level for England. A prominent issue for patients is cleanliness and the condition of the clinical facilities. We know that patients will

consider cleanliness as a factor that would influence their choice of hospital and patient satisfaction is higher when patients are treated in modern, well-equipped buildings.

Prevention is better than cure and commissioners need to ensure there is sufficient focus on prompting self-care and preventing ill-health, as well as working with local partners to ensure a holistic approach addressing the wider determinants of health.

2.2.2 Reason two: the population of north east London is rising rapidly

The population of north east London is projected to rise significantly, taking the population from 1.5 million in 2007 people to nearly 1.8 million in 2017. A higher than average birth rate contributes to this rise, with particularly high rates in the borough of Newham and Tower Hamlets, which have almost double the average birth rate for England. In addition, many young people and families are moving to north east London as a result of local regeneration and increasing employment opportunities. This means that, compared to other parts of the country, north east London has a greater proportion of young people. A consequence of this is that the local NHS must focus on the health needs of pregnant women and those of children and young people.

Conversely, Havering has an older population than any other London borough. North east London must therefore ensure that the full range of birth to end-of-life healthcare services is delivered in a way that ensures high quality outcomes for patients.

The coupling of high incidence of health need and a fast growing population means demand for health services in north east London is set to increase in volume and complexity. Commissioners of health services must ensure that the response to this need is to provide the most appropriate services in the most appropriate settings, ensuring they are high quality and patient-focused. The high incidence of illness and below-average health indicators in north east London tells us that provision of the same type of services is not the answer for the future.

2.2.3 Reason three: the hospital is not always the answer; more care can be delivered outside hospital settings than ever before and patients benefit from care closer to home

There is considerable evidence, as set out in *Healthcare for London: a Framework for Action* and the White Paper: *Our health, our care, our say*, that many people currently attending hospital could be cared for closer to home.

Clinical advances mean that more care can be provided locally than ever before. For instance, modern surgery allows more procedures to be safely delivered as day cases, outside of major hospital settings. More outpatient appointments can take place in the community and diagnostics can move from hospitals to settings closer to home where they are more easily accessed by patients. Access to diagnostics has been highlighted as a substantial barrier to improved management of long term conditions and GPs often cite this as a constraint in managing patients more effectively in the primary care setting.

Patients with minor illnesses or injuries should be seen by the most appropriate professional with the right skills and experience. In many cases, patients will receive this, with improved continuity of care, when they are treated by primary care practitioners outside of hospital.

However, community-based services are frequently not providing a satisfactory alternative to the hospital. This can be seen clearly in the case of urgent care, with patients clearly indicating they are dissatisfied with the availability of their local GP services out of hours. For this reason, patients are relying on A&E for urgent care instead. In addition, patients often

access A&E because the service they really need does not exist, such as specialist nursing care for acute episodes caused by a long term condition. Consequently, north east London has very high rates of A&E attendances and A&E admissions, yet many of these patients would be better served by community-based services.

The vision of *Healthcare for London* is that much of this activity can be located in polyclinics where patients can benefit from the co-location of a wide range of services close to where they live. Clinicians in north east London recognise the importance of communication and integration between community and hospital services and see this as key to the future development of healthcare in the sector.

2.2.4 Reason four: there are workforce challenges which prevent delivery of the best quality care and optimal patient outcomes

Whilst drugs, equipment and increasingly IT infrastructure are important aspects of delivering high quality healthcare, the NHS' key asset is its staff. Suitably trained and practised staff, operating within the right team and in the right care setting has the greatest impact on health outcomes. To achieve the aim of delivering the best possible care in north east London, the NHS must ensure an appropriate workforce is available to resources services effectively.

1. The NHS in north east London faces a number of workforce challenges such as high staff turnover, prolonged vacancy rates, low staff utilisation and high sickness rates - all above average for London. There is variation within these rates – some trusts have significantly higher vacancy rates than others. Consequently, not all services are adequately equipped with the most appropriate workforce and the NHS spends large amounts of money employing agency staff; money that could otherwise be spent on direct patient care.

2. North east London's current configuration of hospital services means, for some clinical services, there are a high number of sites with smaller staff teams and an absence of a critical mass of workforce at each site. Consequently, where there are gaps in rotas as a result of vacancies, the service may be more vulnerable as a result.

Vacancy rates are, in part, due to national shortages of some clinical staff groups, such as paediatricians, midwives, radiologists and pathologists (these latter two are important because of the work they do to support A&E, surgery and other services). National shortages extend to the numbers of individuals currently entering training, meaning that shortages are expected to continue at least in the near future.

National shortages have a significant impact on the NHS' ability to recruit and retain staff. However, for north east London the impact is disproportionately worse than for other London sectors as insufficient numbers of staff are choosing to work in north east London. There are two key reasons identified for this trend:

- **Existing workforce challenges dissuade new trainees** – doctors in training require a requisite amount of supervision and support to achieve their required competencies and consolidate their skills. Some trainees may be reluctant to choose north east London for training because of a concern that workforce challenges means reduced supervision and support of trainees. A vicious circle exists whereby workforce challenges mean fewer trainees which leads to workforce challenges.

- **Clinical trainees typically look for opportunities to specialise** – staff frequently look to work in organisations and networks where their career can grow through access to a wider range of experience, multidisciplinary working and the potential

to specialise. North east London's current configuration of smaller teams with lower levels of patient throughput does not support this opportunity.

Furthermore, the NHS in north east London does not fully utilise its staff's abilities. For instance, doctors in a large acute hospital in London see fewer patients, by almost a quarter, compared to their counterparts elsewhere in England[3]. Similarly, nurses also see relatively fewer patients. We will examine the impact of this more closely in *reason five*.

Whilst there are significant workforce challenges within the sector, there are also important and exciting opportunities becoming available to NHS staff in north east London through changes in working models (see *reason five*), enhanced roles, especially for nurses and midwives, and the development of Health Innovation Education Clusters (HIEC). HIECs will enable high quality patient care and services by quickly bringing the benefits of research and innovation directly to patients, and by strengthening the co-ordination of education and training. The NHS in north east London must harness the benefits of these opportunities to attract, develop and retain its clinical workforce into the future.

2.2.5 Reason five: the need to adopt new models of care and best practice which can deliver better outcomes for patients

Healthcare is constantly evolving to deliver better outcomes to patients. Drugs, devices and IT are part of this innovation, but equally important are the ways in which NHS professionals can train and work differently to deliver improvements. Right now, north east London needs an increase in its skilled workforce to adopt models of care we know deliver improved patient outcomes. In the longer term, the NHS must be flexible enough to respond to changes and innovations in healthcare practice as they arise.

There are three immediate changes to which the NHS in north east London must respond to deliver high quality care:

a. A specialist-delivered model of care, including round the clock provision for urgent care services, to enable early decision-making to improve quality and safety;

b. Increasing sub-specialisation of acute services and the resulting consolidation of some services to support this;

c. Separate streaming of planned and emergency care pathways to improve quality and efficiency.

And one longer-term change that the sector must start planning for:

d. A reduction in hospital bed capacity as a consequence of improved prevention and services moving to community settings.

[3] Hospital Episode Statistics 2006/07

a. *A SPECIALIST-DELIVERED MODEL OF CARE, INCLUDING ROUND THE CLOCK PROVISION FOR URGENT CARE SERVICES*

A further consequence of the workforce challenges we saw in *Reason four* is that new models of care based on workforce arrangements cannot currently be adopted in north east London because of the gaps in skilled workforce. In particular, the move towards round the clock specialist-delivered care is currently out of reach for the NHS in north east London.

The term 'specialist' is used in this instance to refer to the most appropriate clinician to treat the patient. Often this is a consultant or a very senior doctor with significant relevant experience. At other times it may be a midwife or nurse practitioner.

Evidence shows that the earlier and more often a patient is seen by the most appropriate clinician within their pathway, the better the outcome. Studies tell us that if more care were to be delivered directly by fully trained specialists clinical outcomes would be improved and mortality rates would reduce.

There is also an increasing concern that junior doctors who have traditionally delivered the majority of patient-facing care are progressively less experienced and skilled than they have been. This is a consequence of two recent changes; the European Working Time Directive (EWTD) and Modernising Medical Careers (MMC). EWTD protects clinical safety by ensuring that trainee doctors do not work excessive hours by introducing a limit of 48 hours per week. MMC has redesigned training pathways to take into account the effect of EWTD, and the changing nature of healthcare delivery, whilst ensuring that training remains of the highest quality.

As a consequence of EWTD and MMC, clinical specialties are progressively increasing the number of hours per week of consultant presence, as well as developing new senior nursing roles such as nurse practitioner, and professional bodies are recommending that a specialist-delivered model of care should be adopted. For urgent care services, such as urgent medicine, urgent surgery and maternity, this often requires round the clock specialist presence.

North east London's workforce shortages are exacerbated by its configuration of hospitals. Six sites for a population of 1.5 million people means scarce workforce resources are spread thinly across the sector. This means that achieving a specialist-delivered model of care in hospitals is currently out of reach; with particular challenges for urgent surgery and maternity.

b. *INCREASING SUB-SPECIALISATION OF ACUTE SERVICES AND THE RESULTING CONSOLIDATION OF SERVICES TO SUPPORT THIS*

Advances in clinical practice and medical technology are leading to increasing specialisation of acute services. Specialties such as surgery, medicine, and obstetrics and gynaecology comprise many procedures that are highly technical yet small in volume. Better patient outcomes are achieved through sub-specialisation because patients are treated by a clinician who specialises in the specific type of care or surgical intervention required.

Sub-specialisation requires clinicians to see a sufficient volume of patients with a specific type of care or intervention needed to maintain and improve their clinical skills. Evidence shows that for a number of specialties improved patients outcomes are achieved when patients are treated by clinicians and teams who perform a higher volume of that specific care type. Consolidation of services onto fewer sites is sometimes required to increase the volumes and case-mix that can be treated by practitioners.

Some specialties have set guidelines recommending minimum patient caseloads in order for clinical trainees to gain appropriate competencies and for specialist clinicians to maintain their skills. Compared to the rest of the country, the average number of patients a specialist clinician in north east London is able to treat each year is much lower[4]. This is, in part, due to the need for a sufficient catchment population to ensure minimum patient caseloads. Some of the Royal Colleges have made recommendations for preferred catchment populations, but it is difficult to determine a figure that works for every geography and population mix. However, clinicians in north east London agree that the current configuration of hospitals does not enable sufficient catchment populations across the sector.

A key outcome of sub-specialisation is that as clinical practitioners become more specialised there is a trend away from generalisation. For example, in the recent past, breast surgeons carried out breast surgery but also took part in the general surgical rota, performing emergency procedures such as appendectomies, as required. Nowadays, breast surgeons are undertaking increasingly complex breast surgery to the extent that they participate less frequently in general surgical cover, and are no longer sufficiently experienced to perform an appendectomy to achieve an optimal patient outcome. Whilst sub-specialisation should be supported because of the clear improvements in outcomes to patients, north east London must mitigate against the risk of a lack of general surgeons by ensuring sufficient access to specialists round the clock, either through on-site provision or use of clinical networks.

c. SEPARATION OF PLANNED CARE AND EMERGENCY CARE PATHWAYS

Separation of planned care patients and emergencies, sometimes referred to as 'streaming' has been shown to provide significant benefits for patients in terms of quality outcomes and patient satisfaction. Streaming reduces the rates of healthcare acquired infections because planned care and emergency care patients are not sharing the same wards and planned care patients can be screened and treated in advance for infections.

Consolidation of high volumes of specific procedures contributes to improved clinical outcomes by achieving a clinical critical mass for training and practise of clinical specialists. High throughput also contributes to better productivity and improved use of resources.

Planned services in north east London are not currently configured in this way, with most services being co-located with emergency patients and a much thinner spread of volumes and case mix across all six hospital sites rather than achieving a critical mass through the use of elective centres.

d. A REDUCTION IN HOSPITAL BED CAPACITY AS A CONSEQUENCE OF IMPROVED PREVENTION AND SERVICES MOVING TO COMMUNITY SETTINGS

We know from *Reason Three* that clinical advances and improvements in community based care is leading to a lot of healthcare being delivered outside of hospitals. We also know that a focus on preventing ill-health and supporting self-care will mean a reduction in the number of A&E attendances and emergency admissions. These factors, plus improvements in quality and productivity (like lower average length of stay and better discharge procedures) are pointing to a reduction in the need for hospital capacity.

[4] Hospital Episode Statistics data 2006 and 2007

Detailed capacity modeling tells us that in the longer term, despite the rapidly growing population, the NHS in north east London will not require any additional hospital beds. Increases in capacity will need to be in community-based healthcare settings such as polyclinics. There are some exceptions, the key one being in maternity services, where hospital capacity does need to increase.

Healthcare commissioners must therefore ensure that the configuration of services meets this future picture of demand and that the NHS is flexible enough to respond to reductions in demand for hospital services. One difficulty with the current configuration in north east London is that as capacity becomes available, it tends to be spread out across the sector. This means that most hospitals have some unused clinical space on their site; hence money is spent to heat, light, clean and maintain buildings even though they are not being fully utilised.

2.2.6 Reason six: the need to make best use of taxpayers' money

Many hospitals in north east London deliver their services at a cost 'above-tariff'[5]. This means that their costs are higher than the tariff price - the price paid by commissioners - and consequently, the hospitals are making a loss every time they undertake a service at a cost above the tariff price. This had led to three trusts in the sector requiring additional support via the Challenged Trust Board to improve their financial position.

The Care Quality Commission's October 2009 assessment of north east London trust's financial performance shows that improvements are urgently required if they are to be financially viable in the future. Three of the five acute trusts received an overall rating of 'weak', with Barking, Havering and Redbridge receiving an 'inadequate' rating for three out of five measurement categories (financial reporting, financial management, and financial standing).

The position for all trusts is expected to become more challenging as we move from a ten year period of expansionary growth to a 'steady state' of lower annual growth. There will be a greater need for hospitals to operate at or below tariff price to maintain financial viability. Projections show that hospital costs are increasing faster than tariff prices which means the future financial situation is looking worse not better.

Whilst some of these increases are linked to growth in pay costs which may start to slow, it is unlikely that drug costs, medical devices costs and other costs linked to clinical interventions will slow down. Providers will therefore have to look at innovative ways to reduce their costs. There are two broad approaches providers are taking: firstly, improvements in the quality of care delivered to patients can reduce the demand for lengthy hospital stays and the most expensive treatments and interventions. For example, effective management of long term conditions in the community reduces the likelihood of A&E attendances to treat an acute episode, and when a specialist sees a patient early on in their care pathway and has access to a full range of diagnostics; the patient's length of stay is reduced. Secondly, savings can be made from reducing fixed costs and overheads. Duplication of some clinical services across many hospital sites in north east London means higher costs without clinical justification.

[5] Healthcare for London forecast for north east London PCTs

2.3 THE VISION FOR HEALTHCARE IN NORTH EAST LONDON

The vision for health care in north east London is that the local population will enjoy health, well-being and independence equal to the best in London. Wherever possible people will take responsibility for maintaining their own well-being in their own homes, supported by trained community professionals, with out of hospital services accessible in locations close to people's homes and available at convenient times, and when acute care is needed, hospital services that deliver the highest quality clinical outcomes.

Whilst substantial changes are needed to hospitals to make the vision for north east London a reality, commissioners have given a firm commitment that all of the existing hospital sites will continue to provide healthcare services. The shape of services at each hospital will need to change significantly to reflect the changing demand and reduced reliance on hospital inpatient facilities, and provide a more diverse mix of hospital, primary, community and social care available where people need them.

For local people, putting out of hospital care at the heart of the vision for addressing the health needs in north east London will mean that as well as securing high quality hospital services they will also have improved access to services such as general practice, urgent care, intermediate care and more support to self care and maintaining independent and active lives. This is particularly pertinent given the high, and rising, incidence of long term conditions in the sector.

The vision for health services in north east London is one firmly driven by clinical evidence. New models of care and evidence-based trends that deliver improvements in patient outcomes, such as sub-specialisation and round the clock specialist-delivered care, will be adopted and supported. Our aspiration is that this dynamic and forward-thinking approach will attract a first class multidisciplinary workforce as well as investment for training and research, leading to north east London recognised as a sector of choice for the very best specialists.

An appropriately trained and skilled workforce with the opportunities to maintain and improve their clinical ability will staff this NHS, backed-up by necessary equipment, facilities and IT infrastructure. Care will be centred on delivering optimal clinical outcomes as well as patient satisfaction, which will be reflected in the accessibility of services close to people's homes with no lengthy travel times to access health services locally.

This vision will ensure a strong, viable health economy for the future, sufficiently flexible to respond to changes and growth in demand, and one that makes efficient use of existing facilities and financial resources.

2.3.1 Changes already underway

Five key changes have already been agreed and are being implemented to achieve the vision described for north east London, and set the context for the reconfiguration of acute services. These are summarised below and examined in more detail in the paragraphs that follow:

a. Implementation of **Urgent Care Services (UCS)** model that absorbs a minimum of 40% of all A&E attendances

b. **Polysystems** established throughout north east London with polyclinics as their hub

c. Primary care-led **clinical pathway transformation** programme enables reductions in hospital activity levels

d. **Quality and productivity improvements** at all hospitals and in primary and community care services

e. **Paediatric Assessment and Treatment services (PATS)** operational at all hospitals with A&E services

The case for change has confirmed that in order to transform healthcare delivery, it is essential that we adopt a whole systems approach. *Healthcare for London* described how care delivery could be transformed by providing care across a new provider landscape which included the introduction of polysystems to support extended care outside hospital. *Health for North East London* has subsequently articulated a future landscape for acute services and the interdependency with primary care and community health services. Commissioners across north east London have responded to the challenge by developing borough-based care outside hospital strategies.

The shift of services to the community is not a one for one movement of current care but a new vision for a primary and community based system of care, particularly as regards the care of people with long term conditions. Primary care clinicians will work with secondary care clinicians in new ways to provide integrated, individualised care (for more detail, the planned care clinical workstream paper is available separately). Care pathways will be redesigned to support patients to manage their own care and to stay as healthy as possible, with a risk stratification approach targeting support to the most vulnerable and co-ordinating specialist inputs where required. The approach will be multidisciplinary with much care led and delivered by nursing and therapy staff.

It is estimated that the implementation of this vision will see current outpatient activity reduce by up to 20%, with at least 40% of current outpatient and diagnostic activity will be provided in community and primary care settings in the future. All PCTs are currently developing 'transforming primary and community care' plans (available separately) as part of the strategic planning process, with detailed planning in respect of polyclinics and polysystems. In addition to the three polyclinics already operational (Barkantine, Tower Hamlets; Loxford, Redbridge; and Oliver Road, Waltham Forest), PCTs plans also include creating a single point of access and rapid response team to improve end of life services (Tower Hamlets PCT) and implementation of a physical activity care pathway to provide one-to-one support for individuals at immediate risk of inactivity-related ill health (Newham PCT).

PCT plans use assumptions regarding levels of activity involved in the shift to care outside hospitals developed by Healthcare for London; these assumptions have been reviewed by the *Health for North East London* Clinical Working Groups (CWGs) and refined for the local healthcare context. These plans will form part of PCT's annual Commissioning Strategic Plans and will be available in December 2009.

a. URGENT CARE SERVICES (UCS)

All hospitals will have a single emergency access point with a primary care managed urgent care service (UCS). The UCS is likely to operate round the clock and will act as a front-door to A&E which will mean that only patients with serious or life threatening conditions need to be treated within the acute hospital setting of an A&E department.

Detailed work undertaken locally and by *Healthcare for London* estimates that a minimum of 40% of current A&E attendances could be undertaken by UCS, with additional benefits of improving continuity of care through primary care management, ensuring all patients see the most appropriate clinician for their condition, and enabling A&E to focus on patients with serious or life-threatening conditions. However, it is estimated that this figure could rise to between 60% and 75% of A&E activity, with on-site access to next-day outpatient services

for specialist assessment and treatment, which could be especially beneficial for people living with a long term condition, who, without these services, frequently attend A&E for urgent care. As an example, local analysis has identified that 85% of people attending King George A&E do not require hospital admission, therefore, 60-75% of current A&E activity being re-provided elsewhere is considered to be a very achievable proportion.

b. PRIMARY CARE-LED CLINICAL PATHWAY TRANSFORMATION PROGRAMME

The clinical view is that a proportion of demand for hospital services could be significantly reduced with changes to care pathways and improvements to both the access and the quality of prevention-services in the community. Improved access to services such as general practice, urgent care, intermediate care and more support to self care and maintaining independent and active lives will help to keep the local population well and out of hospital. This is particularly pertinent for people living with long term conditions.

As part of PCT demand management strategies, access and quality of services will be reviewed to ensure patients have every opportunity for self care and maintaining their well-being without requiring attendance at A&E or admission to hospital. New and proactive services will also be considered, particularly those for management of long term conditions.

c. POLYSYSTEMS

Polysystems, with polyclinics at their hub will be established throughout north east London. Polyclinics at Loxford (Redbridge), the Barkantine (Tower Hamlets) and Oliver Road (Waltham Forest) are already operational and delivering a range of services in support of the care outside hospital ethos. In total, almost 30 polyclinics are planned to be established in north east London over the next five years. They will provide a range of services including community services, diagnostics, GP services, interactive health information services, minor procedures, ongoing care for long term conditions, outpatient services, pharmacy and urgent care. The full list of planned polyclinics and planned opening dates can be found at *Appendix B*.

Polyclinics will offer local people easier access to services through extended primary care opening hours such as 8am - 8pm, seven days a week, and a wider range of clinical services. Because polysystems are primary-care led, patients will benefit from continuity of care as well as high quality care. This will be of particular benefit to people living with a long term condition which often requires repeat attendance at an outpatient clinic for ongoing monitoring and care management. Supported by easier access to diagnostic services, which will be provided on site at the polyclinic, a range of general outpatient clinics will also be re-provided within the community, working with integrated clinical teams to improve the efficiency of care pathways and the overall experience of patients using the local NHS services.

North east London is committed to establishing polysystems in locations that provide convenient access to the population. Whilst many people will be within walking distance of a polyclinic, we expect a maximum travel distance of 15 minutes (by car; or 30 minutes by public transport) for the majority of people.

d. QUALITY AND PRODUCTIVITY IMPROVEMENTS

As we saw in the case for change, healthcare services in north east London are performing below average for England, indicators such as GP access, rates of healthcare acquired infections, average length of stay, hospital readmission rates and patient satisfaction levels

tell commissioners that the local NHS can do better to provide a high quality service to patients, ensuring that maximum clinical benefit is delivered using the fewest necessary resources.

All healthcare providers in north east London are focusing on identifying priority areas for quality and productivity and putting in place large scale improvement programmes involving pathway redesign and development of appropriate clinical networks.

e. PAEDIATRIC ASSESSMENT AND TREATMENT SERVICES (PATS)

One of the enabling milestones for the proposals for reconfiguration is the implementation of Paediatric Assessment and Treatment services (PATS) at all hospitals with A&E services. PATS will ensure high quality clinical services are delivered to children and the overall experience for both child and family is markedly improved.

All A&E departments will be supported by round the clock paediatric assessment and treatment services, with a facility for short inpatient stays of less than 48 hours. The goal is to provide a specialised paediatric service that will provide early senior assessment with a view to minimising admissions (or reducing length of stay if admission is clinically appropriate) and identifying as quickly as possible alternative services most appropriate to the needs of the individual child.

2.4 THE CASE FOR CHANGE FOR SIX CLINICAL AREAS

The *Health for North East London* programme commissioned clinical working groups (CWGs) to assess the extent of the issues for six priority acute services. They articulated the case for change and identified the vision, proposing solutions to improve health outcomes that will secure quality, affordable health care and fit with the overall vision improving healthcare in the sector.

2.4.1 Children and young people's services

a. THE CASE FOR CHANGE FOR CHILDREN AND YOUNG PEOPLE'S SERVICES

A high proportion of A&E attendances are children attending with minor illness and injuries. This reliance on A&E is a reflection that out of hospital urgent care services are not always accessible to patients. Whilst many children will receive good quality care attending A&E, the extent of variation in service performance in north east London means some children are not always seen by an experienced paediatric clinician.

The very high birth rate in north east London means the sector has a high, and increasing, proportion of children and young people. Ensuring paediatric services are of consistent high quality and accessibility is therefore a priority for the sector.

Whilst basic paediatrics is provided at a quality standard in line with England averages, specialist and surgical paediatrics is not consistently good enough. There is significant variation between different service providers of paediatric surgery within the sector. For emergency paediatric surgery the Healthcare Commission rated four trusts as 'fair' and one as 'poor'. For elective surgery trusts' ratings varied between 'excellent', 'fair' and 'poor'. This variation in quality is partly as a result of variation across the sector of access to clinicians trained in the care of children and young people, with some children being treated by adult specialists.

Currently, the provision of specialist paediatric services is scattered. All hospital sites within north east London provide some form of acute paediatric service, but very specialist services for children can only be found outside of the sector meaning that many children are referred or transferred for treatment further away from home. As a result paediatric tertiary centres such as Great Ormond Street are increasingly experiencing capacity constraints meaning waiting times for north east London patients are going up. Whilst some children will always need to be transferred to tertiary centres, some of this type of care can be provided within the sector. As we know that children benefit when treated close to home, many patients would be better served by the provision of specialist services within the sector.

The Royal College of Paediatrics and Child Health (RCPCH) states that, wherever possible, children should be treated by paediatric specialists in separate dedicated or child-focused facilities. North east London does not yet meet the RCPCH's vision; the majority of the six hospital sites with A&E departments do not have arrangements for extended specialist presence to support the assessment and treatment of children who attend A&E. One outcome of the lack of early specialist review is that children often stay in hospital longer than needed.

The workforce constraints in north east London extend to paediatric specialists. The national shortage of paediatricians is reflected locally and compounded by a local shortage of paediatric nurses. There is a consensus amongst local paediatric clinicians that the continued impact of MMC and EWTD over the next few years on the numbers of staff required to maintain high quality services, will mean that sustaining a full range of paediatric services at the current configuration of six sites will not be possible. North east London is not alone in this; it is estimated that up to a quarter of paediatric units across England may not be sustainable to deliver high quality services into the future[6].

Increasing sub-specialisation has led to much lower percentages of surgeons remaining involved with children and with a very low uptake of training opportunities in general paediatric surgery the pipeline of new clinical staff remains below demand for at least the next few years. One impact of this workforce challenge is the transfer of children to specialist centres out of sector, in order to maintain clinical safety.

Specific evidence is available for paediatric services which indicates patient outcomes are improved where clinical practitioners learn and maintain their skills by treating a greater number of children. There is great variation in the volume of paediatric activity undertaken at each hospital site with some units much smaller than others[7]. This variation in activity volume is linked to variation in the quality of clinical outcomes for children. It is the view of paediatric clinicians in north east London that the sector should be moving to a position where higher volumes per practitioner can be more easily realised.

b. THE VISION FOR CHILDREN'S SERVICES

Many conditions that commonly used to result in a child being admitted to hospital are now rare and hospital-based care should be the exception in children's services. The majority of paediatric illness can be appropriately managed within the home and there is greater scope for more planned care to be provided outside of hospital particularly for children with long

[6] *A Framework for Action*, Healthcare for London 2007

[7] Trust reported data 2007/08

term conditions. The vision for the future is a service model which properly integrates primary care and acute care, is accessible when needed and has an emphasis on self-care.

A crucial element of the vision for children's services is to introduce a single model of paediatric assessment and treatment services (PATS) on all sites with an A&E department. This vision is based on the Starlight Children's Unit at the Homerton University Hospital. PATS should be a round the clock child-focused service with extended specialist presence to facilitate rapid senior assessment of children. This will ensure children are much more likely to be seen and treated by a specialist in the care of children rather than by an adult specialist. The introduction of PATS is intended to improve clinical outcomes and children's safety as well as minimise the need for admission to hospital. PATS will need to be developed as part of wider sector networks for paediatrics, with co-ordination across all providers including standardised protocols and pathways.

The north east London clinical vision for PATS services goes beyond the recommendations made by *Healthcare for London* by recommending round the clock provision of paediatric support to hospitals with A&E departments rather than the 12-hours a day recommended by *Healthcare for London*. Local clinicians believe that a round the clock service is right for the levels of demand and healthcare needs in north east London vision but recognise that this position may need to be reviewed over time to ensure sustainability.

We have seen in the case for change that there are significant workforce challenges facing north east London's ability to maintain safe and high quality services. Paediatric clinicians recommend reconfiguring to provide specialist paediatric services on fewer, ideally two, hospital sites, in line with the sector's vision for two major acute hospitals. This would enable better use of the scarce workforce, enabling the sector to move towards increased paediatric specialist presence whilst minimising the need for an increase in specialist clinician numbers, which would be very difficult to attain. Consolidation in this way also holds significant benefits for addressing the longer-term workforce problems experienced in the sector by improving the attractiveness of north east London as a career base; a larger critical mass offers improved conditions for teaching, training, governance and research. Importantly this increased critical mass also means improvements in clinical outcomes for patients by raising the level of volumes and richness of patient case mix seen by the workforce on each site.

Children and young people in north east London should have access to a range of specialist services close to home, with the need to access services out of sector minimised. North east London clinicians are participating in a pan London review to determine the location of specialist paediatric services across all London sectors, with a view to identifying a solution that meets the needs of the north east London population.

Summary of recommendations from the Paediatrics CWG, endorsed by CRG:

1. Improving access to children's services and continuity of care by **moving care into community settings wherever possible,** supported by multidisciplinary teams

2. Improving quality of care and making best use of scarce workforce resources by **consolidating specialist, high dependency surgical care on to two sites**

    2a) All urgent surgery for children under two years to be consolidated onto one site

    2b) All urgent surgery for children 0-5 years consolidated onto two sites

3. Improving patient outcomes by increasing senior doctor presence early on in urgent care pathways through round the clock specialist-delivered **Paediatric Assessment and Treatment Services (PATS)** to support A&E and urgent medical and surgical services.

4. Optimum outcomes for paediatrics would be delivered from a **configuration of four acute hospitals** with an A&E department, urgent medicine and urgent surgery with a round the clock PATS service.

5. Ensuring greater access by the local population to a range of specialist paediatric services through the proposed **pan London review of tertiary paediatric provision**

2.4.2 Urgent medicine

a. THE CASE FOR CHANGE FOR URGENT MEDICINE

We have seen in *section 2.2.3* that A&E attendances and admissions are particularly high for north east London, yet many of these patients would be better served by community based services. Patchy development of out of hours primary care services contributes to this high rate of use. Patients' understanding of service availability and which services to access out of hours as well as perceptions of higher standards of care in A&E encourages many to access A&E as a first port of call.

The reason for this over-reliance on A&E is recognised to be a reflection of patients' dissatisfaction with the existing provision of community services, for instance the availability of local GPs out of hours.

Patients with long term conditions or minor illnesses or injuries should be seen by the most appropriate professional with the right skills and experience. In many cases, patients will receive this, with improved continuity of care, when they are treated by primary care practitioners in conjunction with specialist advice outside of hospital. With north east London's rapidly growing population improvements need to be made to the accessibility of high quality community based services to reduce A&E attendances and ensure sustainable provision of urgent care services.

The workforce model of care recommended by the College of Emergency Medicine (CEM) presents sizeable challenges for north east London. Like many clinical specialties, the CEM advises that the current model of care, where the majority of care is delivered by junior doctors, is not sustainable for the future, and it makes a recommendation of senior doctor-delivered care round the clock to improve patient outcomes and address some of the difficulties the specialty faces from the introduction of MMC and EWTD. To staff north east London's six A&E departments to this model would require 96 whole time equivalent (WTE) senior doctors; an increase of 59.5 WTE above the current 36.5 WTE. At present, this level of senior staffing is out of reach due to workforce shortages.

In addition to the A&E staffing challenge, there are similar challenges to those clinical services that support the A&E department. In line with the CEM, local physicians and emergency medicine physicians recommend that a high quality A&E service requires on-site access to critical care, a coronary care unit, acute medicine and geriatric medicine, surgical opinion, obstetrics and gynaecology, essential services laboratory and diagnostic radiology. These services are also moving to a specialist-delivered model of care to deliver optimal patient outcomes, and many are experiencing national or local shortages in trained staff that will give rise to severe difficulty in adopting this model.

Consequently, it may not be possible to provide an A&E department on every hospital site in north east London. The potential for moving to fewer A&E departments in some parts of England has been recognised by the CEM. Whilst this potential may not be a solution for rural areas of the country, in urban areas where A&E departments are less than 10km (6.3

miles) apart the CEM states that there may be advantages to consolidating services onto fewer sites[8].

b. THE VISION FOR URGENT MEDICINE

Providing alternatives to A&E, such as urgent care services offers patients' access to GPs, specialist nurses and allied health professions who can best treat them. This is particularly pertinent for people with long term conditions who are frequently admitted to hospital via A&E because of a lack of preventative services in the community. North east London is improving the capacity and capability of its community based services to offer patients accessible, high quality alternatives to A&E, and a focus on prevention will mean patients with long term conditions can better manage their conditions at home, and in the community, avoiding unnecessary admissions.

There is considerable variation across the sector in both 'front end' services to A&E, such as walk-in centres and urgent care services and the 'back end' by way of acute assessment units. This variation may include the level of specialist input and performance of the service. The lack of standardised sector-wide pathways is confusing for both patients and staff.

The vision is to introduce a consistent urgent care pathway across the sector that this will involve:

- **At the 'front end'** - a consistent urgent care model provided by primary care clinicians, supported by multidisciplinary teams, in polyclinics and at the front-door of every A&E. This model will introduce clear guidelines on provision, operate senior-delivered proactive decision-making and utilise networking arrangements to ensure sufficient specialist input to ensure services are easy to access and high quality.

- **At the 'back end'** - a specialist-led Acute Assessment Unit (AAU) behind every A&E department to reduce admissions and length of stay and increase quality of care and improve clinical outcomes. AAUs have been shown to provide significant benefits to patients in terms of outcomes, patient satisfaction, and a reduction in re-presentations to A&E. AAUs can also act as 'virtual resources' to GP who require specialist opinion to support them to manage patients effectively in the community.

In both aspects of the urgent care pathway, local clinicians emphasise the importance of integration and communication between primary care and hospital based services to delivering optimal clinical outcomes, patient safety and seamless care pathways.

It is the consensus of clinical opinion that north east London needs fewer but larger specialist emergency and acute medicine services, to provide those patients who require treatment in a hospital to have better access to specialist opinion and specialist interventions. Better clinical outcomes for these patients could be achieved by creating larger clinical teams to treat greater numbers of patients. Local clinicians recommend a configuration of A&E and supporting services on either four or five hospital sites, with a preference for four in the longer term, with an interim stage of five in the medium term.

The CWG also recognises the interdependency between location of A&E departments and obstetric and gynaecology services. All undifferentiated A&E departments (those accepting all patients, not just those for one condition type, e.g. ophthalmology) require on-site access to specialists in obstetrics and gynaecology. For this reason, location of A&E departments

[8] The College of Emergency Medicine, The Way Ahead 2008-2012, December 2008

and maternity services must be considered together. Clinicians from the Urgent Medicine CWG have worked closely with colleagues from the Maternity and Newborn Care CWG to define the vision for both service areas.

Important additional benefits of consolidation are the positive impact on the workforce. By creating a critical mass of workforce consolidation enables opportunities for extended and enhanced roles such as nurse practitioners and allows greater junior supervision and training opportunities. In this way consolidation can help hospitals in north east London to become increasingly attractive employers of clinical staff.

Summary of recommendations from the Urgent Medicine CWG, endorsed by CRG:

1. Improve access and continuity of care for minor injuries and illnesses by **providing urgent care services co-located with A&E departments and in community settings**

2. Ensure consistently high quality care across the sector through development of standardised, integrated sector-wide urgent care pathways including **Urgent Care services (UCS) and Acute Assessment Units (AAUs)**

3. Improve clinical quality and make best use of scarce workforce resources by **consolidating A&E** and **urgent medicine services onto four or five sites** and ensuring round the clock access to support services such as urgent surgery and paediatrics

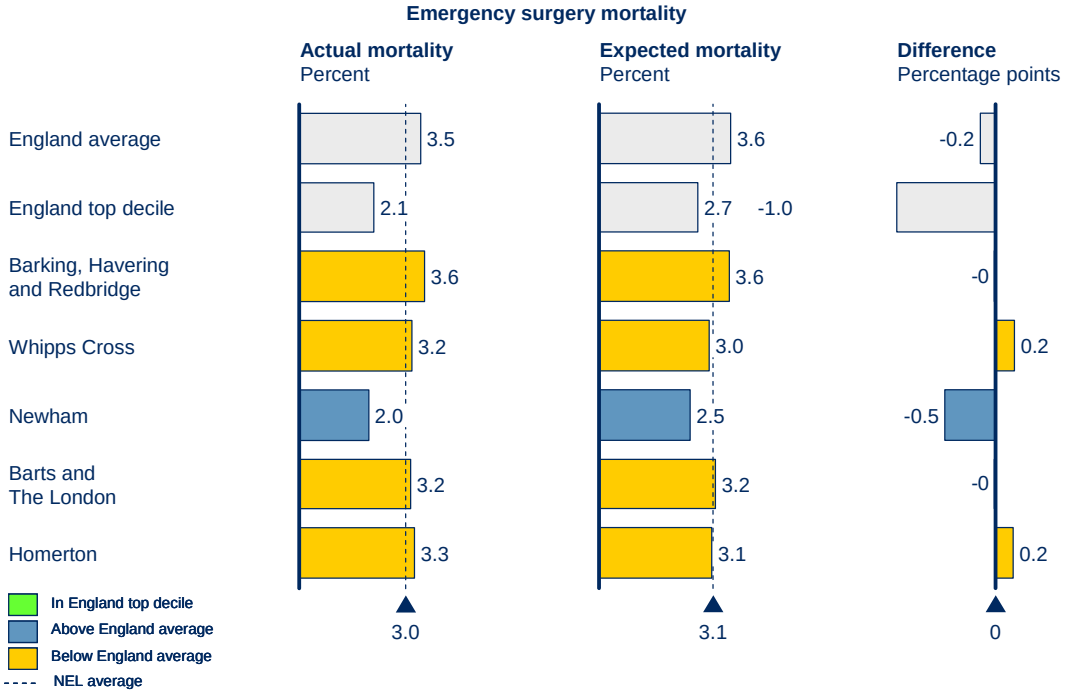
2.4.3 Urgent surgery

a. THE CASE FOR CHANGE FOR URGENT SURGERY

Urgent surgery quality indicators such as mortality rates suggest that improvements need to be made in the way north east London hospitals deliver these services. There is considerable variation in performance across the sector; whilst Newham's mortality rates are among the best in England; other local trusts have below average quality of care for this indicator[9]. This can be seen in the figure below.

[9] Hospital Episode Statistics 2006/07, HES 2006/07

Emergency surgery quality indicators



North east London surgeons and nurses have identified that critical mass, volume and case mix are at the centre of the case for change for urgent surgery. With increasing specialisation and guidelines setting standards for minimum volumes of caseload, it is becoming increasingly difficult for all six sites in north east London to provide the range of surgical expertise required and to see the volume and richness of case mix to enable surgeons to maintain their specialist skills.

The current configuration of north east London further exacerbates the impact of sub-specialisation on urgent surgery. There are a high number of sites with smaller staff teams and an absence of a critical mass of workforce at each site. This means that patients are not always able to be assessed and treated by a specialist with the optimum level of relevant experience.

Evidence shows that improved patient outcomes are achieved when patients are treated by doctors who perform a high volume of that specific treatment or intervention. For example, the Royal College of Surgeons (RCS) has recommended that a hospital requires a population catchment area of 450,000 – 500,000 to achieve the volume and case mix necessary to maintain the clinical skills of surgical teams, given the effect of sub-specialisation. With north east London's population of 1.5 million the sustainability of six hospital sites to deliver high quality care comes into question.

b. THE VISION FOR URGENT SURGERY

The vision is to improve outcomes by consolidating urgent surgical services across the six hospitals to create larger teams, drawing on larger catchment populations to offer opportunities for greater specialisation and improved clinical outcomes. The vision of the Urgent Surgery CRG is that four or five sites hospital sites, matched to the configuration of A&E departments, is the optimal configuration through which to deliver high quality urgent surgery.

As we have already seen in the case for change, the CEM recommends that urgent surgery services are available on-site for patients attending A&E. Therefore, consolidation of A&E

services onto fewer sites must be matched by urgent surgical services as the main route for urgent surgical cases. The RCS has endorsed the CEM's view with their own recommendation that hospitals with A&E departments must have round the clock surgical services present.

Summary of recommendations from the Urgent Surgery CWG, endorsed by CRG:

1. Improve patient outcomes through sub-specialisation by **consolidating urgent surgery onto four or five sites** to enable a round the clock specialist-delivered model of care, co-located with an A&E department and urgent medicine services.

2. **Network models** to access specialist services across multiple sites can deliver improvements in clinical outcomes, however, the view was that fewer sites is a preferable model for sustaining safe and comprehensive services.

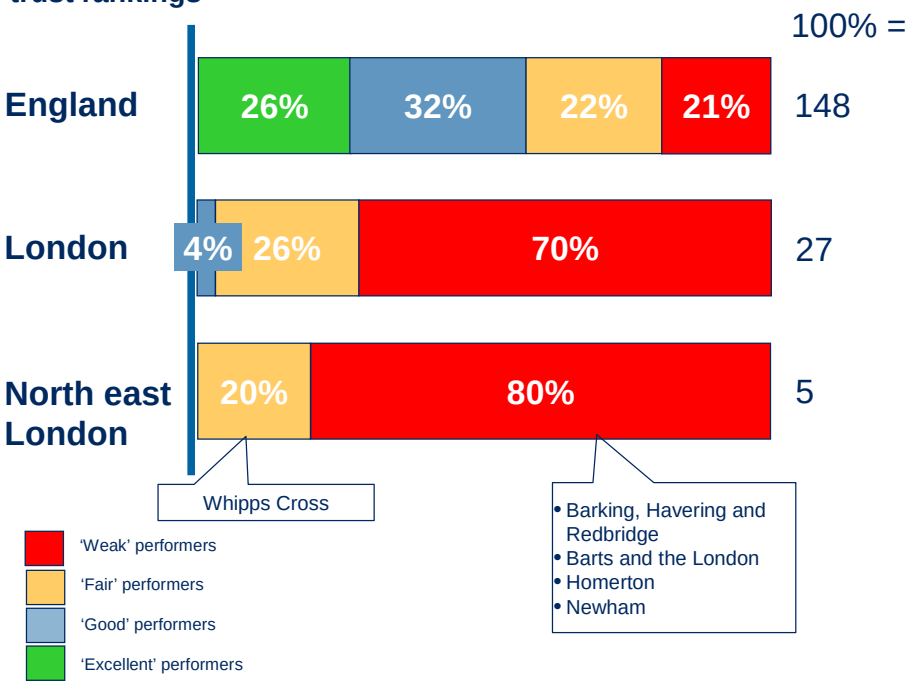
3. Improve clinical outcomes and patient safety by **minimising out of hours surgery**

2.4.4 Maternity and newborn care services

a. THE CASE FOR CHANGE FOR MATERNITY AND NEWBORN CARE SERVICES

Currently maternity services do not perform as well as they should. Four out of five local trusts received a rating of 'weak' from the Healthcare Commission and there is highly variable quality with higher than average levels of caesareans, episiotomies and neonatal complications at some trusts[10]. The need for improvement in the quality of services, coupled with the rapidly rising birth rate in north east London means there is a strong case for change for this service area.

Healthcare Commission overall assessment of maternity services: trust rankings



[10] Hospital Episode Statistics data 2006 and 2007

The birth rate in north east London is well above the England average, and consequently there are increasing pressures on maternity and newborn care services. In 2007/08 there were 29,000 births; projected growth rates for 2017/18 range between 33,000 and 38,000. The pressure of this demand, and the gaps in capacity mean that there is a high rate of transfer of newborns with specialist care needs outside of north east London, often to units many miles away. Ensuring there is sufficient capacity within local perinatal (maternity and neonatal) services to meet this projected demand is of the highest priority.

Whilst capacity must increase in the sector, there are several factors that must be taken into consideration, which means a pan-sector planning process is required. Firstly, there is a clinical consensus in north east London that obstetric-led maternity units should be co-located with A&E departments. This is to ensure that pregnant women attending A&E and requiring specialist treatment can be transferred to a maternity unit on site. This means that reconfiguration plans for A&E departments must go hand in hand with reconfiguration of maternity services. Secondly, capacity increases in maternity services, and the accompanying concentration of specialist staff, must be matched to areas where the birth rate is at its highest to minimise average travel times to units, and matched to neonatal services, particularly neonatal intensive care (NICU) and high-dependency capacity to reduce the number of transfers between sites, and moreover to reduce the number of transfers out of sector. Thirdly, the availability of skilled workforce to staff services must be taken into account when considering capacity expansion.

For maternity services a key driver for change is that workforce challenges are preventing the sector from adopting new models of care recommended by the Royal College of Obstetrics and Gynaecology (RCOG). Evidence summarised in *The future role of the consultant* and *Safer Childbirth* shows that if more care were to be delivered directly by fully trained consultant obstetricians, outcomes for women and their babies would be improved, meaning less maternal morbidity, less foetal morbidity and reduced foetal death rates. Like other clinical specialties there is also increasing concern that, as a continued impact of MMC and EWTD, doctors in training who traditionally have provided the majority of cover in maternity units, are progressively less experienced and skilled than they have been.

Consequently, RCOG recommends that for maternity units of between 4,000 and 8,000 births per year round the clock senior doctor presence should be the goal. This goal requires 168 hours per week of senior doctor time, and RCOG states that a progressive increase should be taken, with a mid-point goal of 98 hours per week. Senior doctor presence in north east London is significantly below these levels, with current averages of between 48 and 66 hours in local maternity units. Modelling suggests that, for six maternity units, a further 60 consultant obstetricians or very senior doctors trained in obstetrics will be needed across the sector to achieve this goal and with workforce shortages this will be hard to achieve. Part of the reason this figure is low is because consultant obstetricians frequently provide cover for gynaecology services. The RCOG recommends that separate rotas should be in place for obstetric and gynaecology services to ensure that sufficient dedicated senior doctor presence is available.

There are further challenges to achieving sustainable staffing for a service with a significant projected increase in demand. Like some other areas of the country north east London has difficulty recruiting and retaining midwives. One to one midwife care is the chief factor that most women cite as reflective of a high quality maternity service. The Healthcare Commission Maternity Assessment of 2006 and 2007 showed that for all north east London trusts, except Barts and the London, staffing levels are below the England average, with a particularly low level at Barking, Havering and Redbridge. There is also a shortage of

neonatal nurses and the UK neonatal staffing study[11] has identified that nationally the rate of vacancies for neonatal nurses remains at around 8%. This leads to poorer outcomes when staffing is inadequate.

The sector also does not have sufficient numbers of staff to provide specialist maternity and post-natal care for patients with complex needs. Patients with higher risk levels should be cared for by the relevant specialists, but too often they may be allocated to units that cannot provide the level of specialisation needed to ensure the highest quality care. A key aspect of the CWG's vision for maternity services is supporting the woman's choice of where to give birth. A range of settings of care for maternity services should be provided within the sector, along with the appropriate skilled workforce, with home birth being a realistic choice for women.

b. THE VISION FOR MATERNITY AND NEWBORN CARE SERVICES

North east London clinicians are agreed that the vision for maternity and newborn services should fulfil the ambitions of the *Maternity National Service Framework* and *Maternity Matters*. Specifically, that:

- Women are supported and encouraged to have as normal a pregnancy and birth as possible, with medical interventions recommended to them only if they are of benefit to the woman or her baby. However, where women do develop medical problems there must be seamless access to high quality medical care.

- There are flexible individualised services designed to fit around the woman and her baby's journey through pregnancy and motherhood, with emphasis on the needs of vulnerable and disadvantaged women.

- Midwifery and obstetric care is based on providing good clinical and psychological outcomes for the woman and her baby, while putting equal emphasis on helping new parents prepare for parenthood.

There is a wide consensus amongst the public, midwives and obstetricians that in order to promote normality and reduce variation of outcome, maternity services should be easier to access, should be delivered close to people's homes and offer choice in antenatal care, place of delivery and postnatal care.

The overriding element of the vision is to improve outcomes at the same time as increasing capacity to meet rising demand. Local clinicians agree that to increase senior doctor presence with north east London's challenging workforce situation, services should be consolidated into fewer units with increased overall capacity. Maternity units should be co-located with A&E departments to ensure seamless transfer of pregnant women attending A&E who require specialised treatment. Reconfiguration into fewer units would also enable greater ability to provide specialist support to women, such as increased access to perinatal mental health services. Continuity of care will be improved and midwifery staffing levels for women in labour improved.

[11] Figures from Neonatal Taskforce Neonatal Workforce Staff Survey Analysis which show that north east London broadly reflects the national situation

Similar to other clinical services, consolidation and development of a critical mass can have significant benefits to the longer-term sustainability of the workforce. Greater concentrations of patients and staff enable better levels of supervision and training of junior staff, further opportunities for sub-specialisation and enhanced roles for medical, midwifery and neonatal nursing staff. One element of this vision is the adoption of the role of Advanced Neonatal Nurse Practitioner; a role that is widely accepted in North America and can help to offset the shortage of trainee doctors whilst improving career options for nursing staff and providing a high standard of care.

Maternity and neonatal networks of care should be formally established to ensure seamless transfer and continuity of care for newborns requiring specialist intervention and treatment.

Summary of recommendations from the Maternity and Newborn care services CWG, endorsed by CRG:

1. **Additional maternity capacity is required** in north east London to meet the growing demand for services, support patient choice and improve patient experience. Capacity should be closely aligned to patterns of demand by locating maternity units in areas where the birth rate projections are highest, and in line with networks of maternity and neonatal care services.

2. Make best use of scarce workforce resources, in particular enable increased on-site specialist presence, by **consolidating from six to five sites with obstetric-led maternity services** with the potential to reduce to four sites if plans to increase midwife-led deliveries are realised.

3. The CRG debated extensively the extent to which **obstetric-led maternity services need to be co-located with other hospital services** and expressed a preference for co-location. The CRG did not rule out the possibility of a standalone maternity hospital but identified a set of requirements that would need to be met to enable this model to be safe and sustainable.

4. **Further work is required** in four key areas to enable a better understanding of the local picture and ensure an optimal solution:

   4a) The views of women and their families who use local maternity services;

   4b) The workforce implications for staffing larger obstetric units;

   4c) The viability of 'standalone' obstetrics and the infrastructure required to support this;

   4d) Care pathways for pregnant women presenting at a major acute hospital or local hospital that does not have onsite obstetrics.

2.4.5 Specialist services

a. THE CASE FOR CHANGE FOR SPECIALIST SERVICES

The Specialist Services CWG covers cardiology, oncology (cancer), vascular surgery and neurosurgery. These services as defined as 'specialist' because there is clinical evidence that centralising services to achieve critical clinical mass drives improvements in quality.

Speciality-specific evidence is available to support the relationship between volume and quality for these four services. This evidence indicates that building up key centres of case-specific specialist staff, equipment and facilities that cover large patient catchment areas enables sufficiently high volumes and richness of case-mix to be treated at these centres. This allows the workforce to train and maintain their expert skills and to utilise specialist facilities and equipment to deliver high quality outcomes.

Consolidation of caseload to dedicated centres enables specialisation by both individual clinicians and the overall units, which has been shown to improve outcomes. The evidence suggests that consolidation of cancer services and other specialist services, such as neurosurgery, vascular surgery and trauma, leads to better clinical outcomes. Currently, in north east London, individual speciality services are spread across too many hospitals. Numerous studies have demonstrated better results at high-volume hospitals with cardiovascular surgery, major cancer resections, and other high-risk procedures[12].

Significant steps forward have already been taken for two specialist services – major trauma and stroke – on a pan London basis. The *Healthcare for London* programme led the consolidation of these services to develop centres of expertise and broadening of patient catchment areas to ensure sufficiently high volumes of patients to deliver the rich case mix required. The outcome for north east London is a major trauma centre at the Royal London hospital and two hyper-acute stroke units at Queen's and the Royal London hospital. This is in line with north east London's vision for these two centres to serve as major acute hospitals for the sector.

The review and reconfiguration planning for major trauma and stroke were undertaken as pan London initiatives because of the volumes involved and the need for an equitable geographical spread across the area. Clinical outcomes for these services suggested that major trauma and stroke should be a priority for reconfiguration. Specialist cardiac and oncology services are due to be reviewed on a pan London basis in the near future. Whereas for neurosurgery and vascular surgery a sector-wide strategy is most appropriate. Clinical outcomes for patients in these services suggest that improvements by way of increasing critical mass to drive clinical quality are required. For example, cancer survival rates for north east London are below EU average, particularly for lung and colon cancers[13]. Variation exists within the sector, with some patients achieving much better outcomes than others.

Like other clinical services, there is major potential for relocation of outpatient appointments and diagnostics from hospital settings into the community for cardiology, oncology, vascular surgery and neurosurgery. For paediatric specialist services see *section 2.4.1*.

b. THE VISION FOR SPECIALIST SERVICES

As we have seen previously, there is evidence to suggest that for highly specialised procedures such as complex arterial vascular work and neurosurgery there is a positive relationship between large volumes of activity and clinical outcome. A further benefit is that patients with multiple co-morbidities can be treated in an advanced setting with more comprehensive infrastructure, leading to improved patient outcomes.

The north east London vision for neurosurgery and vascular surgery is to consolidate services to two sites. The Specialist Services CWG recommends that the minimum threshold for a vascular surgical unit should be approximately 500 procedures per year, which, based on the current activity levels for north east London, implies that the sector has capacity for two major neurosurgical and vascular units. This view is in line with the Academy of Medical Royal Colleges which states that "*people who have experienced major trauma and those*

[12] Luft HS, Bunker JP, Enthoven AC. Should operations be regionalized? The empirical relation between surgical volume and mortality. *N Engl J Med.* 1979;301:1364-9. Begg CB, Cramer LD, Hoskins WJ, Brennan MF. Impact of hospital volume on operative mortality for major cancer surgery. JAMA. 1998;280:1747-51. Dudley RA, Johansen KL, Brand R, Rennie DJ, Milstein A. Selective referral to high volume hospitals: estimating potentially avoidable deaths. JAMA 2000;283:1159-66.

[13] Office for National Statistics for cancers diagnosed 1997-99, Eurocare 4 for cancers diagnosed 1995-99

requiring specialist neurosurgery and vascular care do fare better if they are treated in specialist units"[14].

In the case of neurosurgery, services are already consolidated onto two sites with dedicated units: the Royal London hospital and Queen's hospital. For vascular, the majority of current activity is also carried out at the Royal London and Queen's in dedicated vascular units. However, there is a small proportion of vascular surgery that occurs sporadically throughout the remaining acute sites within the sector. It is the view of the CWG that all vascular activity should be undertaken only at the two sites with dedicated facilities and a critical mass of specialist workforce. This view is in line with the clinical vision for designating the Royal London and Queen's as the two major acute hospitals providing specialist services for the north east London population.

Whilst a review of cardiac and oncology services is due to be undertaken on a pan London basis by *Healthcare for London*, clinicians and health service leaders from north east London will play a critical role in this process. Early assessment by the Specialist Services CWG indicates that:

Cardiac services ~ based on the projected growth in activity, north east London requires three dedicated specialist cardiology centres. The Heart Attack Centre (HAC) should be located with reference to the greatest incidence of myocardial infarctions in the sector, and ideally be co-located in one of the two major acute hospital sites to ensure availability of a wide range of acute support services.

Cancer services ~ the CWG recommends that configuration of cancer services amongst acute providers needs to be compliant with NICE improving outcomes guidance (IOGs), and recognises that there may additionally be opportunity in this sector to go further than the minimum standards set by the IOGs. Reconfiguration options should not be limited to the organisational boundaries of north east London but also take account of Essex and North London. Service models should be built around patient-centred multidisciplinary pathways.

Key issues for reconfiguration have been identified for individual cancer types and oncology services.

Summary of recommendations from the Specialist Services CWG, endorsed by CRG:

1. Improve access by moving outpatient appointments and diagnostics for specialist services into **community settings** where possible

2. Improve clinical quality by **consolidating vascular surgery on two sites** to achieve critical mass

3. Ensure greater access to, and improved outcomes for, specialist cardiac and oncology services through the **pan London review of cardiac and oncology provision**

[14] Acute health care services: A Report of a Working party, Academy of Medical Royal Colleges, September 2007

2.4.6 Planned care services

a. THE CASE FOR CHANGE FOR PLANNED CARE SERVICES

We have already seen in the case for change that non-acute services currently located at hospitals can be provided in community-based settings closer to home where they are more easily accessed by patients. For planned care this means a significant amount of the outpatient appointments and diagnostic services can move from hospital settings.

For planned care services that still require an acute hospital setting the key driver for change is evidence that shows there is substantial benefit to be gained from the streaming of planned services away from emergency care services.

Reductions in healthcare acquired infections can be achieved through streaming. Separation of planned care patients and emergencies reduces rates of infection for both sets of patients because patients are not sharing the same wards and planned care patients can be screened and treated in advance for any infections. Rates of healthcare acquired infections are one of the highest priorities for patients when selecting where to have their treatment, and this contributes to higher rates of patient satisfaction when streaming takes place. Good progress has already been made at Barts and the London and Barking, Havering and Redbridge in separation of elective and emergency services and this needs to be progressed further.

Streaming of planned and emergency care services can be done on the same hospital site, however reconfiguration of emergency care services is required to enable sufficient capacity to be released to allow for streaming.

The creation of elective centres can enable streaming and deliver increased benefits over same-site streaming. Elective centres support improved clinical outcomes through increasing sub-specialisation; high volumes of very specific case mix can be matched to the necessary sub-specialist staff, facilities and equipment. There are examples of successful elective centres operating elsewhere in London and internationally.

Traditionally, planned surgery would be followed by an inpatient stay in hospital. Increasingly, with new, less invasive surgical techniques this work can be done as day case or short stay. Consequently, the demand for hospital beds is set to reduce into the future and hospitals will need to adapt bed capacity across the sector to reflect this. As well as developing elective centres, consideration should also be given to the use of surgical 23-hour units on hospital sites to enable more patients to be scheduled for a short stay but with the back up of co-located intensive care services should they be required.

b. THE VISION FOR PLANNED CARE SERVICES

A greater focus on supporting self-care and preventing ill health, as well as improvements in the quality of health services, will deliver a reduction in the demand for some aspects of planned care. PCTs in inner north east London have estimated that in the region of 17% of outpatient appointments would not be required once these improvements have taken effect.[15]

[15] Inner north east London shifts to settings of care for outpatients

Furthermore, aspects of planned care, such as outpatient attendances, as well as some diagnostic tests and a small amount of minor surgery and treatment can be safely provided in a number of care settings. Major acute hospitals, other hospitals, elective centres and community settings are all appropriate providers of these aspects of planned care services; elective centres can also undertake some non-acute, high-throughput procedures; and hospitals can carry out most planned procedures as well as more complex diagnostic tests. This plurality of provision of planned services is perceived by local clinicians to be a positive step for driving up standards of quality and enabling real patient choice within the sector.

Clinicians in north east London estimate that approximately two thirds of outpatient appointments currently in acute settings could be provided in community settings. This consists of 30% of first appointments in ENT, dermatology, general surgery, orthopaedics, urology and gynaecology and 5% of all other specialties. 50% of follow-up appointments from all specialties can also be included in this category. The development of polysystems, with polyclinics at their hub, throughout north east London will provide the required capacity and capability to enable the shift of this activity to community-based settings.

North east London clinicians also recommend the following diagnostics can be shifted into the polysystems: ECG, pulse oximetry, spirometry, x-ray, ultrasound, vascular Doppler, colonoscopy, standard haematology, microbiology and pathology. This will enable patients to be tested more quickly and closer to their homes, and will also provide greater access to these diagnostics for GPs to manage patients more effectively in the community, particular those living with long term conditions.

North east London clinicians recommend that streaming of elective and emergency services takes place to deliver optimal patient outcomes, reduced rates of healthcare acquired infections and improve patient satisfaction. There is clinical consensus that consideration should be given to the development of elective centres for specific treatment types. The table below shows the activity levels for high volumes specialties that could move to an elective centre setting.

Specialty	No. procedures able to shift to elective centre	% procedures able to shift to elective centre
General surgery	11,823	30%
Gastroenterology	45,183	80%
Ophthalmology	11,335	80%
Orthopaedics	16,350	60%
Urology	23,175	30%
TOTAL	107,872	

In addition to these high volume specialties some consideration can also be given to identifying the proportion of lower volume specialties such as ear, nose and throat (ENT) and gynaecology.

Summary of recommendations from the Planned Care services CWG, endorsed by CRG:

1. The CRG view is that **decisions regarding service models and configuration of elective surgery can be considered separately** from decisions about A&E and urgent medicine, urgent surgery, paediatrics and other specialist services and maternity services.

2. Further work is required to develop a **planned care service commissioning strategy** for north east London. This will be undertaken over the next 12-18 months. Two key elements of this strategy can be anticipated:

2a) Improve access by moving outpatient appointments and diagnostics for planned **services into community settings** where possible

2b) Improve quality and efficiency by **streaming of elective activity** away from emergency activity

2.4.7 Incorporating the visions for the six clinical service areas

The *Health for North East London* programme has taken into consideration the case for change and visions of the six CWGs as part of the process for determining the proposals for change to be tested during consultation. We will review this process in more detail in *Chapter 5*.

2.5 FROM VISION TO REALITY

North east London healthcare commissioners and providers have established a firm commitment to realising the vision for local healthcare.

There is consensus to achieve the goals set out for the whole health economy and for each of the CWGs, a four-pronged approach is proposed. This approach comprises:

1. **A greater focus on supporting self care and preventing ill health ~** we all know that prevention is better than cure, but people in north east London need more help to keep healthy and look after their health needs at home. This is particularly pertinent for people with long term conditions; managing their condition with the support of their GP and skilled community staff will deliver benefits through continuity of care to avoid A&E attendances and admissions to hospital. Commissioners recognise that many of the determinants of good health are outside the boundaries of the NHS, such as housing, employment and education. Commissioners are committed to working with local partners such as local authorities, schools, and the police to ensure holistic solutions are being developed to improve the health of the local population.

2. **Driving improvements in the quality and productivity of healthcare services ~** as we have seen in the case for change, healthcare services in north east London are performing below average for England. Indicators such as GP access, rates of healthcare acquired infections, average length of stay, hospital readmission rates and patient satisfaction levels tell commissioners that the NHS can do better to provide a high quality service to patients, ensuring that maximum clinical benefit is delivered using the fewest necessary resources. All healthcare providers are focussing on identifying their priority areas for quality and productivity and putting in place large

scale improvement programmes involving pathway redesign and development of appropriate clinical networks.

3. **Moving non-acute services out of hospital settings closer to people's homes** ~ patients will benefit from easier access and improved continuity of care through the shift from hospital to community settings, such as polyclinics, for outpatient appointments, diagnostics and some minor surgery and treatments. In order to deliver this shift in the setting of care each PCT in north east London is developing a care out of hospital strategy which will move from the vision to the reality by ensuring sufficient capacity and capability is available in the community to facilitate this shift.

4. **Consolidating acute services onto fewer hospital sites where there is evidence that this will improve patient outcomes** ~ in some acute services north east London is facing specific workforce challenges, exacerbated by EWTD and MMC. Centralisation of these services can help to offset to ensure high quality services are delivered to patients. In addition, increasing sub-specialisation is shown to deliver improved clinical outcomes, and can best be supported by centralisation that widens the patient catchment area to ensure sufficient volumes and richness of case-mix.

The pre-consultation business case focuses on the last of these points: *consolidating acute services onto fewer hospital sites where there is evidence that this will improve patient outcomes.* It is important to note that any centralisation of some acute services must go hand-in hand with *decentralisation* of non-acute services through the move to community settings. This follows the principle set out in *Healthcare for London: A Framework for Action* of 'localise where possible, centralise where necessary'. Through this approach the healthcare service landscape can be matched to best meet the needs of patients and ensure high quality care.

The clinical view is that consolidation of services directly addresses five of the six key drivers for change.

- Consolidation offsets some of the **workforce challenges** experienced in north east London by making better use of the existing workforce, and brings additional benefits in terms of the attractiveness of hospitals to specialist clinical staff by offering greater levels of supervision and training, opportunities to specialise and enhanced roles and career pathways.

- Consolidation enables **new models of care** to be adopted, namely, round the clock specialist-delivered care, streaming of planned care services away from emergencies and it supports sub-specialisation by creating a critical mass of patient volume and case-mix.

- Consolidation enables greater flexibility for future capacity planning to fit with levels of demand as the **population increases** but the demand for hospital beds, for most services, reduces.

- Consolidation supports **best use of the taxpayers money** by removing the current duplication (where it has no clinical justification) of many services across sites in north east London.

- Consolidation, by removing duplication of services, enables more efficient use of money, allowing a greater proportion of available funding to be spent on preventing ill health and **improving the health of the local population**.

Consolidation also supports the move of services from hospital to community settings, by working with local providers to look ahead to a future in which the hospital has a different future, and planning service configuration to support this future.

3. BENEFITS REALISATION FROM THE RECONFIGURATION PROPOSALS

This chapter describes the anticipated benefits from reconfiguration of acute hospital services in north east London, with a particular focus on the clinical benefits, benefits to patients and benefits to staff.

The ambition of *Health for North East London* is to transform the healthcare available so that patients experience a tangible positive impact. Our Joint Clinical Directors (see *Foreword*, page 1) identified four key areas of focus where we believe patients will notice improvements from the work being undertaken in north east London:

- **Improvements in urgent care and A&E services**. We want to improve access to primary care-led urgent care services in polyclinics and at the 'front doors' of A&E departments. This will ensure that A&E doctors and nurses can use their skills and training to focus on the most severely ill or injured patients. We want patients arriving at urgent care services or A&E to be assessed by a senior clinician in less than an hour. All patients who are admitted to hospital should be seen quickly by a senior clinician who will take charge of their care and make sure they can access all the tests and treatments needed to help them recover quickly.

- **Offer women the choice and better quality maternity services that they have told us they would like.** This includes the choice to give birth at home or in a community midwife-led unit. Women who need a higher level of care will have better and earlier access to consultants and senior clinicians. We expect this will lead to fewer complications at birth for women and their babies. We also want to see antenatal and postnatal care available in polyclinics, closer to people's homes, and to provide advocacy services to pregnant women, such as language advocates and access to legal advice and social care services.

- **Improve services for children and young people**. North east London has a very young population and right now we are not always providing the best quality children's services consistently across the sector. We want to see improved assessment and treatment of children in A&E – provided 24 hours a day, seven days a week. Some children with more complex needs will benefit from improved inpatient care at specialist children's wards. We also want to see children's health services better integrated with other services provided closer to home.

- **Reduce the number of planned operations that are cancelled at short notice**. In 2009, over 1,000 patients in north east London are likely to have their surgery cancelled on the day. Our proposals to separate planned surgery from emergency surgery will help us to reduce this number by half.

3.1 A COMPREHENSIVE BENEFITS FRAMEWORK

Health for North East London has developed a draft benefits framework against which to assess the success of the programme. The benefits framework includes benefits that will be driven out through reconfiguration as well as benefits that will come from productivity and service improvement.

The draft benefits framework is founded on a set of criteria which were tested with the public, engaged public, clinicians and managers in a series of workshops that were independently led by Opinion Leader Research held on 20th to 23rd April 2009 inclusive.

The criteria that were agreed are listed below. The first five criteria are applicable to reconfiguration, productivity and service improvement, whilst numbers 6 to 10 only apply to productivity and service improvement and are not enabled by reconfiguration.

1. Clinical quality (including patient experience), safety and workforce;
2. Capacity;
3. Transport access;
4. Deliverability;
5. Finance and use of NHS resources;
6. Workforce development and staff experience;
7. Service access;
8. Reducing health inequalities;
9. Patient involvement;
10. Environment.

Each of the criteria was then developed as follows:

- Key lines of enquiry were developed for each of the criteria;
- These were underpinned by critical success factors;
- The expected benefits were identified; and
- How the benefit will be measured was agreed.

As well as using the criteria to develop the benefits framework, the first five criteria and their underpinning questions were used in the decision making process for selecting reconfiguration options, as described in *section 5.2*.

This draft benefits framework, which will be developed further as the productivity elements of the programme are crystallised, will be used to monitor success of the programme, including the reconfiguration elements, through to implementation and service delivery beyond implementation. The draft benefits framework is attached at *Appendix C*.

3.2 THE CLINICAL BENEFITS OF RECONFIGURATION

Focusing on the work of each of the Clinical Working Groups (CWGs) benefits that will be enabled by reconfiguration have been identified by the Clinical Reference Group for each clinical area and grouped into 'benefits for patients' and 'benefits for staff'. The detail of these benefits is included in the tables that follow, with a summarised view set out below. Non-clinical benefits and benefits derived from quality and productivity improvements (rather than reconfiguration) are included at *Appendix C*.

3.2.1 Benefits for patients

Improved clinical outcomes and higher rates of patient satisfaction will be achieved through:

- Patients are more likely to have input from a senior clinician, with a high level of experience in treating the condition type, earlier in their pathway.
- The most seriously ill patients will be treated by the most highly skilled staff and in facilities that are designed for treating that condition.
- More children can be cared for within north east London and the need for transfer to central London tertiary hospitals is reduced.
- Patients undergoing planned care are less likely to have their surgery or treatment cancelled for non-clinical reasons.
- The likelihood of patients contracting healthcare acquired infections is reduced.

3.2.2 Benefits for staff

North east London hospitals will be able to attract, develop and retain the staff needed to provide high quality healthcare through:

- Opportunities for sub-specialisation for all clinical professions and broadening of non-medical career pathways, for example the development of nurse practitioner roles.
- Improved opportunities for training and supervision of clinical staff in training.
- Advantages of working in a fully-resourced team with sustainable rotas, including support from increased senior clinician input and decision-making.
- Greater throughput of patients per team provides clinicians with increased levels of experience and expertise.

3.2.3 Children's services

The table below sets out the benefits that will be derived from reconfiguration in relation to children's services

The change that will be enabled by reconfiguration	Why do we need reconfiguration?	Clinical benefits	Benefits to the patient	Benefits to staff
Paediatric services should include full access to relevant specialist clinicians to provide a highly specialised multidisciplinary team that includes paediatric anaesthetists, radiologists and nurses.	It is not possible to provide the full team of specialists on every site in the current six site configuration. Moving to five sites makes this more feasible.	Enhanced patient safety and clinical outcomes by ensuring that patients have access to the most skilled and specialist staff when needed.	Greater access to a team of paediatric specialists and support services.	Sub-specialisation opportunities. Advantages of working in a fully resourced team
Complex inpatient paediatric surgery is carried out in specialist paediatric centres by a senior clinician delivered service equipped with the appropriate facilities and specialist staff.	The clinical view is that complex paediatric surgery should be offered at two sites so that highly specialised staff can be grouped together to form clinical teams with the most appropriate skill mix.	Enhanced patient safety and clinical outcomes by ensuring patients at highest risk have access to the most experienced clinical staff and specialised facilities.	Complex surgery on children will only be performed by an expert in performing paediatric surgery. The facilities will be dedicated children's facilities with a child and family-friendly environment.	Sub-specialisation opportunities. Improved opportunities for training and supervision.

The change that will be enabled by reconfiguration	Why do we need reconfiguration?	Clinical benefits	Benefits to the patient	Benefits to staff
Consolidation of paediatric high dependency units, in accordance with *Healthcare for London* strategy, in conjunction with development of care closer to home for critically ill children.	By having two dedicated complex paediatric units in north east London children can be treated in the sector rather than being transferred to central London tertiary units.	Enhanced patient safety and clinical outcomes by ensuring that patients at highest risk have access to the most experienced clinical staff and specialised facilities.	More likely to be seen by a senior clinician who is expert in providing intensive care for children. Children requiring high dependency treatment can be treated within north east London can be cared for closer to home.	Improved opportunities for training and supervision. Sub-specialisation opportunities.
Consolidation of paediatric surgical care to enable access to specialist surgery supported by appropriately specialist staff in accordance with *Healthcare for London* and Royal Colleges guidance.	Consolidation of paediatric specialist surgery onto two sites in north east London gives children access to surgery in the sector rather than having to be treated out of sector.	Enhanced patient safety and clinical outcomes by ensuring patients at higher risk have access to the right facilities.	Children requiring complex surgery can be treated within north east London can be cared for closer to home.	Improved opportunities for training and supervision. Sub-specialisation opportunities.
Reconfiguration provides the critical mass that enables children to be treated in a bespoke child friendly environment in accordance with national policy.	Providing paediatric services on fewer sites enables paediatric resources to be consolidated to provide a more appropriate environment.	More appropriate facilities lead to better clinical outcomes.	Children are treated in a bespoke environment that meets their, and their family's, needs.	Increased job satisfaction.

The change that will be enabled by reconfiguration	Why do we need reconfiguration?	Clinical benefits	Benefits to the patient	Benefits to staff
Reconfiguration will enable the provision of Paediatric Assessment and Treatment Services (PATS) units across north east London as recommended by the Clinical Reference Group.	Reducing the number of A&Es from six to five enables PATS units to be staffed by paediatric specialists. This cannot be achieved for six sites.	Enhanced patient safety and improved clinical outcomes through ensuring rapid assessment by paediatric specialists.	Children are assessed and treated by a paediatric specialist.	Improved opportunities for training and supervision. Sub-specialisation opportunities.

3.2.4 Urgent medicine

The table below sets out the benefits that will be derived from reconfiguration in relation to urgent medicine.

The change that will be enabled by reconfiguration	Why do we need reconfiguration?	Clinical benefits	Benefits to the patient	Benefits to staff
Creation of a more coherent emergency service without introduction of increased risk to patients - in accordance with College of Emergency Medicine guidance.	Given advances in clinical practices, we can no longer sustain the current configuration of six sites for A&E. Moving to five sites will provide a significant step towards the most appropriate workforce models.	Enhanced patient safety and clinical outcomes as the level of activity will enable sustainable staffing at appropriate levels of skill and experience.	More likely to have input from a senior clinician earlier in the patient pathway. More likely to be seen by a senior clinician with a high level of experience in treating that condition. Reduced risk of a senior decision-making clinician not being available at a critical time.	Opportunities for sub-specialisation. Advantages of working in a fully resourced team.
Access round the clock to diagnostic and other support facilities needed by A&E patients	Best quality comes from having diagnostic services available round the clock. We can't sustain this for six sites. We will be more able to achieve this on five sites.	Improved clinical outcomes for patients due to more prompt diagnosis.	Prompt diagnosis, even at night, and therefore quicker treatment.	Able to provide a swift, responsive service to patients. Able to make decisions about patients on a fully-informed basis.

The change that will be enabled by reconfiguration	Why do we need reconfiguration?	Clinical benefits	Benefits to the patient	Benefits to staff
A consistent model of Acute Assessment Units (AAUs) at the 'back end' of every A&E, providing concentrated access to diagnostic facilities and a range of specialist staff to enable speedy assessment of patients and appropriate discharge home, with primary care support if needed, or transfer to a ward.	A fully resourced AAU drives best care and shorter length of stay. The current configuration of six sites doesn't allow for sufficient workforce for the fully resourced AAU. We will be better able to achieve this on five sites.	Improved and more consistent clinical outcomes and patient experience and as patients are assessed with a full range of diagnostics and specialist staff before transfer to a ward or discharge at every A&E.	Consistent professional opinion prior to decision to discharge or admit. A calm and comfortable environment away from A&E, more appropriate for a longer stay.	Patients are assessed in a fully resourced AAU by staff who are experience in undertaking such assessments. GPs across the sector have consistent access to a full range of specialist staff and an integrated service with primary care.
The reconfiguration facilitates optimal deployment of the workforce and helps manage demand and supply gaps - taking account of guidance from Royal Colleges of optimal staffing of services.	The workforce is not sufficient to fully sustain emergency medical services across six sites. We will be better able to achieve this across five sites.	Enhanced patient safety and clinical outcomes through ensuring the sickest patients are seen by the most experienced clinicians.	Patients are more likely to be treated by a senior clinician earlier in the patient pathway.	Opportunities for sub-specialisation. Advantages of working in a fully resourced team.
The designation of hyper-acute units at the Royal London and Queen's provides the opportunity to ensure that remaining stroke services are optimally configured to achieve and sustain enhanced quality of services.	Without change we will have four non-HASU stroke units in north east London. These do not provide the critical mass for optimal provision of service. Consolidation is needed for the quality of service required.	Enhanced clinical outcomes for patients.	More rapid diagnosis leading to better condition management.	Opportunities for sub-specialisation. Improved opportunities for training and supervision. Advantages of working in a fully resourced team.

3.2.5 Urgent surgery

The table below sets out the benefits that will be derived from reconfiguration in relation to urgent surgery.

The change that will be enabled by reconfiguration	Why do we need reconfiguration?	Clinical benefits	Benefits to the patient	Benefits to staff
Increase in the catchment area of each hospital to achieve the caseload and case mix for each team to deliver best quality interventions.	By reducing from six to five sites we will move closer towards the critical mass for caseload and case mix.	Enhanced patient safety and clinical outcomes because the volume of patients being treated enables sustainable teams of the most appropriate skill mix. Higher throughput means better experience for clinicians.	More likely to have input from a senior decision-making clinician earlier and more frequently in the patient pathway. More likely to be seen by a senior clinician expert in that condition.	Opportunities for sub-specialisation. Improved opportunities for training and supervision.
Reconfiguration to five sites has the capacity and resilience to meet variation in demand for urgent theatre slots or availability of beds without disrupting other services.	Consolidating emergency theatres and beds onto five sites enables the whole health system to manage demand across five sites, rather then six sites, giving greater flexibility.	Enhanced patient safety and clinical outcomes and patient experience.	Patients in planned surgery pathways are less likely to have their treatment or surgery cancelled due to emergency demand.	Reduced disruption and associated administration.
Reconfiguration ensures appropriate cover to provide urgent surgery on all sites with an A&E (as per the CRG recommendation) in accordance with guidance from the Royal College of Surgeons.	Consolidating A&E services onto five sites instead of six makes it easier to staff the rotas for emergency surgery.	Enhanced patient safety and clinical outcomes.	Patients entering A&E can be operated on, when needed, for the majority of conditions, without having to be transferred to a different hospital.	Sustainable rotas. Advantages of working in a fully resourced team.

3.2.6 Maternity and newborn

The table below sets out the benefits that will be derived from reconfiguration in relation to maternity and newborn care services.

The change that will be enabled by reconfiguration	Why do we need reconfiguration?	Clinical benefits	Benefits to the patient	Benefits to staff
There will be a suitable number of experienced and skilled senior doctors to deliver 98 hour cover and progress toward 168 hour cover.	Fewer maternity units mean that obstetricians can be grouped together and progress toward the 98 and 168 hour cover. This cannot be achieved of six sites. Moving to five sites will provide a significant step towards achieving the targets for senior doctor cover.	Enhanced patient safety and clinical outcomes by ensuring that care is led by senior clinicians.	The patient is more likely to be seen by a senior clinician when needed.	Staff are supported by an increase in senior clinician presence. Improved opportunities for training and supervision.
Continuity of care in established labour by providing all women with a dedicated midwife.	Grouping midwives in fewer units makes it more feasible to achieve levels of staffing and rotas that enable 1:1 patient care.	Enhanced patient safety and clinical outcomes by ensuring continuity of care through established labour.	A single designated midwife to provide care throughout established labour.	Greater job satisfaction in seeing patients throughout established labour.
Creation of streamed neonate rotas separate from paediatric rotas as recommended by CRG and RCOG.	Reducing the number of sites where paediatric and neonatal services are provided makes it feasible to stream neonate and paediatric rotas.	Enhanced patient safety and clinical outcomes by ensuring that appropriately experienced senior clinician care is available when needed.	More likely to have input from a senior clinician earlier and more frequently in the patient pathway. Reduced risk of a senior clinician not being available at a critical time.	Sub-specialisation opportunities. Improved opportunities for training and supervision.

The change that will be enabled by reconfiguration	Why do we need reconfiguration?	Clinical benefits	Benefits to the patient	Benefits to staff
Reconfiguration will enable high quality of care for the most likely scenarios of 36,700 deliveries per year and resilience to deal with up to 38,000 deliveries per year.	Consolidating onto five instead of six sites will smooth out peaks and troughs in demand for services, and enable the overall demand to be managed more effectively.	Ability to cope with high end delivery forecasts.	Patients will attend larger maternity units that are better equipped for a high number of births.	Improved opportunities for training and supervision.
Reconfiguration makes it more likely that maternity units will be able to provide an environment enabling women to have the privacy and dignity important to them during their stay, in accordance with national policy.	Having fewer maternity units will mean that resources will be focussed on fewer sites enabling the facilities to be designed for the service.	Improved patient experience leading to less stress on patients.	Patients will attend larger maternity units that are better equipped for their needs and benefit from enhanced privacy and dignity.	Job satisfaction.

3.2.7 Specialist services

The table below sets out the benefits that will be derived from reconfiguration in relation to specialist services.

The change that will be enabled by reconfiguration	Why do we need reconfiguration?	Clinical benefits	Benefits to the patient	Benefits to staff
For services that are highly specialised and low volume, there is a clinical rationale for specialist centres that will handle a caseload that supports a team of highly specialised clinicians, support services and specialist facilities.	Concentrating these highly specialised services onto a limited number of sites enables this caseload to be achieved.	Enhanced patient safety and clinical outcomes by ensuring patients at higher risk have access to the most experienced clinical and support staff and specialist facilities.	The most seriously ill patients will be treated by the most highly skilled staff and in facilities that are designed for treating that condition, resulting in improved outcomes.	Opportunities for sub-specialisation. Enhanced roles for non-medical staff e.g. nurse practitioners Improved opportunities for training and supervision.
Reconfiguration enables the specialist services of neurosurgery, vascular and cardiac catheterisation to be consolidated into centres of excellence.	Currently services are widely distributed. Consolidation is needed to achieve centres of excellence for these highly specialist services.	Enhanced patient safety and clinical outcomes by ensuring patients at higher risk have access to the most experienced clinical staff and specialist facilities.	The most seriously ill patients will be treated by the most highly skilled staff and in facilities that are designed for treating that condition, resulting in improved outcomes.	Opportunities for sub-specialisation. Improved opportunities for training and supervision.
Facilitates optimal deployment of the workforce and helps manage demand and supply gaps.	We can't sustain the highly specialist workforce across all locations currently delivering the services.	Workforce is specialised in the procedures as they are treating a high volume of similar cases.	The most seriously ill patients will be treated by the most highly skilled staff resulting in improved outcomes.	Opportunities for sub-specialisation. Improved opportunities for training and supervision.

3.2.8 Planned care

The table below sets out the benefits that will be derived from reconfiguration in relation to planned care services.

The change that will be enabled by reconfiguration	Why do we need reconfiguration?	Clinical benefits	Benefits to the patient	Benefits to staff
Separation (streaming) of patients between elective and emergency surgery in accordance with Healthcare for London and national policy.	Reducing the number of sites within emergency care from six to five provides the capacity to stream planned care away from non-elective care, both for same-site facilities and separate facilities.	Streaming planned care away from emergency care enables planned care patients to be pre-screened for infection reducing the risk of cross infection. The reduced rate of cancelled surgery or treatments (due to emergency pressures) improves clinical outcomes.	The likelihood of hospital acquired infections is significantly reduced. The likelihood of planned treatment being cancelled is significantly reduced.	Broadening of non-medical career pathways to enable sub-specialisation in elective centre care. Increased opportunities for sub-specialisation.
Reconfiguration creates the opportunity to establish elective centres for high volume specialties (e.g. General Surgery, Gastroenterology, Ophthalmology, Orthopaedics, Urology - possibly also ENT gynaecology) - achieving a catchment of 500,000 population to achieve critical mass at procedural level	Reconfiguration creates flexibility of capacity to be available for elective care enabling the potential for centres of excellence to be established for high volume specialties.	Enhanced clinical outcomes by providing critical mass for surgeons for each procedure. Increase the proportion of day case patients. Reduce average length of stay.	For high volume specialties patients are treated by specialists in that procedure.	Broadening of non-medical career pathways to enable sub-specialisation in elective centre care. Increased opportunities for sub-specialisation.

4. THE FINANCIAL CONTEXT FOR NORTH EAST LONDON

The financial focus of this PCBC relates primarily to the impact of the reconfiguration proposals, rather than developing a strategic financial plan for the health economy of north east London.

This chapter describes, at a high level, the financial challenges facing both commissioners and acute providers in the area and indicates the scale of savings that could be delivered to address this challenge.

The information used for the financial analysis contained in this chapter is the best available at the time. Further refinements of this analysis will be made should information be updated. All of the forecasts have been calculated on a 'real-terms basis', with costs deflated to a 2007/08 price base.

4.1 THE COMMISSIONERS' PERSPECTIVE

At the current time, the PCTs are in the process of completing Commissioning Strategy Plans (CSPs) for 2009/10 to 2015/16. The analysis contained within this PCBC is still work in progress; the CSPs, when published in December, will expand upon the summary contained here.

4.1.1 Financial outlook

Along with the rest of London PCTs in north east London are planning for a period of financial challenge. The planning assumptions that the PCTs are assuming are based upon those issued by NHS London in September 2009:

- There will be a sustained period when allocations will show 0% annual real-terms growth. Best and worse-case scenarios are also being prepared with real-terms growth forecast between 0.75% and -2.5%.

- Healthcare cost inflation, including pay costs, will outstrip funding growth and impact commissioning spend

- Tariffs to acute providers are likely to be held at lower rate than inflation, giving the PCTs some benefit.

- Growth in the population and changing demographics will add to costs. On average activity is forecast to grow at 1.1% per annum resulting from demographic change. However, the rate of change varies significantly across the sector; the highest being Newham where annual growth is forecast at around 2.2%.

- The PCTs are also assuming that there will be acute activity growth in excess of demographic growth of 0.9%. This is consistent with the way that demand for services has increased over recent years. Primary and community care demand will also grow.

- The cost of community, mental health and primary care commissioned services has been increased annually in line with the acute tariff but *before* any efficiency savings.

The full set of assumptions is shown in *Appendix D.*

Taken together the PCTs estimate that if no action were taken to contain costs there would be an annual revenue shortfall across the two sectors of £392m (base case estimate) rising to £540m with the downside estimate of allocations.

Annual Surplus/Deficit Assumptions Before Applying Savings Programme

Outer NE London

	BASE ASSUMPTIONS				
	NHS Redbridge	NHS Havering	NHS Waltham Forest	NHS Barking & Dag	Outer NEL
	£'000	£'000	£'000	£'000	£'000
2009/10	5,228	-6,652	4	8,746	7,326
2010/11	-12,996	-11,241	-8,394	-8,395	-41,025
2011/12	-18,408	-15,023	-16,018	-13,688	-63,137
2012/13	-24,096	-19,099	-22,515	-19,191	-84,901
2013/14	-30,067	-23,478	-29,304	-24,913	-107,762
2014/15	-36,335	-28,167	-36,395	-30,863	-131,761
2015/16	-42,910	-33,175	-43,803	-37,052	-156,940
2016/17	-49,805	-38,510	-51,541	-43,490	-183,346

	UPSIDE ASSUMPTIONS				
	NHS Redbridge	NHS Havering	NHS Waltham Forest	NHS Barking & Dag	Outer NEL
	£'000	£'000	£'000	£'000	£'000
2009/10	5,228	-6,652	4	8,746	7,326
2010/11	-12,996	-11,241	-8,394	-8,395	-41,025
2011/12	-15,638	-12,207	-13,075	-11,423	-52,344
2012/13	-18,559	-13,473	-16,644	-14,664	-63,341
2013/14	-21,768	-15,045	-20,509	-18,127	-75,449
2014/15	-25,277	-16,930	-24,681	-21,821	-88,710
2015/16	-29,097	-19,139	-29,174	-25,757	-103,166
2016/17	-33,240	-21,678	-34,000	-29,945	-118,864

	DOWNSIDE ASSUMPTIONS				
	NHS Redbridge	NHS Havering	NHS Waltham Forest	NHS Barking & Dag	Outer NEL
	£'000	£'000	£'000	£'000	£'000
2009/10	5,228	-6,652	4	8,746	7,326
2010/11	-12,996	-11,241	-8,394	-8,395	-41,025
2011/12	-26,903	-23,655	-25,042	-20,635	-96,235
2012/13	-40,815	-36,090	-40,243	-32,862	-150,010
2013/14	-54,748	-48,558	-55,456	-45,093	-203,854
2014/15	-59,134	-51,333	-60,554	-49,504	-220,525
2015/16	-63,835	-54,435	-65,975	-54,160	-238,404
2016/17	-68,862	-57,871	-71,734	-59,070	-257,537

Inner NE London

	BASE ASSUMPTIONS			
	NHS Tower Hamlets	NHS City & Hackney	NHS Newham	Total Inner NEL
	£'000	£'000	£'000	£'000
2009/10	9,696	12,228	2,838	24,762
2010/11	-5,904	-1,572	-6,884	-14,360
2011/12	-15,942	-24,009	-19,522	-59,473
2012/13	-23,915	-37,069	-29,759	-90,743
2013/14	-32,939	-47,278	-42,164	-122,381
2014/15	-42,165	-56,175	-52,214	-150,554
2015/16	-51,604	-65,317	-62,009	-178,931
2016/17	-61,266	-74,674	-72,893	-208,833

	UPSIDE ASSUMPTIONS			
	NHS Tower Hamlets	NHS City & Hackney	NHS Newham	Total Inner NEL
	£'000	£'000	£'000	£'000
2009/10	9,696	12,228	2,838	24,762
2010/11	-5,904	-1,572	-6,884	-14,360
2011/12	-12,515	-20,411	-15,804	-48,729
2012/13	-17,052	-29,891	-22,327	-69,270
2013/14	-22,637	-36,522	-31,024	-90,183
2014/15	-28,430	-41,845	-37,370	-107,644
2015/16	-34,439	-47,416	-43,464	-125,320
2016/17	-40,675	-53,205	-50,651	-144,531

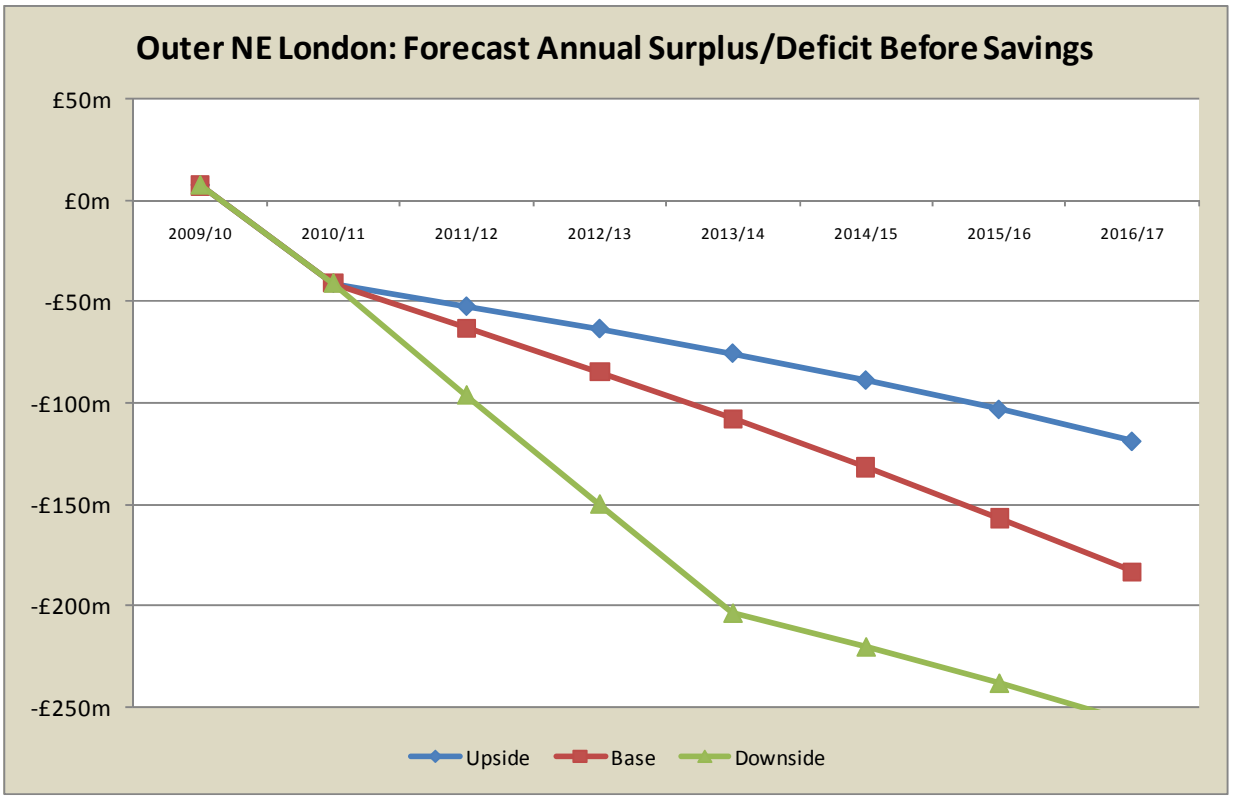
	DOWNSIDE ASSUMPTIONS			
	NHS Tower Hamlets	NHS City & Hackney	NHS Newham	Total Inner NEL
	£'000	£'000	£'000	£'000
2009/10	9,696	12,228	2,838	24,762
2010/11	-5,904	-1,572	-6,884	-14,360
2011/12	-26,454	-35,042	-30,924	-92,420
2012/13	-44,643	-58,747	-52,200	-155,591
2013/14	-63,577	-79,263	-75,292	-218,132
2014/15	-70,465	-85,727	-82,819	-239,011
2015/16	-77,574	-92,445	-90,106	-260,125
2016/17	-84,914	-99,385	-98,494	-282,793

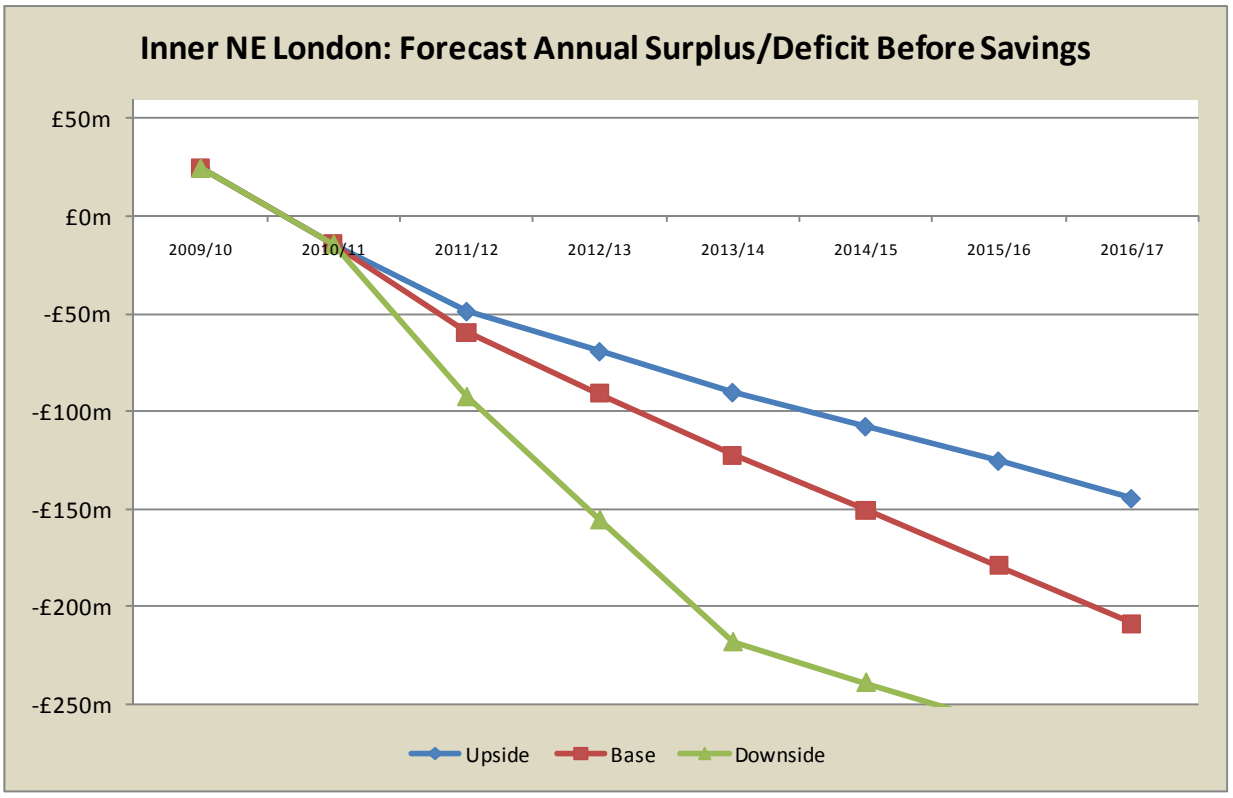
Both Sectors Total

	BASE ASSUMPTIONS		
	Total Outer NEL	Total Inner NEL	Total for Two Sectors
	£'000	£'000	£'000
2009/10	7,326	24,762	32,087
2010/11	-41,025	-14,360	-55,385
2011/12	-63,137	-59,473	-122,610
2012/13	-84,901	-90,743	-175,644
2013/14	-107,762	-122,381	-230,143
2014/15	-131,761	-150,554	-282,314
2015/16	-156,940	-178,931	-335,871
2016/17	-183,346	-208,833	-392,179

	UPSIDE ASSUMPTIONS		
	Total Outer NEL	Total Inner NEL	Total for Two Sectors
	£'000	£'000	£'000
2009/10	7,326	24,762	32,087
2010/11	-41,025	-14,360	-55,385
2011/12	-52,344	-48,729	-101,073
2012/13	-63,341	-69,270	-132,610
2013/14	-75,449	-90,183	-165,632
2014/15	-88,710	-107,644	-196,354
2015/16	-103,166	-125,320	-228,486
2016/17	-118,864	-144,531	-263,395

	DOWNSIDE ASSUMPTIONS		
	Total Outer NEL	Total Inner NEL	Total for Two Sectors
	£'000	£'000	£'000
2009/10	7,326	24,762	32,087
2010/11	-41,025	-14,360	-55,385
2011/12	-96,235	-92,420	-188,655
2012/13	-150,010	-155,591	-305,601
2013/14	-203,854	-218,132	-421,985
2014/15	-220,525	-239,011	-459,536
2015/16	-238,404	-260,125	-498,529
2016/17	-257,537	-282,793	-540,330





The PCTs in outer north east London start in 2009/10 broadly in balance overall but without a programme of savings this position will decline rapidly. In inner north east London although the starting position is slightly better the position thereafter is increasingly more challenging each year as the population grows faster than in outer north east London.

4.1.2 Measures being taken to address the potential shortfall

The measures that PCTs are proposing to meet this challenge fall into the following broad areas. These were developed from work done by *Healthcare for London*, which identified a range of potential savings that could be achieved:

- **Decommissioning services**: cease commissioning and providing low value-added interventions (e.g. grommets, some joint replacements, some outpatient follow-ups). Productivity gains in the acute providers to reduce length of stay should also provide gains for PCTs from reduced trim-point tariffs. In the longer term savings of between £60m and £150m have been identified by *Healthcare for London.* Decommissioning of services is subject to appropriate consultation and engagement.

- **Improved management of long-term conditions**: provide care proactively for people living with a long term condition, outside of hospital to prevent avoidable use of hospital services.

- **Shifting acute activity to a lower cost setting**: reduce unit price for those services that can be safely and more cost effectively provided through a different pathway out of the hospital and closer to home. Analysis shows that savings of around £11m per annum can be found from changing shifts to community-bases settings in the short-term. The *Healthcare for London* estimate of the savings (net of new investment required) in the longer term is between £10m-£70m.

- **Reduced unit costs for services not covered by fixed tariffs**: introducing limited competitive procurement for community and primary care services will reduce unit costs and increase productivity. Forecasts of the potential that could be saved range between £270m and £550m depending on how aggressive the commissioners chose to be in procurement of these services and the flexibility that primary care contracts allow.

- **Prevention**: reduce demand for acute services by extending screening, identifying people at risk and proactively managing the health of those people. Potential savings have not been forecast, because the relationship between a prevention initiative and a resulting change in spending is not sufficiently understood.

Potential savings targeted for north east London in *Healthcare for London* analysis

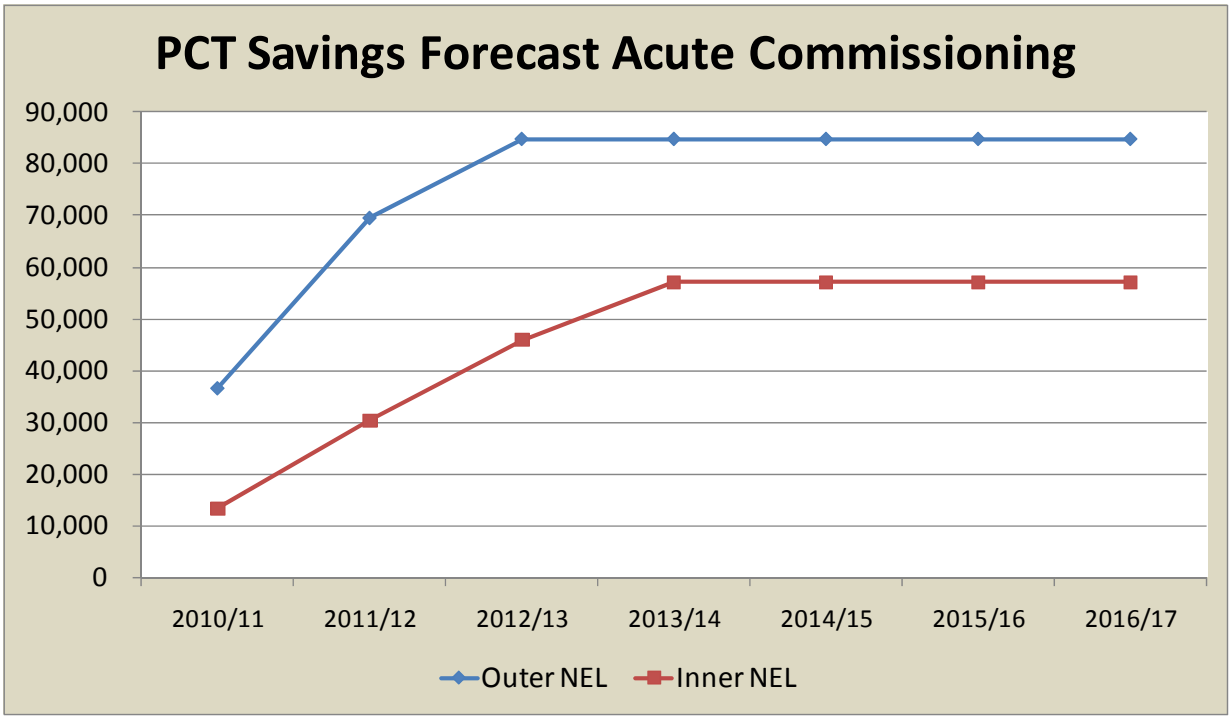
Measures	Core Forecast Savings	Aggressive Forecast Savings
Decommissioning/ long term conditions	£60m	£150m
Shifting the settings of care	£10m	£70m
Reduced unit costs	£270m	£550m
Total	**£340m**	**£770m**

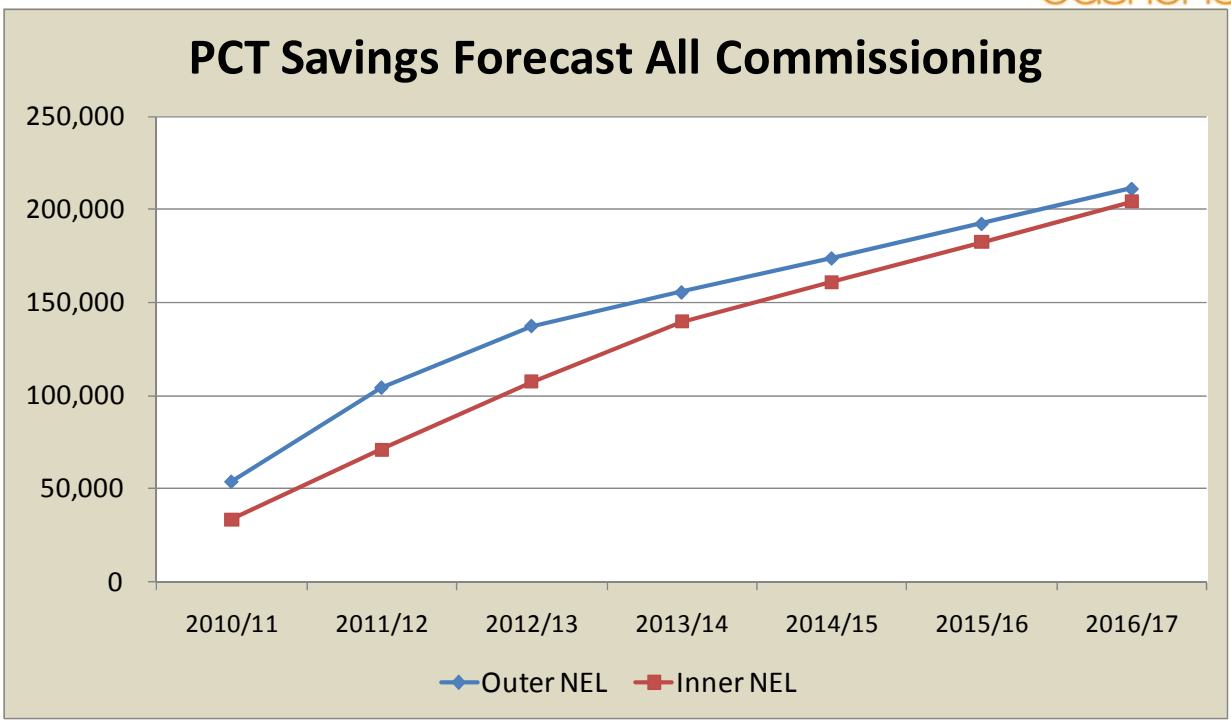
The PCTs have made initial forecasts of the effect of savings from decommissioning, improved management of long term conditions and from shifting settings of care. The tables below have assumed net savings of £142m from these two areas (4.9% of turnover), which is part way between £70m-£220m identified by *Healthcare for London,* shown in the above table. Of this around £95m relates to decommissioning and the balance, £55m, from shifting settings of care. This translates into reductions in income to the acute providers of £300m. This is incorporated into the forecasts of acute financial performance.

A saving of 4.0% per annum is forecast for non-acute services, which equates to the *Reduced Unit Costs* estimate above. In total this equates to £273m per annum by 2016/17 (9.4% of turnover). For most NHS services this saving will be delivered by including an efficiency gain in the calculation of the annual uplift.

Total Forecast Savings from Commissioning

	Annual Forecast Savings									
	NHS Redbridge £'000	NHS Havering £'000	NHS Waltham Forest £'000	NHS Barking & Dag £'000	Outer NEL £'000	NHS Tower Hamlets £'000	NHS City & Hackney £'000	NHS Newham £'000	Inner NEL £'000	Total £'000
Savings from Acute Services										
2010/11	9,385	9,913	10,683	6,705	36,686	3,750	3,987	5,635	13,372	50,057
2011/12	17,981	19,091	19,817	12,683	69,572	8,641	9,013	12,680	30,334	99,906
2012/13	22,132	23,659	23,599	15,455	84,846	13,205	13,693	19,021	45,919	130,765
2013/14	22,132	23,659	23,599	15,455	84,846	16,303	17,333	23,482	57,119	141,964
2014/15	22,132	23,659	23,599	15,455	84,846	16,303	17,333	23,482	57,119	141,964
2015/16	22,132	23,659	23,599	15,455	84,846	16,303	17,333	23,482	57,119	141,964
2016/17	22,132	23,659	23,599	15,455	84,846	16,303	17,333	23,482	57,119	141,964
Savings from Community, Mental Health and Primary Care Services										
2010/11	3,924	4,829	4,703	3,815	17,270	6,285	6,921	6,883	20,090	37,360
2011/12	7,963	9,736	9,524	7,731	34,954	12,659	14,156	13,910	40,725	75,679
2012/13	12,068	14,653	14,399	11,692	52,813	19,021	21,600	20,924	61,545	114,357
2013/14	16,245	19,586	19,335	15,705	70,871	25,377	29,260	28,030	82,666	153,538
2014/15	20,500	24,539	24,338	19,776	89,153	31,735	37,141	35,081	103,957	193,110
2015/16	24,839	29,517	29,416	23,911	107,683	38,102	45,250	42,147	125,499	233,182
2016/17	29,269	34,525	34,576	28,116	126,487	44,486	53,593	49,228	147,307	273,793
Total Savings Forecast										
2010/11	13,309	14,741	15,386	10,519	53,956	10,035	10,908	12,519	33,461	87,417
2011/12	25,944	28,827	29,341	20,414	104,525	21,299	23,170	26,590	71,059	175,585
2012/13	34,201	38,313	37,998	27,147	137,659	32,226	35,294	39,944	107,464	245,123
2013/14	38,378	43,245	42,934	31,160	155,717	41,680	46,594	51,512	139,785	295,502
2014/15	42,633	48,198	47,937	35,231	173,999	48,038	54,475	58,563	161,075	335,075
2015/16	46,972	53,176	53,016	39,366	192,529	54,405	62,583	65,629	182,617	375,147
2016/17	51,401	58,184	58,176	43,571	211,333	60,789	70,926	72,710	204,425	415,758





The tables below show these savings included in the PCT expenditure forecasts.

Annual Surplus/Deficit Assumptions Including Aggressive Savings Plan

Outer NE London

	BASE ASSUMPTIONS				
	NHS Redbridge	NHS Havering	NHS Waltham Forest	NHS Barking & Dag	Outer NEL
	£'000	£'000	£'000	£'000	£'000
2009/10	5,228	-6,652	4	8,746	7,326
2010/11	314	3,501	6,993	2,124	12,931
2011/12	7,535	13,805	13,323	6,725	41,388
2012/13	10,105	19,213	15,483	7,956	52,758
2013/14	8,310	19,767	13,630	6,248	47,955
2014/15	6,298	20,031	11,542	4,368	42,239
2015/16	4,062	20,001	9,212	2,314	35,589
2016/17	1,596	19,674	6,635	82	27,987

	UPSIDE ASSUMPTIONS				
	NHS Redbridge	NHS Havering	NHS Waltham Forest	NHS Barking & Dag	Outer NEL
	£'000	£'000	£'000	£'000	£'000
2009/10	5,228	-6,652	4	8,746	7,326
2010/11	314	3,501	6,993	2,124	12,931
2011/12	10,305	16,620	16,266	8,990	52,181
2012/13	15,642	24,839	21,354	12,483	74,318
2013/14	16,610	28,200	22,425	13,034	80,268
2014/15	17,356	31,268	23,256	13,410	85,289
2015/16	17,875	34,037	23,842	13,609	89,363
2016/17	18,161	36,506	24,176	13,626	92,469

	DOWNSIDE ASSUMPTIONS				
	NHS Redbridge	NHS Havering	NHS Waltham Forest	NHS Barking & Dag	Outer NEL
	£'000	£'000	£'000	£'000	£'000
2009/10	5,228	-6,652	4	8,746	7,326
2010/11	314	3,501	6,993	2,124	12,931
2011/12	-960	5,172	4,299	-221	8,290
2012/13	-6,614	2,223	-2,245	-5,715	-12,351
2013/14	-16,370	-5,312	-12,522	-13,933	-48,136
2014/15	-16,501	-3,135	-12,616	-14,273	-46,526
2015/16	-16,863	-1,259	-12,960	-14,794	-45,875
2016/17	-17,460	313	-13,558	-15,499	-46,204

Inner NE London

	BASE ASSUMPTIONS			
	NHS Tower Hamlets	NHS City & Hackney	NHS Newham	Total Inner NEL
	£'000	£'000	£'000	£'000
2009/10	9,696	12,228	2,838	24,762
2010/11	4,131	9,336	5,635	19,101
2011/12	5,357	-839	7,069	11,587
2012/13	8,311	-1,775	10,185	16,721
2013/14	8,741	-684	9,348	17,404
2014/15	5,873	-1,700	6,349	10,522
2015/16	2,801	-2,734	3,620	3,687
2016/17	-477	-3,747	-183	-4,408

	UPSIDE ASSUMPTIONS			
	NHS Tower Hamlets	NHS City & Hackney	NHS Newham	Total Inner NEL
	£'000	£'000	£'000	£'000
2009/10	9,696	12,228	2,838	24,762
2010/11	4,131	9,336	5,635	19,101
2011/12	8,785	2,759	10,787	22,330
2012/13	15,174	5,403	17,617	38,194
2013/14	19,043	10,072	20,487	49,602
2014/15	19,608	12,630	21,193	53,431
2015/16	19,966	15,167	22,164	57,298
2016/17	20,113	17,721	22,059	59,894

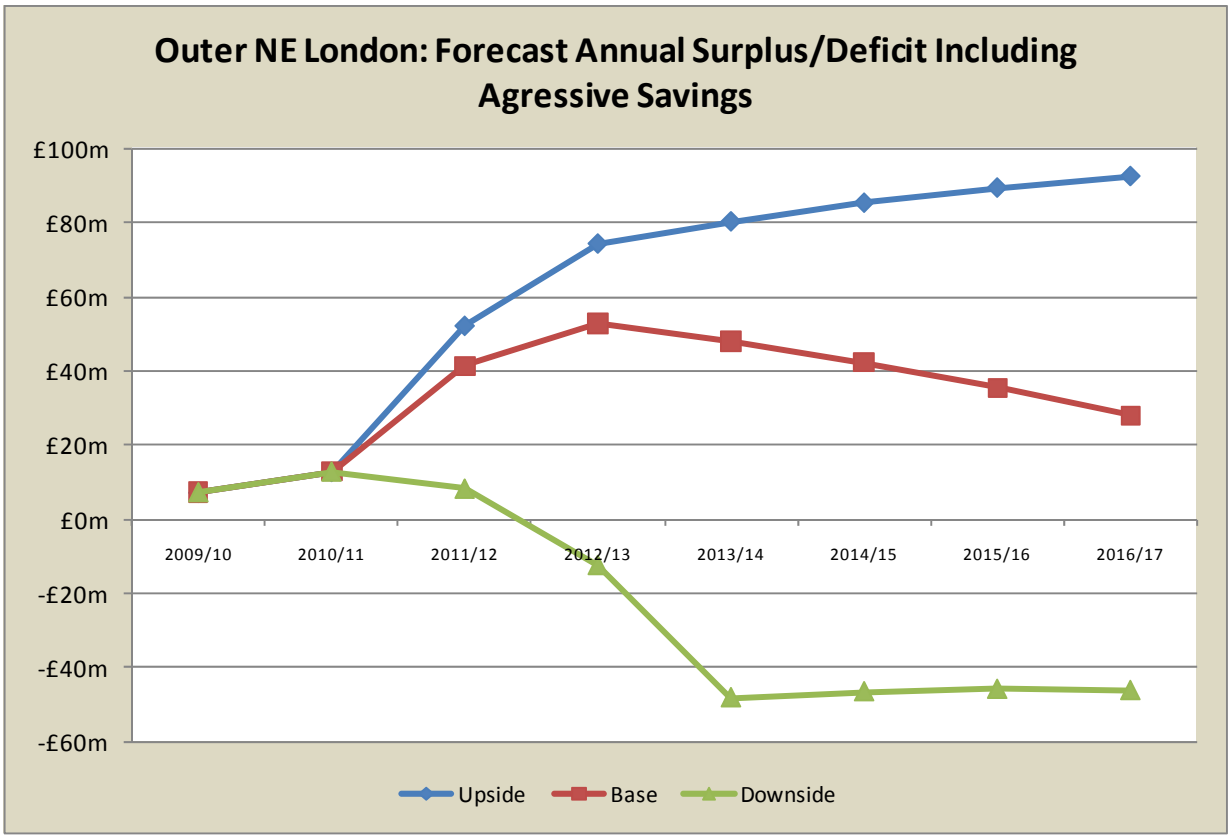
	DOWNSIDE ASSUMPTIONS			
	NHS Tower Hamlets	NHS City & Hackney	NHS Newham	Total Inner NEL
	£'000	£'000	£'000	£'000
2009/10	9,696	12,228	2,838	24,762
2010/11	4,131	9,336	5,635	19,101
2011/12	-5,154	-11,873	-4,334	-21,361
2012/13	-12,417	-23,454	-12,256	-48,127
2013/14	-21,897	-32,670	-23,780	-78,347
2014/15	-22,427	-31,253	-24,256	-77,936
2015/16	-23,168	-29,862	-24,477	-77,507
2016/17	-24,125	-28,459	-25,784	-78,368

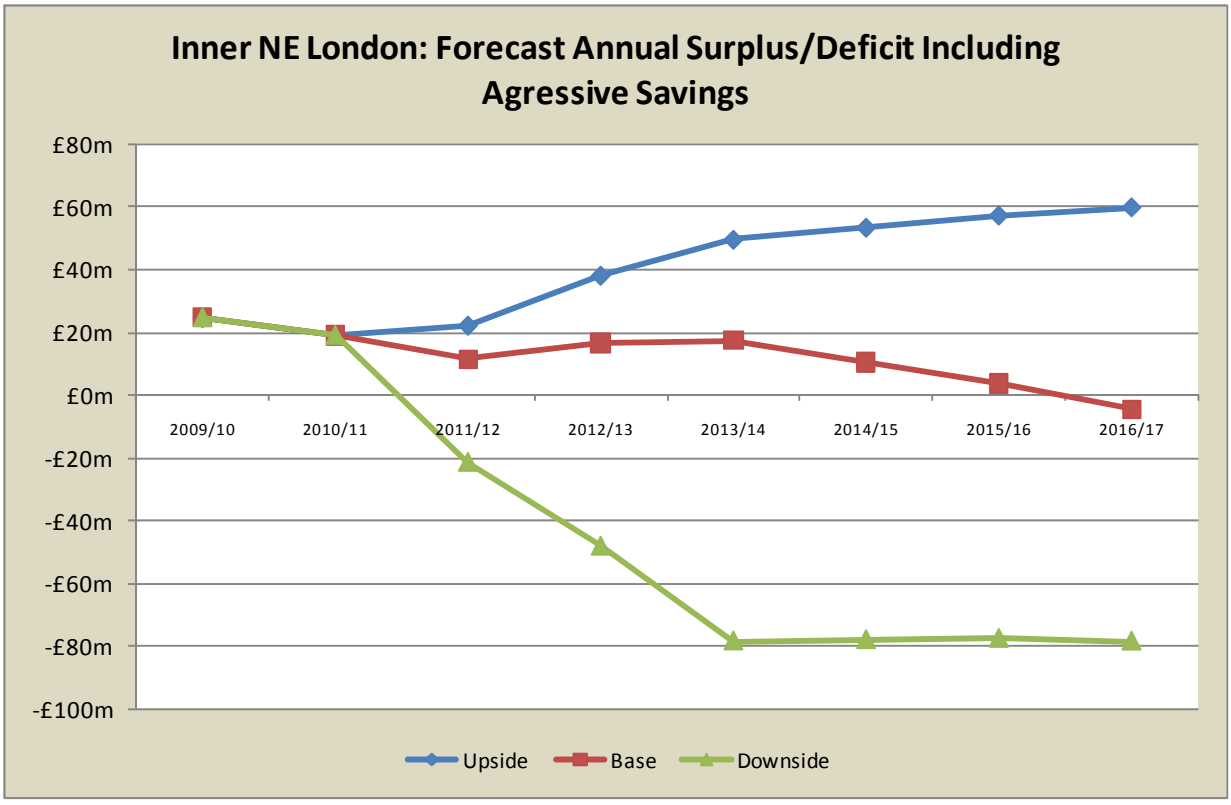
Both Sectors Total

	BASE ASSUMPTIONS		
	Total Outer NEL	Total Inner NEL	Total for Two Sectors
	£'000	£'000	£'000
2009/10	7,326	24,762	32,087
2010/11	12,931	19,101	32,033
2011/12	41,388	11,587	52,975
2012/13	52,758	16,721	69,478
2013/14	47,955	17,404	65,360
2014/15	42,239	10,522	52,760
2015/16	35,589	3,687	39,276
2016/17	27,987	-4,408	23,579

	UPSIDE ASSUMPTIONS		
	Total Outer NEL	Total Inner NEL	Total for Two Sectors
	£'000	£'000	£'000
2009/10	7,326	24,762	32,087
2010/11	12,931	19,101	32,033
2011/12	52,181	22,330	74,512
2012/13	74,318	38,194	112,512
2013/14	80,268	49,602	129,870
2014/15	85,289	53,431	138,721
2015/16	89,363	57,298	146,661
2016/17	92,469	59,894	152,362

	DOWNSIDE ASSUMPTIONS		
	Total Outer NEL	Total Inner NEL	Total for Two Sectors
	£'000	£'000	£'000
2009/10	7,326	24,762	32,087
2010/11	12,931	19,101	32,033
2011/12	8,290	-21,361	-13,071
2012/13	-12,351	-48,127	-60,478
2013/14	-48,136	-78,347	-126,483
2014/15	-46,526	-77,936	-124,462
2015/16	-45,875	-77,507	-123,382
2016/17	-46,204	-78,368	-124,573





In both inner north east London and outer north east London the savings shown will be enough to bring the PCTs into, or very close to, financial balance assuming the base case allocation assumptions. In the CSP submissions the PCTs will address the extent to which

further savings will be required which would come from either a more aggressive approach to savings from the acute sector or, more likely, from further efficiency within community and primary care services, or a combination of the two.

Savings from the commissioning of acute services proposed by outer north East London are more heavily weighted towards 2010/11 and 2011/12 than in inner north east London. This reflects the fact that outer north east London PCTs are starting from a more difficult financial position and will therefore be the focus for an accelerated savings programme.

4.1.3 Risks associated with these forecasts

The PCTs recognise a number of risks associated with these forecasts. Broadly these are:

- Variations in allocation: the forecasts show a wide range of possible income levels to commissioners.

- Population growth: the population of north east London has been growing for some years. The assumption made is that it will continue to grow and that demand for healthcare will increase at the same rate. This activity growth is based on forecasts issued by the General London Assembly (GLA). However the actual growth in the population and the effect that this will have on demand for services could vary from the plan.

- The programme of initiatives being introduced by commissioners to change the way that acute healthcare is delivered is extremely challenging. In order to realise the savings identified new models of service delivery and new care pathways will need to be delivered very rapidly to reduce the use of acute hospitals. There are risks surrounding the delivery of the programme, in particular the pace at which it can be introduced. There also risks surrounding the effectiveness that the initiatives will have on reducing the demand for and cost of acute services.

- Financial viability of the whole health economy will be undermined if the acute providers are not able to deliver significant productivity gains to match the loss of income that is forecast if acute activity is reduced, and the growth in healthcare costs and real tariff deflation.

The actions that commissioners may be able to introduce to mitigate these risks are:

- The savings outlined above are concentrated into the early years of the programme giving the opportunity to develop further savings plans in later years if necessary.

- The savings programme in outer north east London is being pursued aggressively in the first three years to provide a £40m pa margin (see graph on previous page) above break-even on the base-case forecast of allocation. Should any of the modelling assumptions be worse than anticipated then there is the option to introduce further acute sector saving initiatives in later years.

- The modelling assumptions used in non-acute sector are in line with NHSL guidance and are considered conservative; for example, 8% per annum increase in drugs spend. The *Healthcare for London* proposals suggest that further savings could be achieved in primary care; indeed drug expenditure has been limited to 1-4% in recent years.

4.1.4 Conclusion: commissioners

Commissioners are forecasting savings of £415m per annum in total by 2016. Of this £142m per annum will come from changes to services commissioned from acute providers through decommissioning some services and introducing changes to patient pathways. This level of savings will be necessary to address a potential recurrent shortfall created by growing patient demand at a time when there is likely to be only minimal growth in allocations at best. The savings programme is ambitious and will need to be introduced early in this planning period. There are risks around allocations and expenditure, so PCTs will be developing plans to mitigate against risks in their CSPs, as well as working with providers to facilitate cross-sector transformation.

4.2 THE PROVIDERS' PERSPECTIVE

4.2.1 Methodology for forecasting provider income and expenditure

Health for North East London developed an activity, income and cost model to forecast the effect of changes to activity and pricing/ cost inflation on the financial position of trusts. The principal purpose of the model is to contrast the effect of the alternative reconfiguration options. Forecasting used 2007/08 activity and costs as the baseline to which assumptions have been applied for each year up to 2016/17.

This modelling is based on assumptions from NHS London, north east London PCTs and providers, and feedback from the Clinical Reference Group (CRG). The assumptions and methodology of the activity projections were discussed and signed off by north east London Directors of Commissioning, and have been shared with the NHS London, PCTs and providers.

Health for North East London's modelling accounts for the following effects:

- Demographic and non-demographic growth in demand
- Changes in activity due to changes in the designation of sites as major acute, hospital with A&E or hospital with Urgent Care Service (UCS), and repatriation of activity to hospitals on the basis of travel time modelling
- Shifts to settings of care out of hospital and decommissioning
- Tariff changes and healthcare cost inflation over and above Consumer Price Index (CPI)
- Productivity gains
- Impacts of reconfiguration (including transition costs)

Costs are all on a 2007/08 real-terms basis, so indices used are net of the underlying CPI. *Appendix D* lists the assumptions built into the provider cost assumptions.

A cost scaling approach has been developed in the model to forecast changes to expenditure as a result of the changes to income that in turn are derived from changes to activity. All provider costs were broken down between direct and indirect costs. Following discussion with the provider Directors of Finance, the assumption has been made that for every 1% increase in income there is a 0.95% increase in direct costs and 0.50% increase in indirect costs.

A different and more specific approach has been taken where there is a major site rationalisation. Site reconfiguration gives the opportunity to save a much greater proportion of the fixed costs. The assumption has been made that 100% of costs are saved where a whole service is transferred away from a site.

4.2.2 The Challenge for acute providers

Acute providers in the sector face a large financial challenge in the period up to 2016/17. The pressures faced include:

- Providers have been asked to assume that there will be real-term decreases in the value of tariff income. The assumption made is that tariff will decrease by 3% per year from 2011.

- There will be specific shifts of activity out of the acute hospitals as a result of the new initiatives in community and primary care that were presented in *Healthcare for London: A Framework for Action.* The acute hospitals will lose income from these activity shifts to other providers but will also be able to reduce costs. The assumption made is that the net financial loss after taking account of the reduced expenditure will be approximately 25% of the tariff income.

- PCTs will introduce measures that will reduce the total volume of activity in hospitals. These are referred to throughout as demand management savings. The assumption has been made that this will result in a negative net impact of approximately 25% of the value of the tariff associated with these activities.

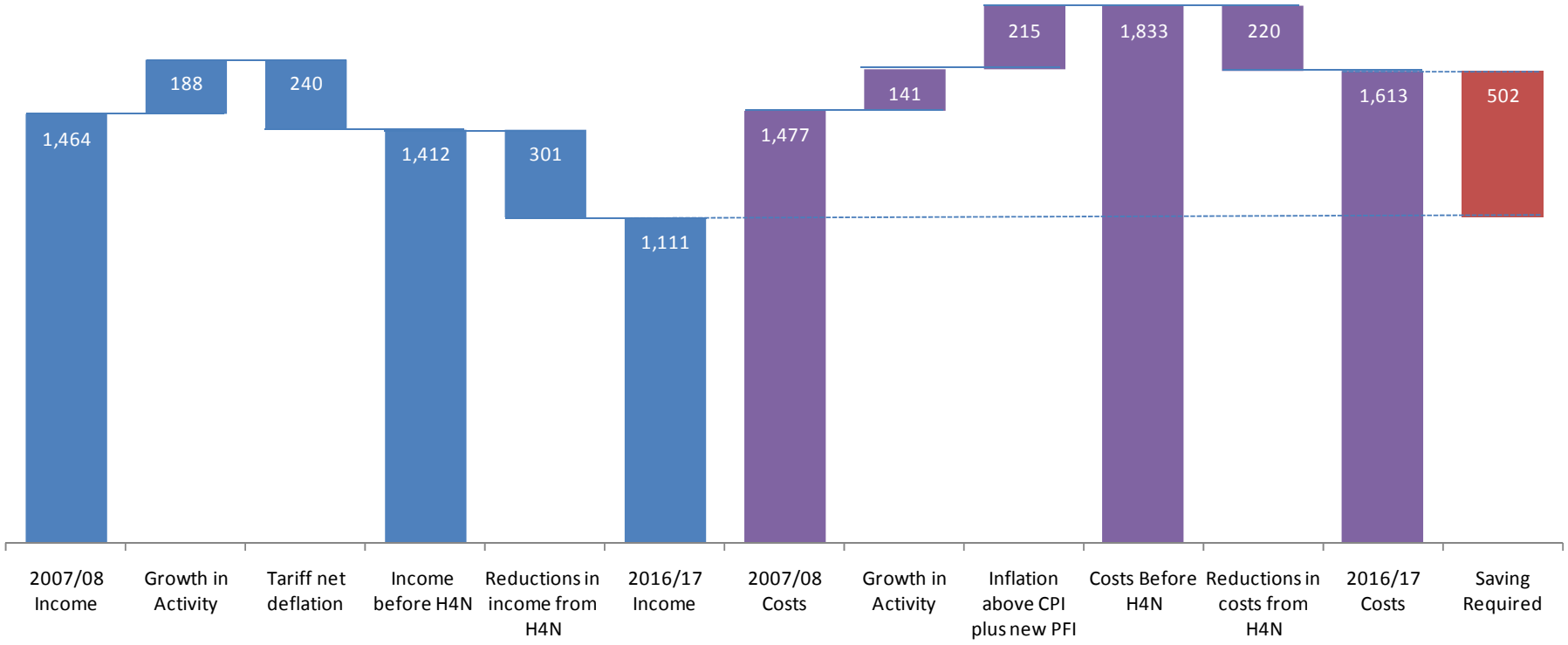
The figure that follows illustrates the financial challenge for all acute trusts in north east London in aggregate[16].

[16] Trust submissions 2007/08, NHS London analysis

Financial Challenge for Acute Trusts

Trust Income and Expenditure 2007/08-2016/17

(2007/08 £m)



1. Income includes PCT funding from outside NEL. Income shown is an HRG 4.0 re-priced version of actual trust submissions. The income as submitted by trusts is 1,405
2. Growth based on Demographics; Non-demographics and trust submitted figures
3. Tariff decreases 0.2% in 2008, 0.3% in 2009, 0.8% in 2010 and 3% thereafter (Monitor guidance letter March 2009)
4. Includes shifts in SoC and Demand management; SoC excluded Settings of Care are: GP, Home, UCC at Polyclinic; Midwife-led stand alone unit and Rehabilitation; Demand management assumes a decommission of activity as suggested by CWGs
5. 2016 data is interpolated using 2017 data
6. Cost scales with activity growth at 75%
7. Healthcare costs inflation of 2.2% per year in 2007/08 and 2009/10. 2.7% in 2010/11 and 1% subsequently (source: NHS London)
8. Cost scales with activity decline at 95% direct, 50% indirect, and 0% estate)

The pressures above are generic cost pressures that apply to all acute providers. In addition there are a number of issues that apply to specific trusts. BHRUT was reporting a deficit at the end of 2008/09: Barts and the London will need to cover the cost of their new PFI scheme that opens during 2010/11.

The tables below (full details including year on year analysis, are included in *Appendix E*) show the forecast deficit of each trust before any productivity gains have been applied. This shows the size of cost saving that each trust will need to deliver to achieve financial viability.

Forecast Surplus/Deficit before any Savings or Productivity Gains

£millions	2008/09 Reported Surplus/ Deficit	2016/17 Forecast Surplus/ Deficit	Required Saving - % of Expenditure
Barking Havering & Redbridge University Hospitals Trust	-26.1	-139.2	-35%
Barts & the London Trust	10.6	-210.8	-32%
Homerton University Hospital NHS Foundation Trust	3.4	-41.8	-28%
Newham University Hospital Trust	0.2	-52.3	-27%
Whipps Cross University Hospital Trust	0.9	-57.2	-33%
Total	-11.0	-501.2	-32%

The analysis shows that in total the sector needs to make savings of £501m to bring the annual spending back to the level of income. This equates to 32% of the current level of spending.

4.2.3 Opportunities for productivity gains

Productivity gains have been assumed which could close this financial gap and put the sector back into balance. These productivity gains have been developed from the NHS London analysis of affordability and include:

- Moving to best in class nurse productivity and spending levels with a potential saving of 21-37% of nursing costs
- Moving to best in class doctor productivity and spending levels with a potential saving of 9-43% of doctor costs
- Reducing drug spend to best in class through reductions in branded drug prices, variability in prescribing, and increases in generic prescribing (22-25% of drug costs)
- Reduction in outpatient 'did not attend' (DNA) rates (0.5-4% of outpatient costs)
- Reductions in overheads to benchmarked best practice (34-42% of overhead costs)

The effect of reduced average length of stay (ALOS) is included within the savings identified for nursing, doctors and overheads. This is not intended to be an exhaustive list – there are potentially more savings to be found, for example, in clinical support services such as theatres and diagnostics. NHS London's affordability work identified an overall potential saving of 32% of costs from productivity gains.

These translate into to the productivity gains seen in the figure that follows.

Average productivity assumptions applied	
Cost category	NEL
Total direct	**36%**
Staff - medical	**41%**
Staff - nursing	**34%**
Staff - other clinical	**35%**
Staff - agency	**35%**
Drugs	**33%**
Other clinical supplies and services	**33%**
Total indirect	**34%**
Staff - management	**40%**
Staff - other	**39%**
Other general services	**39%**
Other	**40%**
Depreciation and amortisation	**0%**
Total costs	**32%**

The table below shows the effect of applying this level of productivity gain to each provider. It demonstrates that for most trusts this level of savings will be sufficient to meet the deficits forecast above. The exceptions are BHRUT and Whipps Cross that fall short of breakeven.

Forecast Surplus/Deficit Including Aggressive Productivity Gains but before any Reconfiguration

£millions	2008/09 Reported Surplus/ Deficit	2016/17 Forecast Surplus/ Deficit
Barking Havering & Redbridge University Hospitals Trust	-26.1	-7.9
Barts & the London Trust	10.6	5.5
Homerton University Hospital NHS Foundation Trust	3.4	5.5
Newham University Hospital Trust	0.2	8.9
Whipps Cross University Hospital Trust	0.9	-1.5
Total	-11.0	10.5

A full presentation of income and expenditure for each Trust, including a year-on-year breakdown is included in *Appendix E*.

Whilst the two sectors as a whole are returned to financial balance two trusts, BHRUT and to a marginal extent Whipps Cross are forecast with small deficits in 2016/17. Both of these deficits are affected by reconfiguration which is addressed in *Chapter 9*.

The 32% savings shown above are described as 'aggressive' because of the challenge that they pose for commissioners and providers. *Healthcare for London* also defined a less aggressive set of productivity savings based on initiatives that would be easier to introduce. The table below shows the forecast surplus for trusts when the productivity gains are moved to

this less aggressive range. This level of saving will not be enough to bring the economy back into balance; all the providers show deficits in 2016/17 in this scenario.

Forecast Surplus/Deficit Including Less Aggressive Productivity Gains but before any Reconfiguration

£millions	2008/09 Reported Surplus/ Deficit	2016/17 Forecast Surplus/ Deficit
Barking Havering & Redbridge University Hospitals Trust	-26.1	-66.8
Barts & the London Trust	10.6	-90.6
Homerton University Hospital NHS Foundation Trust	3.4	-15.1
Newham University Hospital Trust	0.2	-17.9
Whipps Cross University Hospital Trust	0.9	-25.8
Total	-11.0	-216.3

It is recognised that the scale of the aggressive savings is substantial. However, there is considerable opportunity to improve productivity and reduce costs through reduced ALOS, and significant improvements can be made to how we use the current workforce.

4.2.4 Conclusions: acute providers

Acute providers in the sector face a significant financial challenge over the next years as a combination of:

- Real-terms reduction to NHS tariffs
- Loss of income as the location of care shifts to alternative settings and as activity reduces due to demand management initiatives
- Cost inflation

In aggregate trusts will need to find savings of around 32% of costs to maintain financial balance. In addition BHRUT is starting from a deficit position with a large PFI at Queen's and BLT has the cost of a significant PFI scheme to finance.

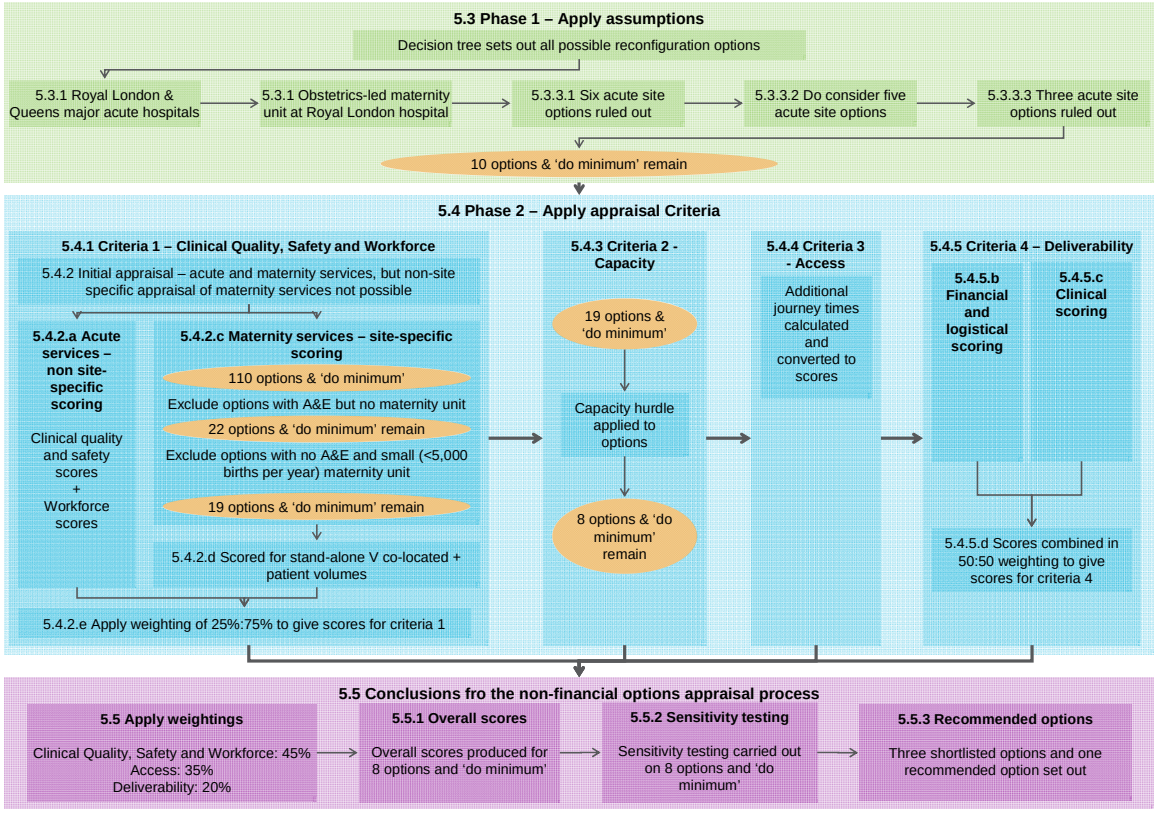
There is the potential to achieve sufficient savings to match this shortfall through meeting the best levels of productivity and cost efficiency seen elsewhere in England. However, trusts will need to be aggressive in finding and delivering these savings and savings programmes need to be implemented from 2009/10 even in those trust that are currently in financial balance.

In the case of BHRUT and Whipps Cross this alone may not be enough to achieve financial balance. Some of the savings required will need to come from reductions to overheads which in turn will require rationalisation of estate and reconfiguration.

5. NON-FINANCIAL OPTIONS APPRAISAL

The case for change identified that significant change is needed to the configuration of hospitals in north east London. Part of this change is consolidation of some services to fewer sites and increased provision of out of hospital services. To develop a set of robust options for change, the *Health for North East London* programme undertook a rigorous process to identify reconfiguration options that would deliver the required change in the most beneficial way.

This chapter describes the non-financial options appraisal processes that have supported the development of the PCBC and the option that will be subject to formal public consultation. The structure of this chapter and a summary of the process are shown in the diagram below.



5.1 PRINCIPLES THAT UNDERPIN THE WORK OF THE PROGRAMME

5.1.1 Programme aims agreed at the outset

All NHS organisations that form the *Health for North East London* have agreed a set of programme aims. These are to:

- Improve the health of the whole population, reducing inequalities;
- Improve service quality as measured by safety, patient experience, access and quality standards;
- Ensure ongoing financial sustainability.

All local NHS organisations are committed to working together to deliver these aims. There is a clear recognition of the importance of engaging clinicians, patients and local residents in the change programme, as well as the importance of integrated working with local authorities and other local partner organisations. As such the programme actively seeks ways to:

- Enable clinicians to drive the changes required;
- Develop meaningful partnerships with patients and local residents in the development and delivery of their local health services;
- Ensure the work of the programme is effectively linked to the work of local strategic partnerships.

A further principle was agreed by the programme that, whilst substantial changes are needed to hospitals to make the vision for north east London a reality, all of the existing hospital sites will continue to provide healthcare services. However, the shape of services at each hospital will need to change significantly to reflect the changing demand and reduced reliance on hospital inpatient facilities, and provide a more diverse mix of hospital, primary, community and social care available where people need them.

During each phase of the non-financial options appraisal process, the outcomes were tested against these aims and principles.

5.1.2 Settings of care

In addition to the above, an important aspect of the clinical design process was the hospital models, based on those developed by *Healthcare for London* (see *Chapter 2*). *Health for North East London's* Clinical Reference Group (CRG) has reviewed these models in relation to the local healthcare context, and recommended that three hospital models are most appropriate for north east London. These are described below and were subsequently used as part of the clinical design process.

- ***Major acute hospitals –*** services include an A&E department, urgent care services and diagnostics as well as urgent medicine, urgent surgery, obstetrics and gynaecology and other acute services. A major acute will provide a local hospital service for its catchment population, as well as consolidated specialist services such as hyper-acute stroke and (in some cases) major trauma, vascular surgery and neurosurgery.
- ***Hospitals with A&E*** – services will include an A&E department, urgent care services and diagnostics as well as urgent medicine, urgent surgery, obstetrics and gynaecology and other acute services. Hospitals with A&E will not, as a rule, be a centre for consolidation of specialist services.
- ***Hospitals with urgent care services (UCS)*** – services will include a round the clock urgent care service, extended polyclinic services and a full range of diagnostic services. This type of hospital will play an important role in preventing ill health and supporting self care for the local population through continuity of care via an extensive range of proactive and joined-up primary care services.

a. ELECTIVE SERVICES

Whilst current options' modelling has elective care remaining at all hospital sites, it is anticipated that further consideration will be given to the optimal configuration of elective services once agreement has been reached on the configuration of acute services, specialist services, paediatrics and maternity services. In addition to locating elective services in acute hospitals, elective centres will be considered as sites for high-throughput elective surgery, as well as location of elective services alongside other healthcare services, such as community hospitals.

b. BED-BASED REHABILITATION SERVICES

The CRG recommended that consideration should be given to location of some rehabilitation and intermediate care beds on the same site as other community-based healthcare services such as a community hospital, polyclinic or hospital with UCS.

The settings of care described above formed an important part of identifying the configuration of services, and any necessary co-location of services for north east London.

5.1.3 The 'do minimum' scenario

Throughout this chapter reference is made to the 'do minimum' scenario. The scenario is 'do minimum' rather than 'do nothing' because some agreements about reconfiguration have already been made and planning and/ or implementation is already underway. These activities are closely connected with the clinical proposals for change presented in this pre-consultation business case, and in some cases are dependent on the reconfiguration changes to fully deliver their objectives (see *section 2.3* for further detail on these activities).

The 'do minimum' scenario includes the following assumptions:

- **That a minimum of 40% of hospital activity can shift to community settings ~** that there will be significant changes in settings of care to provide more services in the community, closer to home. This will include the development of polysystems, with polyclinics at their hub, with greater access to a full range of primary care and community services, as well as diagnostics. This shift in setting of care is in line with what has already been agreed by the London JCPCT following *Healthcare for London's Consulting the Capital* formal consultation exercise. Clinical estimates suggest that a minimum of 40% of current outpatient and diagnostic activity will be provided in community and primary care settings and this shift can be phased over a three year period.

- **That clinical pathway transformation will mean approximately 20% of hospital activity is no longer required ~** the clinical view is that a proportion of demand for hospital services could be significantly reduced with changes to care pathways and improvements to access and quality of prevention services in the community. It is estimated that through transformation of clinical pathways and other improvements approximately 20% of the current demand for hospital services will no longer be required.

- **That significant improvements in healthcare quality and productivity will be made ~** all healthcare providers in north east London are undertaking programmes to improve the quality and productivity of services. North east London is currently performing below average for England, against indicators such as GP access, rates of healthcare acquired infections, average length of stay, hospital readmission rates

and patient satisfaction levels, and these indicators will be a key focus as part of the improvement programmes.

- **That Royal London and Queen's will be the providers of major trauma and hyper-acute stroke care on behalf of north east London ~** decisions made following *Healthcare for London's Consulting the Capital* public consultation are to provide hyper-acute stroke units at Royal London and Queen's, and major trauma services at Royal London.

5.2 CRITERIA FOR NON-FINANCIAL OPTIONS APPRAISAL

Appraisal criteria were developed as a way of differentiating between the available options based on what is most important to realising the vision for healthcare in north east London.

The criteria needed to be standards or principles that could be applied to each option either on a pass/fail 'hurdle' basis or a scoring given. A number of criteria had to be rejected on the basis that whilst they reflected an important factor for the healthcare vision they did not enable differentiation between options. For example, patient satisfaction was identified as a key factor for the future of healthcare in the sector; however, it was determined that all options had the potential to deliver the same levels of patient satisfaction.

The final criteria were developed in consultation with the general public, the engaged public, clinicians and managers. Members of the public were also involved in weighting the relative value of the decision-making criteria. This part of the process is described in more detail in *section 5.5* of this chapter.

There are four non-financial decision criteria, with key lines of enquiry supporting each one as discussed in the paragraphs that follow. The financial criteria, and assessment against them, are discussed in the next chapter of the PCBC.

5.2.1 Clinical quality, safety and workforce

Key lines of enquiry:

- Will the option comply with or exceed the guidelines on clinical quality, safety, efficiency and effectiveness of patient care set by the Government, Royal Colleges and NICE?

- Will the option allow the NHS in north east London to attract, develop and retain the staff needed to provide high quality healthcare that provides senior clinical decision making early in the patient pathway?

These criteria were assessed in two parts: (1) for acute services (2) for maternity services. Options were scored and ranked in score order.

5.2.2 Access

Access is defined as travel times to hospital sites. Initial assessment was undertaken based on modelling; this work will be reviewed as part of the Integrated Impact Assessment (see *section 1.9*) which will also look at blue light access, disabled access and road access.

Key lines of enquiry:

- Will the option ensure that there is no significant increase in journey times for carers, patients and visitors including public and private transport?

This criteria was assessed by modelling the cumulative additional travel times for the population for each of the options, and then the options were scored and ranked in score order.

5.2.3 Capacity

This criteria reviews the ease of availability of clinical space, using bed capacity as a proxy, where it is needed to support the clinical vision for north east London.

Key lines of enquiry:

- Will the option have the capacity to deliver predicted demand for healthcare and have flexibility to downsize if demand is less than anticipated?

This criteria was treated as a 'hurdle' rather than a system for scoring. Therefore options either 'passed' or 'failed' for this criteria.

5.2.4 Deliverability

Deliverability is defined as the ease with which options can be delivered as part of the short-to-medium term vision for the sector, with a lead time of 3-5 years.

Key lines of enquiry:

- Will the option enable sustainable change to be delivered within the next 3-5 years?

For this criteria, the question was answered in two parts. Firstly how deliverable are the options in terms of the amount of change to be undertaken, and then secondly how deliverable are the options in relation to the clinical aspirations of north east London – i.e. which options best support delivery of the overall vision of high quality local and major acute hospital care for resident. The options were scored and ranked in score order.

5.3 PHASE ONE: A DECISION-TREE TO IDENTIFY A LIST OF POTENTIAL OPTIONS FOR ACUTE SERVICES

This section describes the first phase of the decision-making process. A decision tree was developed as the starting point to identify a full range of potentially acceptable options.

An underpinning assumption was that there would need to be at least three hospital sites in north east London that include A&E and other acute services required to support A&E (see *section 5.3.3*). The decision tree therefore focused on the options for three, four, five and six sites (the 'do minimum' scenario) offering A&E and other acute services.

Phase One was developed in conjunction with the Clinical Reference Group (CRG) and was signed-off by the CRG at their meeting of 24th June 2009. *The full decision-tree is included at Appendix F.*

There were three stages within Phase One:

1. Confirming the location of the major acute hospital sites;

2. Identifying any options that should be excluded from the decision-making process;

3. Identifying a list of potential configuration options for acute services.

5.3.1 Confirming that the major acute hospitals for the area will be located at the Royal London and Queen's

It was determined that there should be two 'fixed' hospital sites which would apply to all options: the Royal London Hospital, Whitechapel and Queen's Hospital, Romford. These hospital sites were identified as being the major acute hospitals for the area. The reasons for this decision are outlined in the paragraphs that follow, and this decision was confirmed at the CRG meeting of 24th June 2009.

As part of the *Healthcare for London* work to identify suitable sites across London at which to consolidate major trauma and stroke services, the Royal London was selected as a site for both major trauma and a hyper-acute stroke unit; Queen's Hospital was selected as a site for a hyper-acute stroke unit.

Based on *Healthcare for London's* settings of care (see *section 2.1*), the location of major trauma and stroke services at these sites means both require an A&E department, and indicates that these are 'major acute hospitals'; sites at which further supporting acute services should be maintained or built up to ensure the right mix of services is accessible on one site, and that the site is able to serve a wide patient catchment area.

The proposed designation of these sites as major acute hospitals has two further consequences for the reconfiguration design within the sector:

- The Royal London and Queen's become the recommended hospital sites for consolidation of specialist paediatric services, neurosurgery and vascular surgery. This is in line with *Healthcare for London's* settings of care in terms of concentrating specialist services on key sites and the need to make the best use of existing facilities.

- Specialist obstetric provision will be provided at the Royal London and Queen's (alongside local service for local catchment population).

With the Royal London and Queen's hospitals proposed as major acute hospitals, the hospital sites remaining in the sector will need to serve as hospitals with A&E or hospitals with UCS.

The CRG confirmed that:

- *all options considered would include the fixed points of the Royal London and Queen's as major acute hospitals;*

- *all options would include obstetrics-led maternity units at the Royal London and Queen's.*

5.3.2 Determining the optimal configuration for planned care services

Current options modelling has planned care remaining at all hospital sites; major acute hospitals, hospitals with A&E and hospitals with UCS. However, the CRG believes that there are models of care that can deliver higher quality outcomes and improvements in productivity than retaining this existing configuration.

Configuration of planned care services will be considered once agreement has been reached on the configuration of acute services, specialist services, paediatrics and maternity services.

In addition to locating planned care services in hospitals, elective centres will be considered as sites for high-throughput planned surgery, as well as location alongside other healthcare services, such as community hospitals.

5.3.3 identifying options that should be excluded from the decision-making process

There were three questions that were considered in relation to options based on the number of sites for accident and emergency and other acute services.

1. **Can the current configuration of six sites with acute services be considered as a viable option for the future?**

   It was determined by the CRG that the current configuration of six hospitals with A&E in north east London cannot be considered as a viable option for the future as it cannot achieve the clinical standards set out in the clinical and workforce criteria (see *section 5.2.1*). In particular the six site option would not achieve the necessary critical mass to sustain delivery of urgent care services including paediatrics and urgent surgery.

   However, it was agreed that the six site option should continue to be appraised throughout the option appraisal process to act as a baseline for comparison.

At their meeting on the 24th June, the CRG advised that: • *the current configuration or 'do minimum' scenario should be excluded.* *However, it was agreed that this option would feature throughout the option appraisal to act as a baseline for comparison.*

2. **Can we rule out five-site options on the basis of the clinical case that it would not be sustainable to deliver urgent care across five sites for a population of 1.8 million?**

   The question is based on the premise that effective and safe A&Es require a critical mass of catchment population to provide the best services. Whilst there is a lot of debate about the optimum size, there is consensus that catchment populations of less than 300,000 are not optimal and greater than 400,000 would be desirable. On this basis, if the configuration were being designed from scratch to best align to demand, a five site option serving a population of 1.8 million would be marginal.

CRG agreed that there was not a good basis to exclude five site options, and therefore the five site options were included in the option appraisal process.

CRG advised:

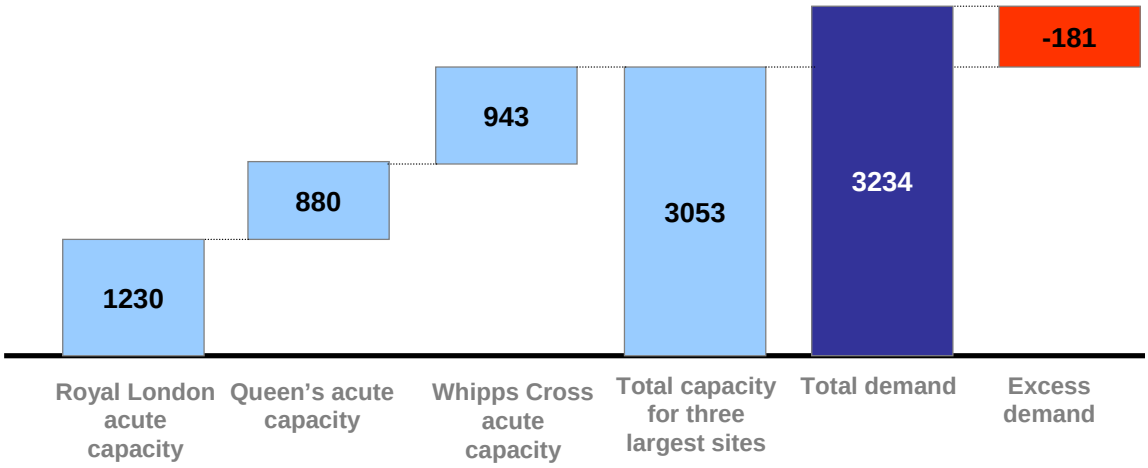
- *That five site options should be considered in the option appraisal process.*

3. Can we rule out three sites with acute services on the basis of capacity and deliverability?

Modelling indicated that three-site options should be ruled-out on a capacity and deliverability basis. Significant additional investment would be required to provide the necessary capacity at three sites.

The result of this modelling was presented to the CRG 24th June 2009 and it was confirmed that three sites options should be ruled out on this basis. The modelling showed that even if the largest three sites, the Royal London, Queen's and Whipps Cross, were filled exclusively with acute services (i.e. no elective services or maternity) there would still be an excess demand of 181 beds for acute activity. The results of the analysis are shown in the diagram that follows.

A three-site option does not provide sufficient acute capacity



This demonstrates that, whilst potentially attractive clinically, reducing the acute sites to three is not feasible without significant investment to increase acute capacity. Depending on future demand and continued reductions in lengths of stay, this option might become feasible in the longer term.

By extension, this analysis also confirms that the underlying assumption not to consider one or two site options is correct.

At their meeting of the 24th June, the CRG advised that:

- *any option involving acute services located on three-sites only should be excluded.*

This was endorsed by the Steering Group at their meeting on 29th June 2009.

5.3.4 Identifying a list of configuration options for acute services

Following the removal of the excluded options, the application of the decision-tree identified ten options for acute services plus 'do minimum'. These options comprised:

- Four options of five-site combinations
- Six options of four-site combinations

The full list, with descriptions for each option, is shown in the table that follows:

Option number	Option description
1	'Do minimum': No reconfiguration - six hospitals with A&E
2	Two major acute hospitals, three hospitals with A&E; King George is a hospital with UCS
3	Two major acute hospitals, three hospitals with A&E; Homerton is a hospital with UCS
4	Two major acute hospitals, three hospitals with A&E; Newham is a hospital with UCS
5	Two major acute hospitals, three hospitals with A&E; Whipps Cross is a hospital with UCS
6	Two major acute hospitals, two hospitals with A&E; King George and Homerton are hospitals with UCS
7	Two major acute hospitals, two hospitals with A&E; King George and Newham are hospitals with UCS
8	Two major acute hospitals, two hospitals with A&E; King George and Whipps Cross are hospitals with UCS
9	Two major acute hospitals, two hospitals with A&E; Newham and Homerton are hospitals with UCS
10	Two major acute hospitals, two hospitals with A&E; Homerton and Whipps Cross are hospitals with UCS
11	Two major acute hospitals, two hospitals with A&E; Whipps Cross and Newham are hospitals with UCS

5.4 PHASE TWO: SCORING AGAINST THE DECISION-MAKING CRITERIA

Following the use of the decision tree in Phase One, ten possible options plus 'do minimum' were identified for configuration of acute services.

The next phase of the non-financial options appraisal process scored configuration options against the criteria set out in *section 5.2*.

5.4.1 An overview of Phase Two

There were four key stages within Phase Two, with a number of sub-stages for scoring of the criteria for 'clinical quality and workforce', and three sub-stages for the scoring of 'deliverability':

1. Scoring against the criteria for **'clinical quality, safety and workforce'** (ranked)

    - Configuration options for acute hospital services scored on a non site-specific basis. Scoring was undertaken separately for 'clinical quality and safety' and 'workforce'.

    - Separate rules and scoring system developed for maternity services as it was determined maternity services needed to be considered on a site-specific basis. A full list of configuration options was identified which includes all possible variants for maternity services – 110 options plus 'do minimum'.

    - Application of maternity rules which excluded 91 of the 110 options leaving 19 options remaining plus 'do minimum'.

    - Scoring of the remaining 19 options for maternity services.

    - Combining the scores for acute services and maternity services.

2. Assessment against the criteria for **'capacity'** (hurdle)

3. Scoring against the criteria for **'access'** (ranked)

4. Scoring against the criteria for **'deliverability'** (ranked)

    - Scores were given to each of the remaining options for how easy the reconfiguration of services is to deliver within a 3-5 year timescale;

    - Scores were given for each of the remaining options for how easy the clinical quality aspirations are to achieve;

    - Combining the scores for ease of deliverability and the ease with which the appropriate clinical quality will be delivered.

5.4.2 Scoring against the criteria for 'clinical quality, safety and workforce'

a. SCORING CONFIGURATION OPTIONS FOR ACUTE SERVICES ON A NON SITE-SPECIFIC BASIS

At their meeting of 15th July 2009, the CRG undertook a scoring exercise of the options on a non site specific basis to determine their relative strengths against the decision-making criteria: *clinical quality and workforce*. The five site, four site and three site option bundles were assessed against two principles (three site options were included in this stage of the analysis to confirm the decision to rule them):

1. **Clinical quality and safety** ~ is the option likely to comply with or exceed the guidelines on clinical quality, safety, efficiency and effectiveness of patient care set by the Government, Royal Colleges and NICE and the recommendation of the Clinical Working Groups?

2. **Workforce ~** is the option likely to allow the NHS in north east London to attract, develop and retain the staff needed to provide high quality healthcare that provides senior clinical decision-making early in the patient pathway?

The detailed analysis is presented at *Appendix G* and the overall scores (out of a maximum of four) are shown in the table that follows. A relatively high score indicates that the option does well against the criteria for assessment, and a relatively low score indicates that the option does less well against the criteria for assessment.

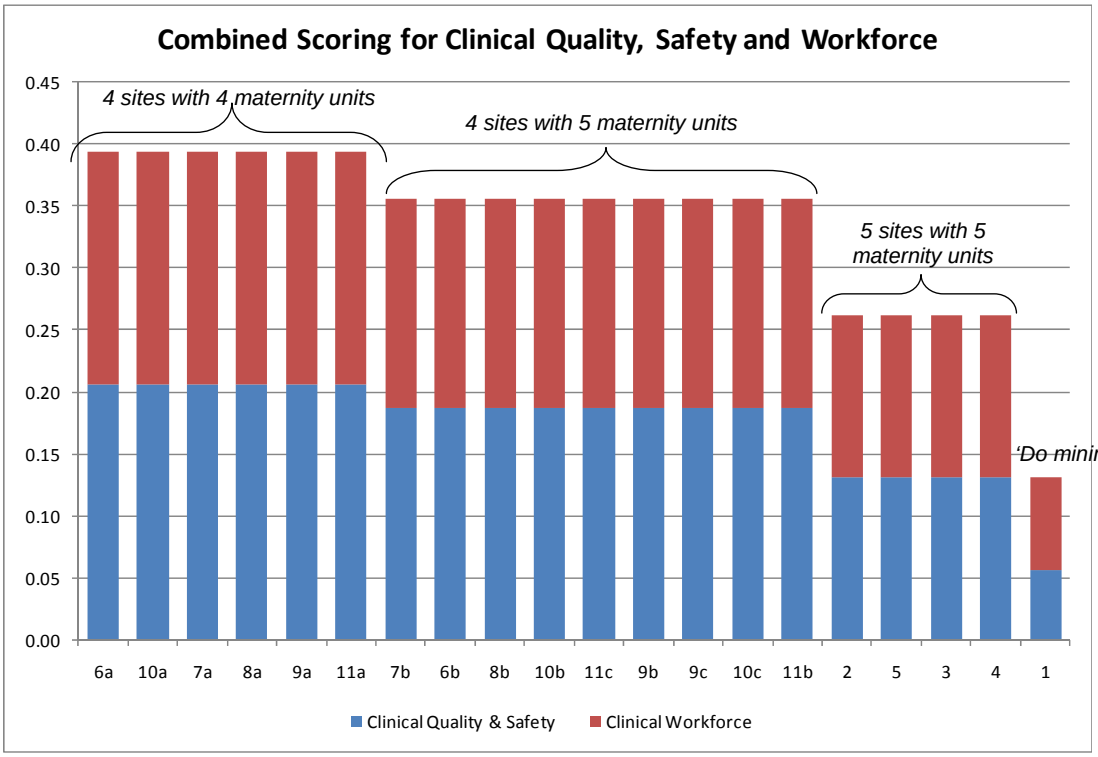
	Clinical quality and safety		***Workforce***	
	Average 'Score'	**Ranking**	**Average 'score'**	**Ranking**
Six sites / 'do minimum'	**1.38**	**5**	**1.38**	**5**
Five sites with acute services and five maternity	**2.75**	**3**	**2.38**	**4**
Four sites with acute services and four maternity	**3.50**	**1**	**3.25**	**2**
Four sites with acute services and five maternity	**3.38**	**2**	**3.00**	**3**
Three sites with acute services and four or five maternity	**2.00**	**4**	**3.75**	**1**

At the CRG meeting it was agreed that maternity options could not be properly considered on a non site specific basis, as account would need to be taken of patient flows and the number of births at each site. It was therefore agreed that a separate maternity event should be held to consider maternity options.

Adjusting the scoring for clinical quality, safety and workforce to remove the questions about maternity, the resulting scores are shown in the table that follows. Whilst the average scores changed the overall ranking was identical.

	Clinical quality and safety			*Workforce*			
	Score including maternity	Score *excluding* maternity	Ranking	Score including maternity	Score *excluding* maternity	Ranking	Combined scoring
Six sites / 'do minimum'	**1.38**	**1.00**	**5**	**1.38**	**1.33**	**5**	**1.17**
Five sites with acute services and five maternity	**2.75**	**2.33**	**3**	**2.38**	**2.33**	**4**	**2.33**
Four sites with acute services and four maternity	**3.50**	**3.67**	**1**	**3.25**	**3.33**	**2**	**3.5**
Four sites with acute services and five maternity	**3.38**	**3.33**	**2**	**3.00**	**3.00**	**3**	**3.17**
Three sites with acute services and four or five maternity	**2.00**	**2.00**	**4**	**3.75**	**4.00**	**1**	**3.00**

The diagram below sets out the results on an option by option basis.



CRG noted that this scoring reflected a preference for consolidation to two major acute hospitals and two other hospitals for north east London in the longer term from a 'non maternity' perspective, and when only considering clinical quality and workforce.

b. RULES AND SCORING SYSTEM DEVELOPED FOR MATERNITY SERVICES

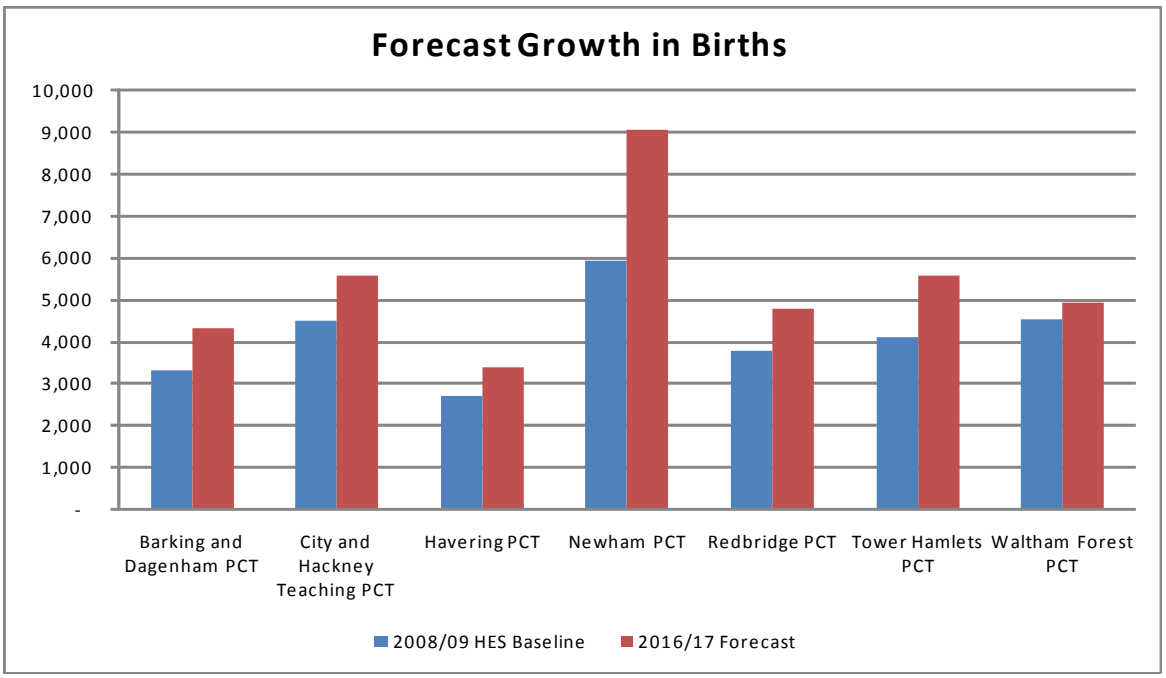
Following the CRG's initial scoring of options for 'clinical quality, safety and workforce' a separate maternity event was held on 5th August 2009. Using detailed modelling of birth rate projections and maternity capacity, the expert group considered specific maternity options against clinical and workforce criteria. *A full write up of the maternity group workshop is available separately.*

Several points of note regarding modelling used for the maternity review:

1. The group used modelling projections of the number of births per year in their review; the modelling suggests a need to plan for up to 38,000 births per annum for north east London by 2016/17. This is an electoral ward-based population/ birth projection mapped to closest maternity unit on average travel time, adjusted for current flows.

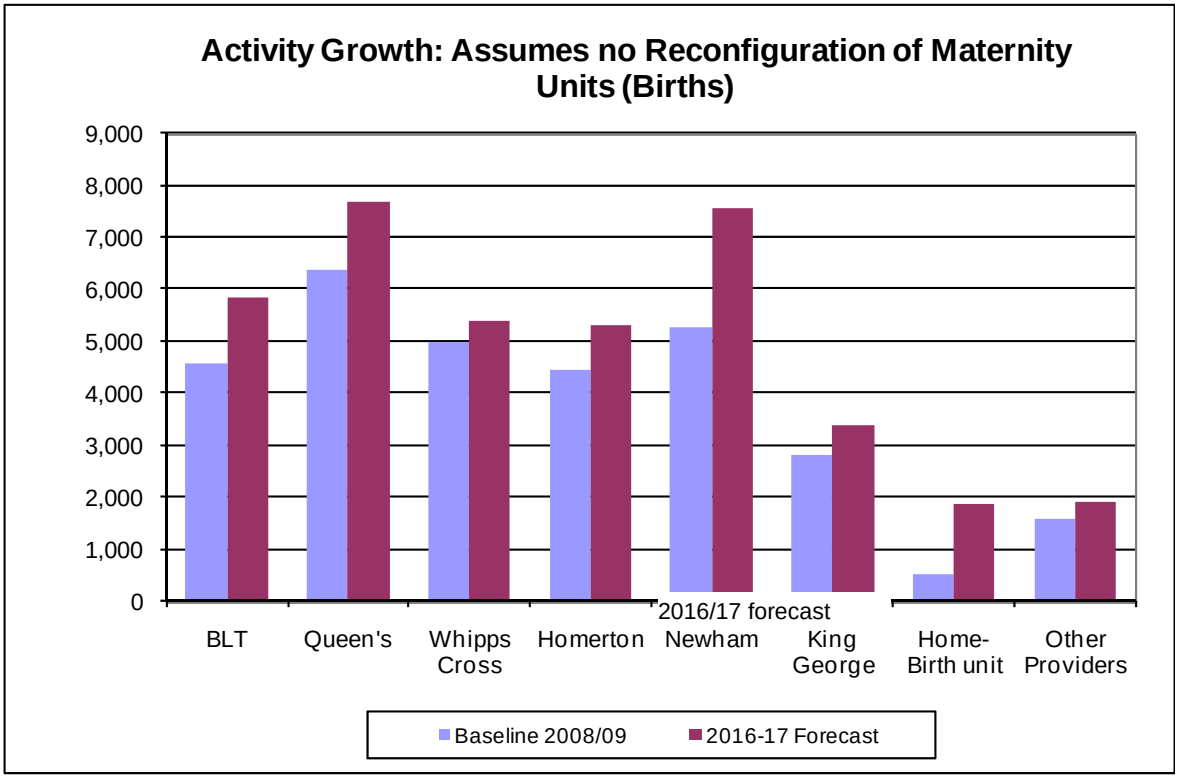
2. The number of births is based upon a projection that takes account of predicted population growth, plus an additional 2% per annum growth representing an underlying growth in the birth rate.

	2008/09 HES Baseline	Population Growth	Non-demographic Growth	2016/17 Forecast	Increase %
Barking and Dagenham PCT	3,334	364	626	4,324	29.7%
City and Hackney Teaching PCT	4,489	279	811	5,579	24.3%
Havering PCT	2,711	187	493	3,391	25.1%
Newham PCT	5,935	1,847	1,288	9,070	52.8%
Redbridge PCT	3,791	297	695	4,783	26.2%
Tower Hamlets PCT	4,122	646	803	5,571	35.2%
Waltham Forest PCT	4,534	(315)	731	4,950	9.2%
Sector	28,916	28,916	28,916	37,668	30.3%



3. The modelling is based on the majority of these births being delivered in obstetric-led settings but recognises the potential over time for more births to take place outside of hospital settings, in standalone midwifery-led units or home births.

4. The number of births projected by hospital site and PCT varies significantly across the sector with high birth rates in Newham particularly driving high levels of projected births at Newham hospital.



5. A full list of configuration options was identified which included all possible variants for maternity services – 110 options plus 'do minimum'. This list is included as *Appendix H*.

There were several key areas of discussion at the maternity group workshop, which were subsequently used to determine 'rules' for assessing configuration options. These were:

- Small obstetric units with less than 4,000 births per annum were becoming clinically and economically sub-optimal, mainly because of the requirements for clinical rotas.

- Very large maternity units (12,000 births or more per year) were felt to be undesirable.

- A preference for co-location of obstetric led maternity services with acute medical, surgery and critical care services, with a clear view in favour of all hospitals with core acute provision being supported by co-located obstetric and gynaecology services.

- There was significant consideration of whether an obstetric-led maternity service can be safely maintained at a site without A&E. The clinical consensus was that in order

to sustain the full range of clinical support services required a 'standalone' maternity unit would need to deliver a minimum of 8,000 births per year, ideally more.

Informed by discussions at the maternity group review, as well as recommendations from the maternity clinical working group, two rules were developed to exclude options that would be clinically unviable for maternity services, and two criteria for scoring options were identified.

c. APPLICATION OF THE 'RULES' FOR MATERNITY TO EXCLUDE CLINICALLY UNVIABLE RECONFIGURATION OPTIONS

1. **Options with acute services provision but no co-located maternity unit were excluded ~** if a site has an A&E it should have an obstetric-led maternity unit. This meant that all options with a hospital with A&E but without an obstetric-led maternity unit were ruled out of the option appraisal.

Out of the 110 options, plus the 'do minimum', 88 were ruled out on the basis that there were A&E sites with no obstetric-led maternity unit.

This left 22 options plus the 'do minimum' to be evaluated. All of these options have a maternity unit at both the Royal London and Queen's, as it is recommended both sites be major acute hospitals. These options can be seen in the table that follows.

Option number	Option description
1	'Do minimum': No reconfiguration - six acute sites, six maternity units
2	Two major acute hospitals; three hospitals with A&E; five maternity units – King George is a hospital with UCS
3	Two major acute hospitals; three hospitals with A&E; five maternity units – Homerton is a hospital with UCS
4	Two major acute hospitals; three hospitals with A&E; five maternity units – Newham is a hospital with UCS
5	Two major acute hospitals; three hospitals with A&E; five maternity units – Whipps Cross is a hospital with UCS
6a	Two major acute hospitals; two hospitals with A&E; four maternity units – King George and Homerton are hospitals with UCS
6b	Two major acute hospitals; two hospitals with A&E; five maternity units King George and Homerton are hospitals with UCS and maternity unit at Homerton
6c	Two major acute hospitals; two hospitals with A&E; five maternity units King George and Homerton are hospitals with UCS and maternity unit at King George
7a	Two major acute hospitals; two hospitals with A&E; four maternity units; King George and Newham are hospitals with UCS
7b	Two major acute hospitals; two hospitals with A&E; five maternity units; King George and Newham are hospitals with UCS and maternity unit at Newham

7c	Two major acute hospitals; two hospitals with A&E; five maternity units; King George and Newham are hospitals with UCS and maternity unit at King George
8a	Two major acute hospitals; two hospitals with A&E; four maternity units; King George and Whipps Cross are hospitals with UCS
8b	Two major acute hospitals; two hospitals with A&E; five maternity units; King George and Whipps Cross are hospitals with UCS and maternity unit at Whipps Cross
8c	Two major acute hospitals; two hospitals with A&E; five maternity units; King George and Whipps Cross are hospitals with UCS and maternity unit at King George
9a	Two major acute hospitals; two hospitals with A&E; four maternity units; Newham and Homerton are hospitals with UCS
9b	Two major acute hospitals; two hospitals with A&E; five maternity units; Newham and Homerton are hospitals with UCS and maternity unit at Homerton
9c	Two major acute hospitals; two hospitals with A&E; five maternity units; Newham and Homerton are hospitals with UCS and maternity unit at Newham
10a	Two major acute hospitals; two hospitals with A&E; four maternity units; Homerton and Whipps Cross are hospitals with UCS
10b	Two major acute hospitals; two hospitals with A&E; five maternity units; Homerton and Whipps Cross are hospitals with UCS and maternity unit at Homerton
10c	Two major acute hospitals; two hospitals with A&E; five maternity units; Homerton and Whipps Cross are hospitals with UCS and maternity unit at Whipps Cross
11a	Two major acute hospitals; two hospitals with A&E; four maternity units; Whipps Cross and Newham are hospitals with UCS
11b	Two major acute hospitals; two hospitals with A&E; five maternity units; Newham and Whipps Cross are hospitals with UCS and maternity unit at Whipps Cross
11c	Two major acute hospitals; two hospitals with A&E; five maternity units; Newham and Whipps Cross are hospitals with UCS and maternity unit at Newham

2. **Maternity units that are not located on a hospital site with A&E and had fewer than 5,000 births per annum.** These were identified as clinically and financially unviable based on the low numbers of births at any one site. The threshold was agreed to be 5,000 births.

Of the remaining 22 options, three were ruled out on the basis of a projection of fewer than 5,000 births. This left 19 options plus the 'do minimum' to be evaluated. The three options that were removed were:

- 6c – Four acute sites, five maternity units – two hospitals with UCS at King George and Homerton. Maternity unit at King George. The site at King George had a very small standalone maternity unit with less than 5,000 births;
- 7c - Four acute sites, five maternity units – two hospitals with UCS at King George and Newham. Maternity unit at King George, The site at King George had a very small standalone maternity unit with less than 5,000 births;

- 8c – Four acute sites, five maternity units - two hospitals with UCS at King George and Whipps Cross. Maternity Unit at King George. The site at King George had a very small standalone maternity unit with less than 5,000 births

d. SCORING OF THE REMAINING RECONFIGURATION OPTIONS AGAINST THE SPECIFIC MATERNITY CRITERIA FOR 'CLINICAL QUALITY, SAFETY AND WORKFORCE'

1. **Standalone versus co-located.** Whilst there was a consensus preference for co-located maternity units over standalone units, options with standalone obstetric-led maternity units were not excluded but had scores reduced.

2. **Patient volumes**. Certain thresholds of births are required to make a maternity unit economically and clinically viable. A scoring system was developed to assess the relative strengths of each option based on these thresholds, with separate scoring for standalone and co-located maternity units.

Each of the 19 options plus the 'do minimum' was scored on the basis of these rules. A detailed account of the scoring methodology for maternity, based on these rules, is included at *Appendix I*.

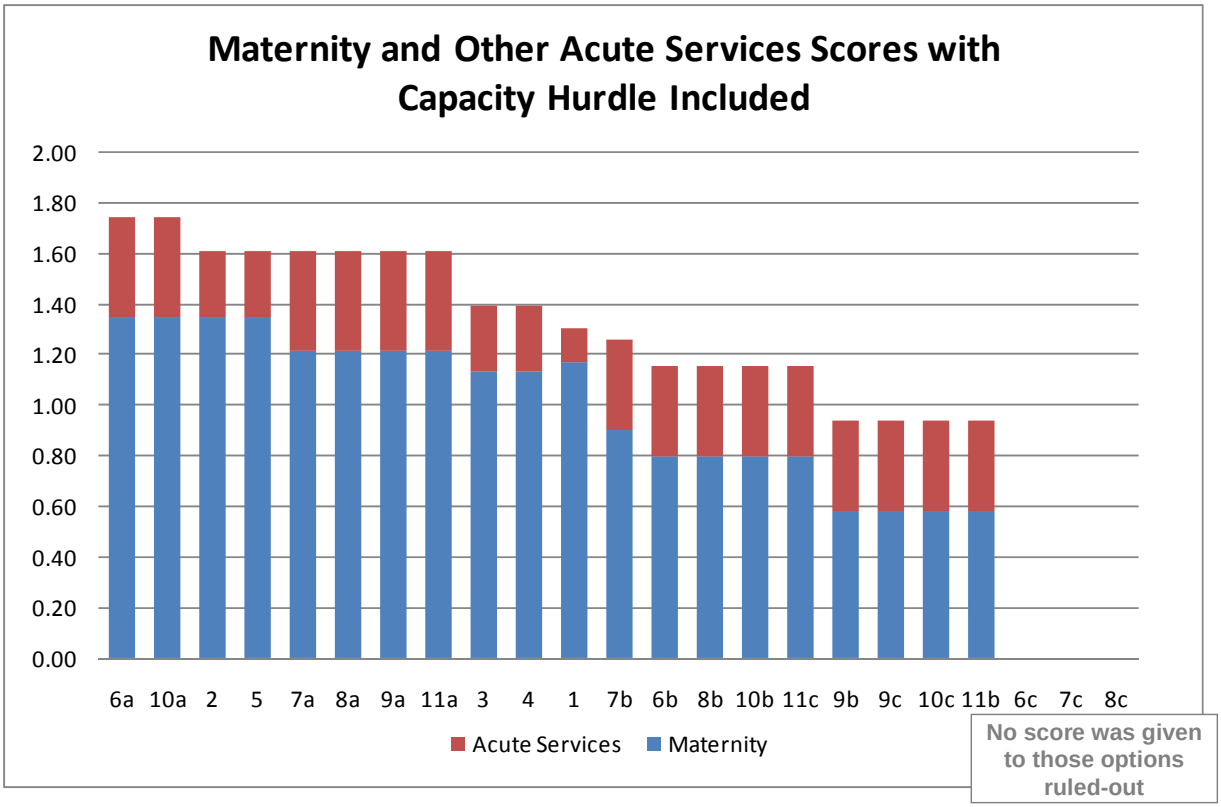
e. COMBINING THE SEPARATE SCORES OF ACUTE SERVICES AND MATERNITY SERVICES

The final step in the process for evaluation against clinical quality, safety and workforce was to combine the two sets of scores from (a) acute services and (b) maternity services. These were combined and analysed as follows:

- The maternity scores were added, on the basis of a 75%:25% weighting between *maternity* and *acute services* (see section 5.5.2 for explanations of different weightings).

- This gave overall scores, out of a maximum of 1.8, which are shown in the figure below:

A breakdown of the scoring for both maternity and acute services separately and the combined scores is included at *Appendix J*.



5.4.3 Using the 'capacity' criteria as a hurdle

Nineteen options remained as viable reconfiguration options following scoring for 'clinical quality and workforce'. These nineteen options plus the 'do minimum' were subsequently tested against the 'capacity' hurdle.

a. METHODOLOGY FOR THE 'CAPACITY' CRITERIA

This criteria required bed capacity modelling at each current hospital site for each of the nineteen options plus the 'do minimum' scenario. This modelling considered:

- Population and demand growth;
- Likely productivity gains such as improvements in average length of stay;
- The shift of activity to alternative settings;
- Changes to patient flows from service reconfiguration based on nearest hospital and established patient preferences.

Each trust provided information on the additional capacity that could be made available for patient activity, classified into three categories:

1. Existing spare clinical capacity;
2. Additional clinical capacity that could be brought into use with modest investment;

3. Potential for further additional capacity that could be added but requiring new build or major refurbishment.

Each option was then analysed against the available space, and in particular whether new build or major refurbishment would be required.

The analysis was reviewed at a workshop held on 6th August 2009, attended by Directors of Finance, Directors of Commissioning and Directors of Performance.

It was determined that the capacity criteria should be applied as a 'hurdle' that options either 'passed' or failed', rather than using the criteria to score and rank options. This reflects the need to ensure the requisite capacity is available for the future.

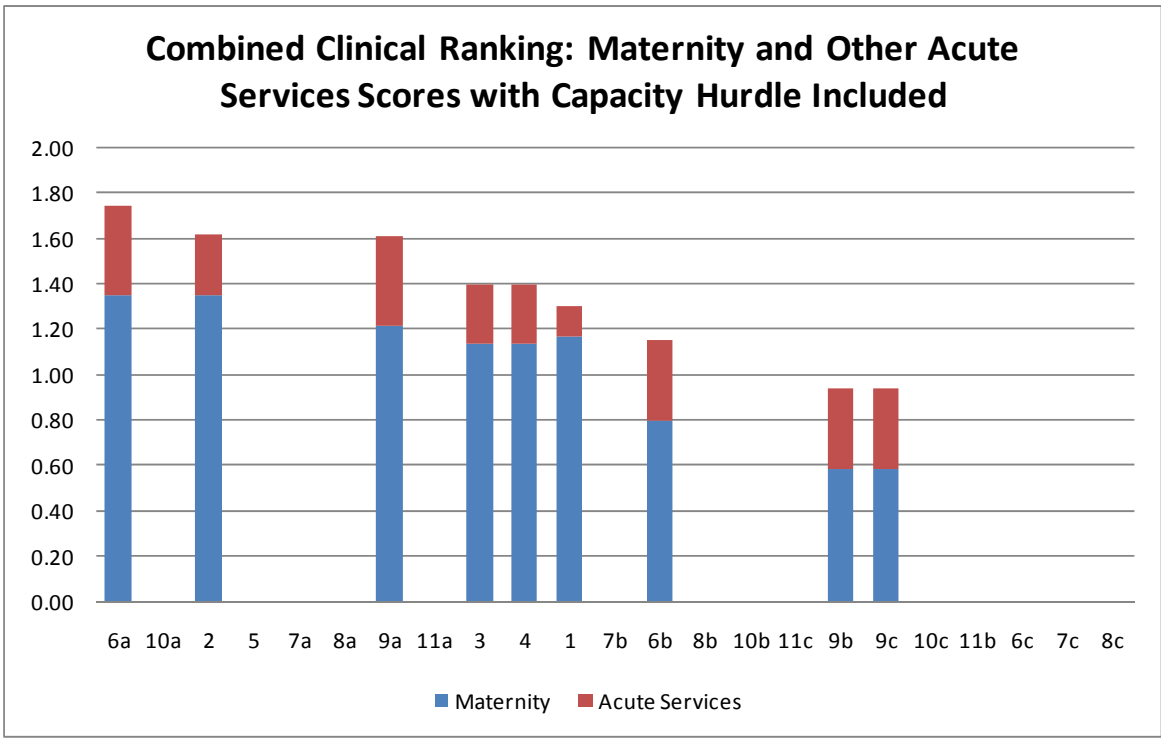
b. FINDINGS FOR THE 'CAPACITY' CRITERIA

The results of the modelling of each option for capacity show that eight options 'pass' the capacity and maternity hurdle. The following table shows the full list of 22 remaining options plus the 'do minimum' (22 options are shown at this point rather than 19 as the three options ruled out on the basis of maternity unit size are included for completeness). The options that are shown in grey in the table below are those that have been ruled out on the basis of a very small maternity unit or on the basis of the capacity criteria. The reasoning for ruling options out is explained.

Option no.	Option description	Ruled out - very small maternity unit at a standalone site	Ruled out - Capacity criteria
1	'Do minimum': no reconfiguration - 6 acute sites, six maternity units		Does not make good use of existing capacity
2	Five acute sites, five maternity units – UCS at King George		
3	Five acute sites, five maternity units - UCS at Homerton		
4	Five acute sites, five maternity units - UCS at Newham		
5	Five acute sites, five maternity units - UCS at Whipps Cross		Requires significant capital investment at North Middlesex Hospital
6a	Four acute sites, four maternity units - UCS at King George and Homerton		
6b	Four acute sites, five maternity units - UCS at King George and Homerton; maternity unit at Homerton		
6c	Four acute sites, five maternity units – UCS at King George and Homerton; maternity unit at King George	Small standalone maternity unit at King George with fewer than 5,000 births	

Option no.	Option description	Ruled out - very small maternity unit at a standalone site	Ruled out - Capacity criteria
7a	Four acute sites four maternity units - UCS at King George and Newham		Requires significant capital investment at Queen's Hospital
7b	Four acute sites five maternity units - UCS at King George and Newham; maternity unit at Newham		
7c	Four acute sites five maternity units – UCS at King George and Newham; maternity unit at King George	Small standalone maternity unit at King George with fewer than 5,000 births	
8a	Four acute sites, four maternity units - UCS at King George and Whipps Cross		Requires significant capital investment at Newham Hospital
8b	Four acute sites, five maternity units – UCS at King George and Whipps Cross; maternity unit at Whipps Cross		
8c	Four acute sites, five maternity units – UCS at King George and Whipps Cross; maternity unit at King George	Small standalone maternity unit at King George with fewer than 5,000 births	
9a	Four acute sites, four maternity units - UCS at Newham and Homerton		
9b	Four acute sites, five maternity units - UCS at Newham and Homerton; maternity unit at Homerton		
9c	Four acute sites, five maternity units – UCS at Newham and Homerton; maternity unit at Newham		
10a	Four acute sites, four maternity units – UCS at Homerton and Whipps Cross		Requires significant capital investment at Newham Hospital
10b	Four acute sites, five maternity units – UCS at Homerton and Whipps Cross; maternity unit at Homerton		
10c	Four acute sites, five maternity units – UCS at Homerton and Whipps Cross; maternity unit at Whipps Cross		
11a	Four acute sites, four maternity units - UCS at Whipps Cross and Newham		Requires significant capital investment at North Middlesex Hospital as well as some investment at King George's and Homerton
11b	Four acute sites, five maternity units - UCS at Newham and Whipps Cross; maternity unit at Whipps Cross		
11c	Four acute sites, five maternity units – UCS at Newham and Whipps Cross; maternity unit at Newham		

Following the exclusion of thirteen options on the basis of capacity, plus an additional exclusion for maternity unit size, the remaining eight options (plus the 'do minimum' which has been kept in the analysis to act as a baseline) scores for clinical quality and maternity are shown in the figure below.



5.4.4 Scoring against the criteria for 'access'

Eight options remained as viable reconfiguration options following scoring for 'clinical quality and workforce' and 'capacity'. These eight options were subsequently assessed and scored for 'access'. Whilst 'do minimum' had been excluded on clinical quality and capacity grounds, it was kept in the analysis for access to illustrate the baseline.

a. METHODOLOGY FOR THE 'ACCESS' CRITERIA

Access has been defined as average patient travel times to hospital sites. There were two methods of calculation using the *Hstat* model of travel times (see *Appendix K* for a detailed account of the Hstat review). They were:

- From the central point of a ward to the nearest hospital with a fully functioning A&E;
- From a point in the ward that reflects the middle of the population given its density.

The primary method used to measure the impact of each reconfiguration option on access was the cumulative effect on travel time that resulted from each variation. The shortest and longest travel times effected by the options were also tested to ensure that these were within an acceptable range.

The access assessment for this criteria therefore considered two questions: what is the impact of each option on travel time as measured by:

- The total additional travel time for patients measured in patient years by car and public transport?

- The longest travel times by car from the centre of a ward to the nearest hospital?

Cumulative travel times were measured from a centralised location in each ward to the nearest hospital with A&E in north east London. Both public transportation times and private (personal car / taxi) transportation times were calculated to determine current travel time by ward and the change in travel time experienced by each ward under different configuration options. Ranking for cumulative hours was calculated on a weighted average of public and private transportation, based on an index of vehicle ownership within the ward as detailed in the 2001 UK census results.

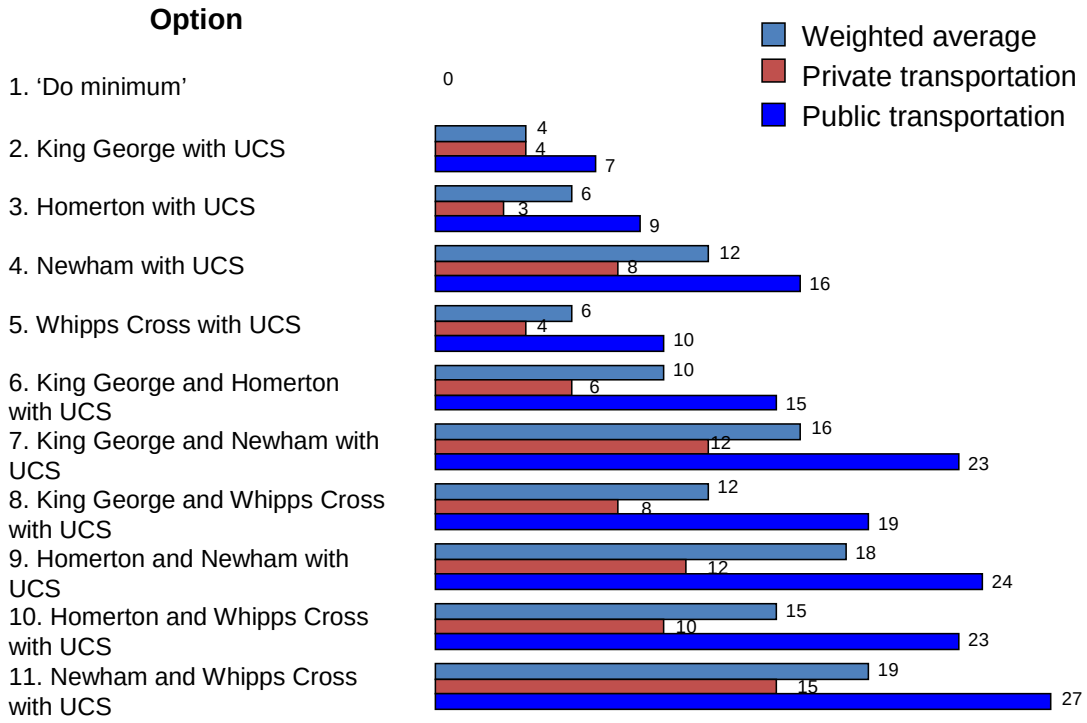
Longest travel times: Using the same travel time measurement as for cumulative times, the ward with the most significantly increased travel time was determined for each reconfiguration option. Private transportation, which tended to see larger increases than public transportation, was analysed for each option and the most affected ward identified.

b. FINDINGS FOR THE 'ACCESS' CRITERIA

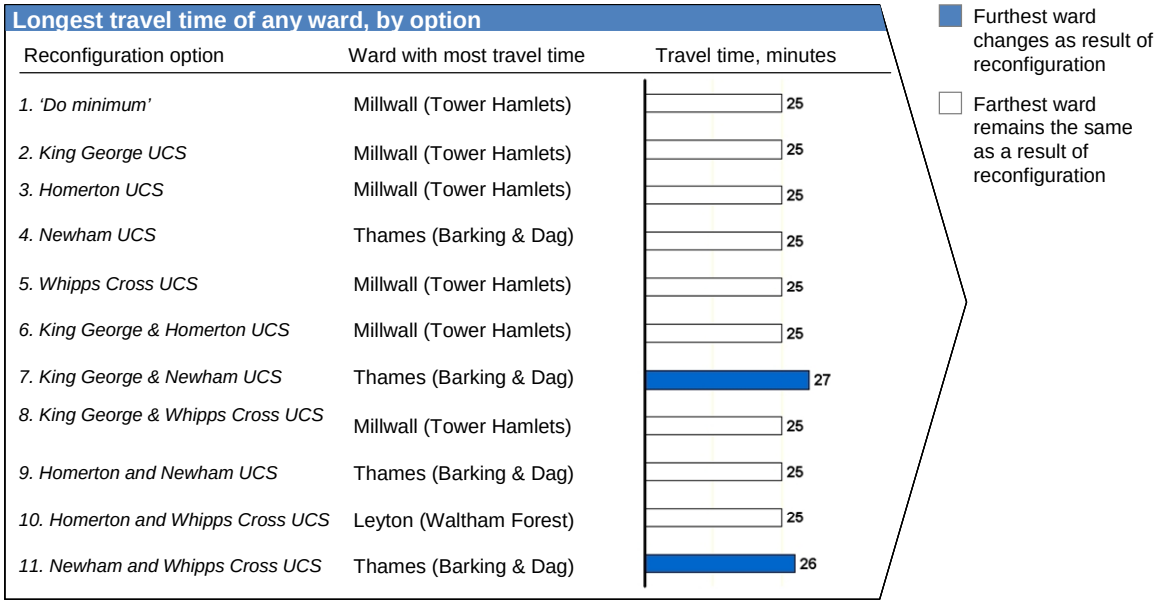
The findings for **cumulative travel times** are shown in the figure that follows, analysed in terms of patient years[17]. Analysis shows that cumulative travel time increases the most when Newham becomes a hospital without A&E or when multiple sites become hospitals without A&E, especially when they include Newham. The large increase in travel time when Newham becomes a hospital with UCS is due to high population growth in the area and the relative longer distance between Newham Hospital and other hospital sites in north east London. The least impact occurs when King George, Homerton, or both of those sites become hospitals with no A&E service. This trend was consistent across public, private, and weighted transportation options. The small effect seen when King George becomes a hospital with UCS is due to its close proximity to Queen's, as shown by the low distance between King George and Queen's in the table below which shows the distances between hospitals.

[17] Patient-years are calculated as Whole Time Equivalents, 117,000 minutes or 37.5 hours a week, 52 weeks a year

Reconfiguration impact on cumulative travel time, patient years



The findings for **longest travel times** by car are shown in the figure that follows.



In the 'do minimum' scenario, where no reconfiguration occurs, the ward with the longest travel time is Millwall (Tower Hamlets) with a total private transportation travel time of 25 minutes. This ward remains the farthest in all but five of the options. In fact, only options that involve Newham or Whipps Cross cause the farthest ward to change.

The option creating the longest ward travel time is *Option 7* – four A&E sites with King George and Newham as hospitals with UCS - causes Thames ward (Barking and Dagenham) to have a total private transportation travel time of 27 minutes.

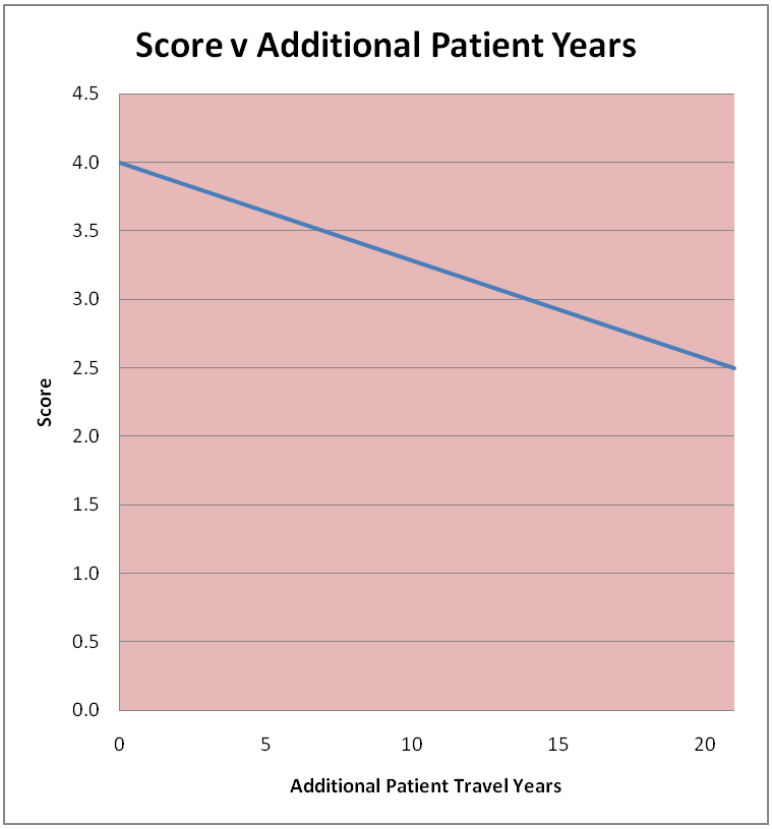
In summary, the findings for scoring against the 'access' criteria are:

- Under most options the longest ward travel time does not change;
- The maximum journey time under any option is 27 minutes;
- No option can be excluded on the basis of unreasonable travel times.
- The lowest impact on patient travel occurs if King George, Homerton or Whipps Cross becomes a hospital with UCS.
- The greatest impact on patient travel occurs if Newham becomes a hospital with UCS.

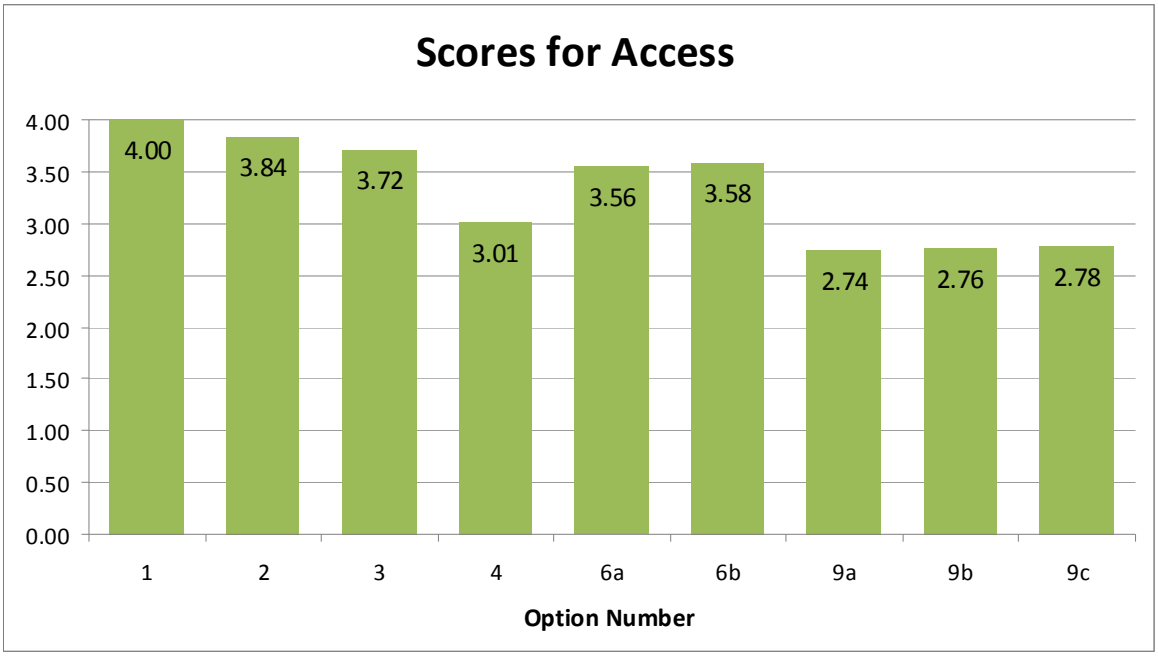
c. APPLYING THE 'ACCESS' CRITERIA SCORES

The ranking of options by travel times in patient years was converted to a score out of four. This conversion is shown in the graph below.

All the options get a score of at least 2.5 out of 4 as none of the options gives a very poor result against the access criteria. The highest score of four goes to the 'do minimum' scenario as there is no change to travel times under this option.



The results of the scoring of each option for access indicate that Option *2* (five sites with King George a hospital with UCS) scores highest with a score of 3.84, followed by Option *3* (five sites with a hospital with UCS at Homerton) with a score of 3.72. The full results are shown in the figure that follows.



5.4.5 Scoring against the criteria for 'deliverability'

The remaining eight options plus 'do minimum' were scored for 'deliverability'.

a. METHODOLOGY FOR THE 'DELIVERABILITY' CRITERIA

Deliverability was defined as within a three to five year period, based on the relative ease of delivering the change proposed under each option. There were two elements to the deliverability scoring:

- The first was to consider the non-clinical deliverability of the option;
- The second was to consider the clinical deliverability of the option given the current performance of the hospitals.

b. FINANCIAL AND LOGISTICAL DELIVERABILITY OF THE OPTIONS

Scores for deliverability were given to options based on the following assumptions (highest scoring first):

- A five-site option, with five maternity units, is relatively easier to deliver than a four-site option, due to the lower requirement for additional capacity and the 'fit' between maternity and acute service provision.
- A four-site option, with four maternity units, scores lower relative to a five-site option, due to additional capacity required at each of the four sites, particularly for maternity units.
- A four site option, with five maternity units scores lower than others due to the need to work through 'standalone' maternity infrastructure and pathways.
- Options involving Homerton and Newham as hospitals with UCS score lower as modelling suggests significant additional investment is required to provide sufficient

capacity at Whipps Cross which will need to absorb the A&E demand from Homerton and Newham.

c. CLINICAL DELIVERABILITY

The underlying assumption for all options is that all hospital sites can achieve upper quartile clinical performance by 2016/17. However, the case for change identifies that some trusts are performing better than others, and there is significant variation between quality of service and patient experience at each hospital. Whilst there are many examples of very high quality services, it is acknowledged that there is significant room for improvement.

At their meeting of 7th October 2009, the CRG was therefore asked to consider which option makes the best contribution to achieving upper quartile clinical performance by 2016/17. There were two issues that they considered:

- CRG considered which of the hospitals have the greatest improvements to make to achieve required level of performance. Options that involve reshaping of these hospitals received a higher score. Options reshaping King George get the highest scores for two reasons

    - Whipps Cross, Homerton and Newham are closer to the desired clinical vision for hospitals with A&E. For instance, King George does not currently provide stroke, trauma (non-major trauma) or orthopaedic services.

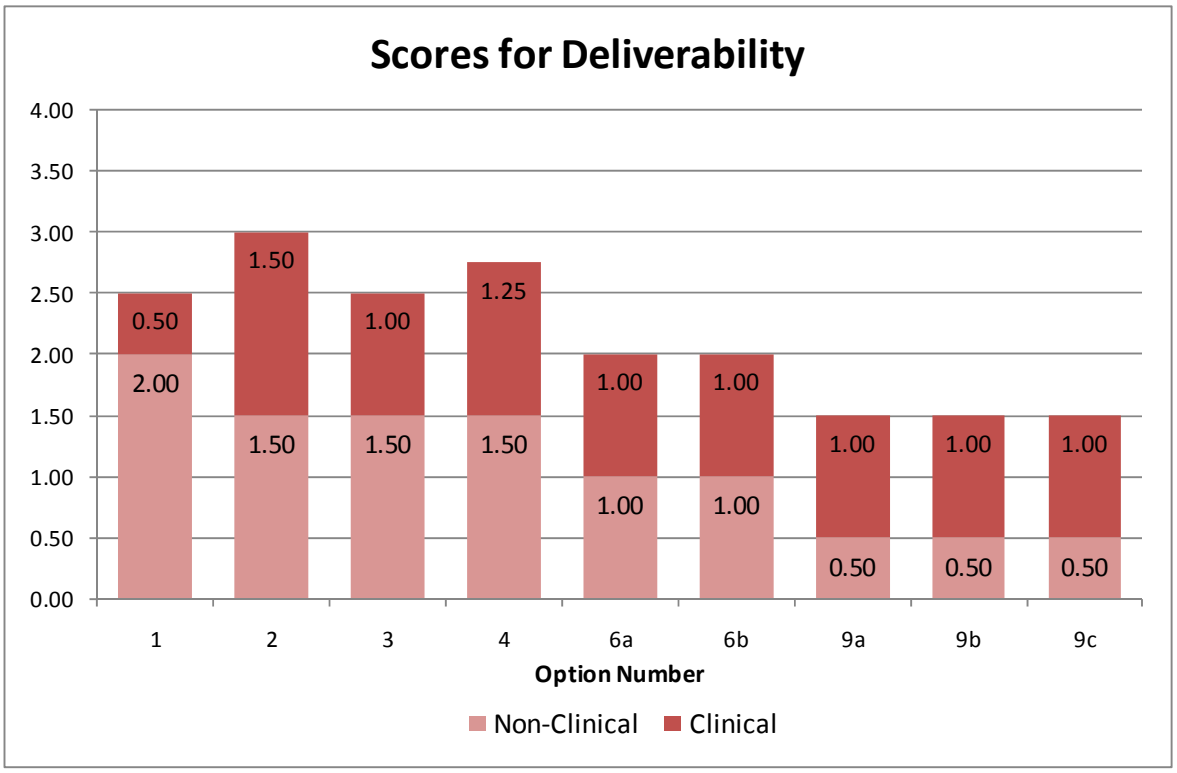
    - King George is experiencing significant challenges meeting clinical quality standards. A factor in and/ or contributor to this is the difficulty in recruiting and retaining clinical staff and the impact this has on training and education.

- The CRG considered the extent to which the option helps the Royal London and Queen's hospitals to fulfil the major acute model, and attain the targets and service quality standards, expected from major acute hospitals. At the current time, Queen's is experiencing difficulty delivering a high quality acute offering - remodelling of King George enables clinical skills and capacity to be consolidated at Queen's which will support improved quality and sustainability.

Each option was scored against these key areas.

d. FINDINGS FOR THE 'DELIVERABILITY' CRITERIA

The two scores for deliverability (clinical and non-clinical) were combined to give an overall score. The results of the scoring of each of the eight remaining viable options for deliverability, plus the do minimum scenario, are shown in the figure that follows:



The results indicate that *Option 2* (five sites with King George as a hospital with UCS) scores highest for deliverability with a score of 3. This is followed by option 4 (five sites with Newham as a hospital with UCS).

It is noteworthy that if deliverability were to be defined as a longer period of time than three to five years, for instance a ten year period, scores would be different, with some four site options scoring higher than five site options.

5.5 CONCLUSIONS FROM THE NON-FINANCIAL OPTIONS APPRAISAL PROCESS

A non-financial options appraisal weighting event was held on the 18th August 2009 to weight the decision-making criteria. A total of 35 people attended, comprising clinicians, managers, the engaged public and the general public. 29, of the 35, live in north east London and 11 work in the NHS in north east London.

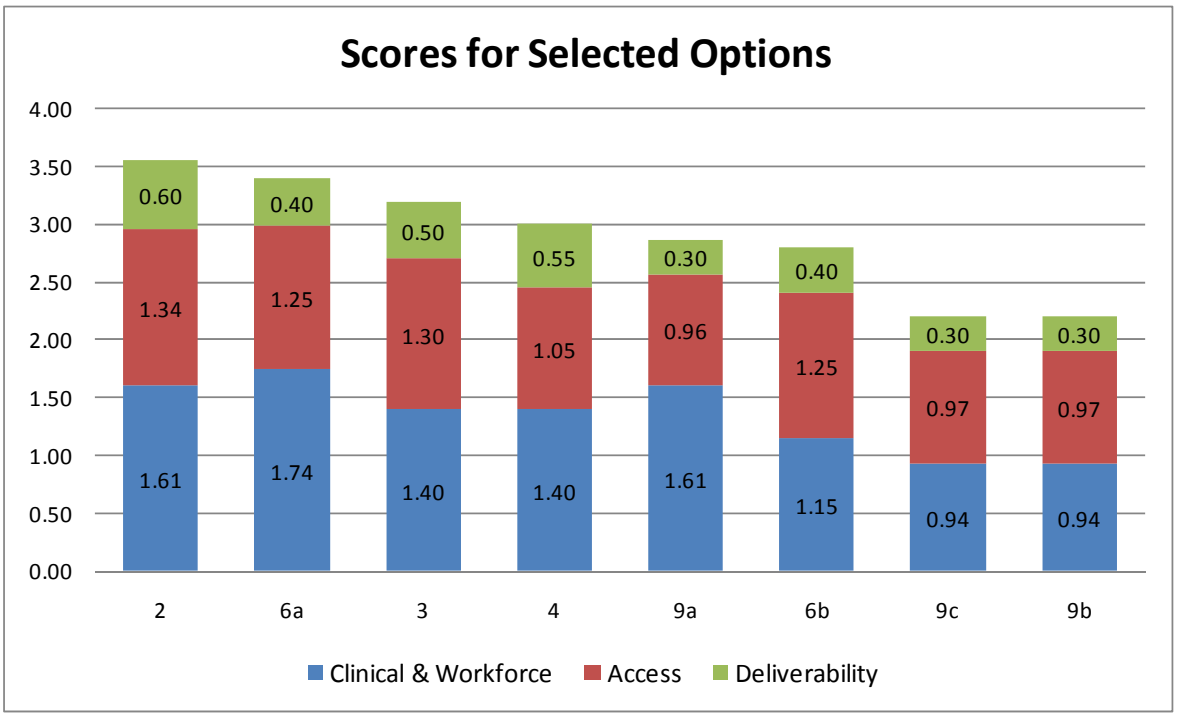
Participants were asked a series of questions to ascertain their preferences in relation to the decision-making criteria. Subsequent to the workshop, it was agreed that capacity would be a 'hurdle' criteria (i.e. pass / fail rather than comparative) and therefore the results of the event were re-calculated to give the following weightings:

- Clinical quality and workforce 45%
- Access 35%
- Deliverability 20%

These results have been used to weight the criteria in the calculation of the final scores for each option.

5.5.1 Overall scores

Using these weightings the overall scores for each of the options are shown in the figure that follows.

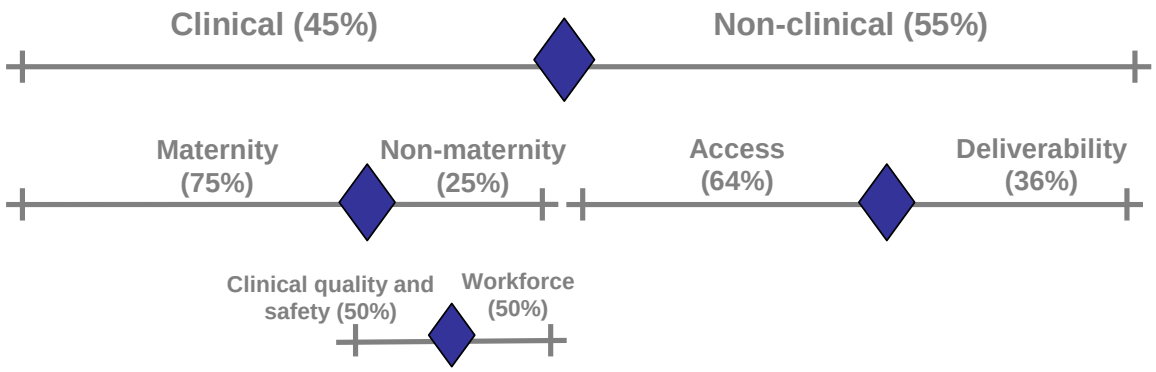


The above graph shows that the rank order for the overall scores was as follows:

- **Option 2:** five sites, five maternity units; King George a hospital with UCS
- **Option 6a:** four sites, four maternity units; King George and Homerton hospitals with UCS
- **Option 3:** five sites, five maternity units; Homerton a hospital with UCS
- **Option 4:** five sites, five maternity units Newham; a hospital with UCS
- **Option 9a:** four acute sites, four maternity units; Newham and Homerton hospitals with UCS
- **Option 6b:** four acute sites, five maternity units; King George and Homerton hospitals with UCS, with a maternity unit at Homerton
- **Option 9c:** four acute sites, five maternity units; Newham and Homerton hospitals with UCS, with a maternity unit at Newham
- **Option 9b:** four acute sites, five maternity units; Newham and Homerton hospitals with UCS, with a maternity unit at Homerton

5.5.2 Sensitivity testing

'Weightings' for each decision criteria were chosen in order to complete the non-financial options appraisal process. The following weightings were applied to combinations of the decision criteria (these were informed by the event held on 18th August 2009 involving members of the public and stakeholders – see *section 5.5*): The relative weightings of the criteria, and their elements are shown in the diagram that follows.



- *Clinical* criteria (clinical quality, safety and workforce) versus *non-clinical* criteria (access and delivery) – 45% / 55%
    - Within clinical: *maternity* versus *non-maternity* 75% / 25% (the emphasis on maternity within this ratio is a reflection of the need to co-locate A&E services with maternity).
        - Within non-maternity: *clinical quality and safety* versus *clinical workforce* 50%/ 50%
- Within non-clinical: *access* versus *delivery* 64% / 36%
- *Capacity* was not weighted as it was used as a pass/ fail hurdle

Sensitivity analysis was performed on the list of 22 options plus the 'do minimum'. The objective was to vary the weightings to test the robustness of the highest-scoring option (Option 2) by identifying how significantly the weightings would need to change to replace the highest scoring option with an alternative option. The scope of the possible change is from 0% to 100% on each combination of criteria.

The results of the sensitivity analysis showed that the highest-scoring option is a robust option under the weighting and scoring systems used. The highest-scoring option remains the highest scoring of the five-site options under all sensitivities.

There were two sensitivity tests that resulted in option 6a (Homerton and King George's become hospitals with UCS) attaining the highest scored option:

- Clinical versus non-clinical requires a shift from the existing 45% / 55% to a weighting of 65% / 35%. This changed weighting consequently favours four site options above five site options.

- Maternity versus non-maternity criteria requires a shift from the existing 75% / 25% to a weighting of 57% / 43%. This changed weighting consequently favours four site options above five site options.

Sensitivities were also applied to the assumptions regarding number of births to test whether the highest scoring option changes when lower rates of growth are assumed. *Option 2* remained the highest-scoring option when:

- 0% non-population growth is applied instead of the 2% assumption
- The GLA forecasts of births are used in place of the *Health for North East London* forecasts.

5.5.3 Recommendations by the Clinical Reference Group

Based on the results of the combined scoring the CRG recommended a shortlist of three options, plus a recommended option.

- Royal London and Queens as major acute hospitals, Newham, Homerton and Whipps Cross as hospitals with A&E and **King George** as a hospital with UCS (option 2).
- Royal London and Queens as major acute hospitals, Newham, King George and Whipps Cross as hospitals with A&E and **Homerton** as a hospital with UCS (option 3).
- Royal London and Queens as major acute hospitals, Homerton, King George and Whipps Cross as hospitals with A&E and **Newham** as a hospital with UCS (option 4).

With the highest-scoring option as the recommended option: Royal London and Queens as major acute hospitals, Newham, Homerton and Whipps Cross as hospitals with A&E and King George as a hospital with UCS (option 2).

As part of this recommendation, CRG noted several important considerations:

- CRG endorsed a recommendation of five sites on the basis that it would allow clinical and financial benefits to be delivered in the short to medium term. However, there was a strong view from the CRG that further consolidation of hospital provision may be required to support clinical and financial sustainability of north east London health services in the longer term.
- Whilst some of the four-site options scored relatively strongly within the option appraisal process they are not recommended as options for consultation at this stage for the following reasons:
    - In recognition of the significant implementation challenges that would relate to a reduction from six sites to four sites, and therefore to allow time for initial implementation of out of hospital based care to understand what the detailed requirements to transition to four sites in this new healthcare landscape.
    - To enable further work to be undertaken on the optimum configuration of services across the three proposed non-major acute hospital sites.
    - To enable discussions on potential organisational alliance or merger of Homerton, Newham and Whipps Cross hospitals to be taken forward and, if approved, implemented - with a view to determining the extent to which some

of the clinical and financial pressures within the system can be resolved through the greater efficiencies and economies of scale that this would allow.

- To enable further work to be undertaken to better understand the capital and revenue implications of different configuration options across Homerton, Newham and Whipps Cross hospital sites.

It is also noteworthy that hospitals with urgent care services (UCS) should have a core set of services as a minimum, with the potential for location of further services at these sites which would bring additional benefits, for instance the location of rapid access outpatient clinics with direct booking from the UCS. What this means for King George is examined in further detail in *Chapter 8*.

5.5.4 Summary

In summary, the five site options are preferred over the four site options.

Of the five site options:

- Reshaping Whipps Cross has been excluded on capacity grounds due to the level of activity flowing to North Middlesex University Hospital Trust (NMUHT) and the consequent impact on that trust's capital requirements. It had additionally been noted that NMUHT needs to absorb additional activity from changes at Chase Farm. Therefore, changes at Whipps Cross would need to be phased to take account of changes at Chase Farm. For this reason, options which include significant reshaping of Whipps Cross are not deemed to be deliverable.

The option to reshape King George is recommended for the following reasons:

- Reshaping of King George to a hospital with UCS has the lowest adverse impact on travel and access;

- King George is currently the hospital that is furthest from the desired model for a hospital with A&E. It currently does not provide acute stroke, trauma or orthopaedic services. King George has difficulties in sustaining paediatric rotas, and only caters for low risk obstetrics;

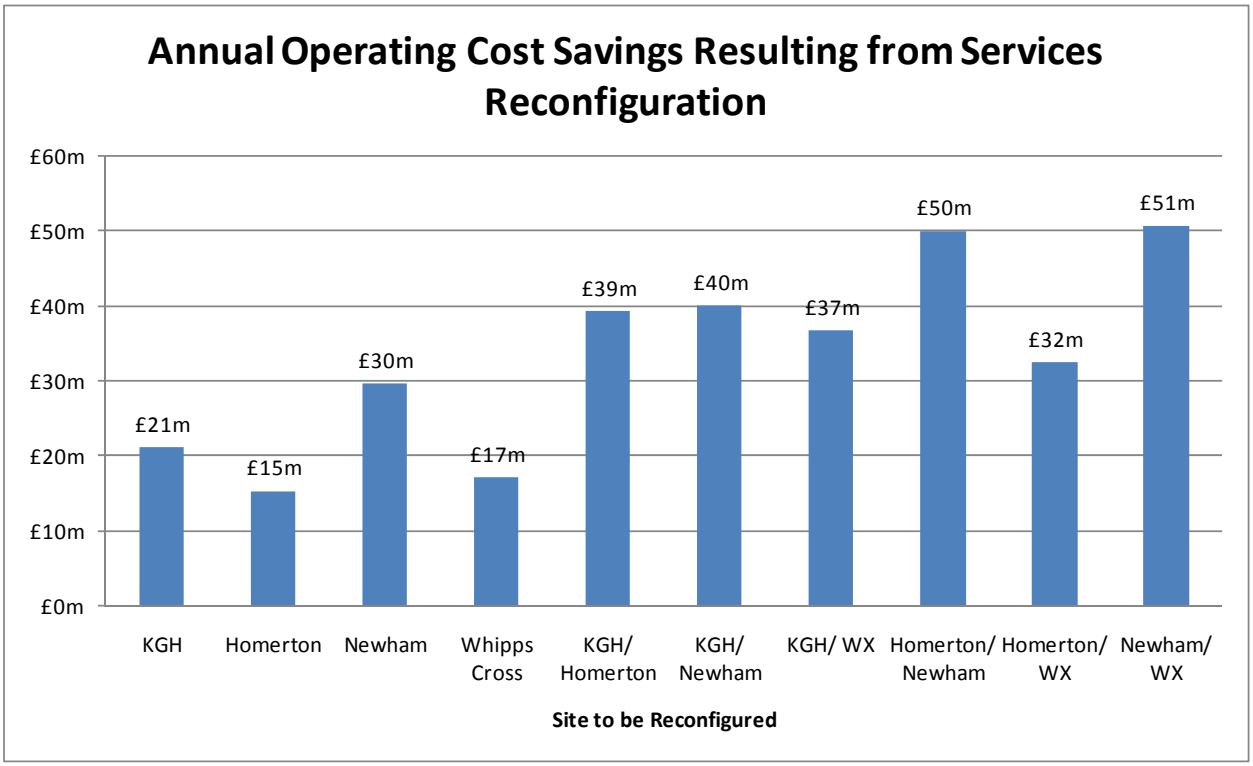
- Reshaping King George will have the greatest positive impact on whole system quality, and specifically supporting Queen's to deliver high quality services, through best use of workforce and addressing clinical quality and safety issues.

6. FINANCIAL ASSESSMENT OF OPTIONS

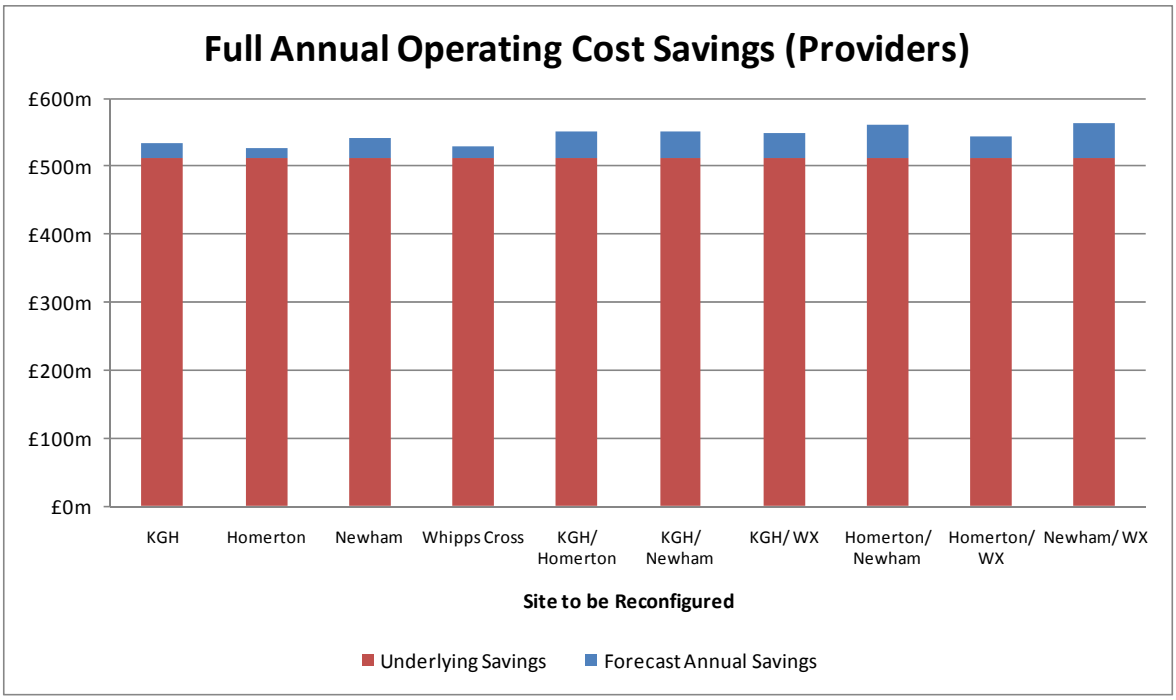
6.1 THE SAVINGS ACCRUING FROM ALL OPTIONS

The review of hospital services is clinically, not financially, driven; however, options must be affordable for the whole health economy. Providers need to ensure their costs are at or below tariff, particularly as the NHS moves from a ten year period of expansionary growth to a 'steady state' of lower annual growth. It is recognised by the programme that the majority of savings will need to come from improvements to quality and productivity gains, and a smaller amount from reductions in fixed costs and overheads i.e. savings made through reconfiguration.

Financial analysis was undertaken for each of the eleven options for the location of A&E services (see *section 5.3.4* for full list) to determine the annual savings delivered by each (excluding impact of capital investments). This is shown in the figure below.



The cost savings above are the 'pure' savings associated with the changes to the reconfiguration of the sites. They are on top of the savings productivity gains that providers will need to deliver that were discussed in the context section which are generic to all options. Taken together the savings forecast is:



The conclusions to be reached from the above are that:

- Reconfiguration of two hospitals with A&E to hospitals with UCS will lead to greater savings than reconfiguration of one.
- Reconfiguration of Newham from a hospital with A&E to a hospital with UCS will produce more savings than the same reconfiguration at the other three sites.
- No option increases operating costs.

6.2 THE SAVINGS ACCRUING FROM THE THREE SELECTED OPTIONS

In the non-financial options appraisal (see *Chapter 5*) it was explained that the four site options and the option to transform Whipps Cross from a hospital with A&E to a hospital with UCS were rejected on the capacity criteria. This left three options remaining.

The table below shows how the forecast operating cost savings will be distributed across the trusts that are affected by each reconfiguration option.

Effect of Selected Options on Trust Financial Performance
Forecast 2016/17 Recurrent Surplus-Deficit

	Do Minimum Option	Option 2 King George		Option 3 Homerton		Option 4 Newham	
		Suplus/ Deficit	Gain/Cost	Suplus/ Deficit	Gain/Cost	Suplus/ Deficit	Gain/Cost
Queens Hospital	-£13.4m	£4.5m	£17.9m	-£12.9m	£0.6m	-£2.5m	£10.9m
King George Hospital	£5.5m	£2.7m	-£2.7m	£5.9m	£0.4m	£12.3m	£6.8m
Sub-Total BHRUT	-£7.9m	£7.3m	£15.2m	-£6.9m	£1.0m	£9.8m	£17.7m
Whipps Cross	-£1.5m	£2.0m	£3.5m	£2.6m	£4.0m	£4.9m	£6.3m
Homerton	£5.5m	£5.8m	£0.2m	£2.7m	-£2.9m	£12.3m	£6.8m
Newham	£8.9m	£11.4m	£2.5m	£11.4m	£2.6m	-£4.4m	-£13.3m
Barts and the London	£5.5m	£5.2m	-£0.3m	£16.1m	£10.6m	£17.7m	£12.1m
NEL Total	£10.5m	£31.7m	£21.1m	£25.8m	£15.3m	£40.2m	£29.7m

These costs relate to the acute services on each site. Therefore where a site no longer has an A&E department under an option the income and expenditure that results in the forecast surplus/deficit above relates to the acute services that would remain on the site (generally outpatients and elective surgery). Community and primary care services, including UCS, are not included.

Option 4 (Newham becomes a hospital with UCS) offers the largest annual saving. This is because it has the largest volume of activity to displace; savings are derived from the economies of scale gained from having fewer sites so the larger the volume of activity displaced the greater the level of savings. So the very characteristic that produces the highest contribution to revenue savings also makes the option the most difficult to implement and will cause the most disruption to patients. This is reflected in the scoring for deliverability and access in the non-financial option appraisal that results in this option not being presented as the preferred option.

A further issue with this option is that the income related to the remaining acute services on the Newham hospital site would not be enough to cover the forecast cost of those services. This is because of the PFI scheme on the hospital site. In other options all overheads are treated as variable costs, and so similar margins are maintained before and after reconfiguration. As Newham's PFI cannot be treated as a variable cost, this leads to a deficit. The consequence of this is that the non-acute services on the site would have to absorb more of the overheads of the site to make it viable.

Full year on year analysis is included at *Appendix L*.

6.3 CONCLUSIONS

All three options make a positive contribution to the sectors' financial position. *However Option 4* will make the financial viability of services remaining on the Newham site very challenging.

No site that retains an A&E department after the reconfiguration is in a worse financial position as a result of the reconfiguration.

7. RECOMMENDATIONS FROM THE OPTIONS APPRAISAL

Having assessed the options against non-financial and financial decision making criteria, this chapter sets out the recommended option for change.

7.1 SUMMARY OF THE NON-FINANCIAL OPTION APPRAISAL

Based on the results of the combined scoring the CRG recommended a shortlist of the three options, plus a recommended option.

- Royal London and Queens as major acute hospitals, Newham, Homerton and Whipps Cross as hospitals with A&E and **King George** as a hospital with UCS (option 2).
- Royal London and Queens as major acute hospitals, Newham, King George and Whipps Cross as hospitals with A&E and **Homerton** as a hospital with UCS (option 3).
- Royal London and Queens as major acute hospitals, Homerton, King George and Whipps Cross as hospitals with A&E and **Newham** as a hospital with UCS (option 4).

With the highest-scoring option as the recommended option: Royal London and Queens as major acute hospitals, Newham, Homerton and Whipps Cross as hospitals with A&E and King George as a hospital with UCS (option 2).

7.2 SUMMARY OF THE FINANCIAL ANALYSIS

The above three shortlisted options were modelled for their financial consequences for acute hospital trusts in north east London. This financial assessment was contrasted with the financial consequences of the 'do minimum' scenario (see *section 5.1.3* for an explanation of the 'do minimum' scenario).

Financial analysis shows that all three shortlisted options make a positive contribution to the financial position of the north east London health economy. It also shows that no site retaining an A&E department following reconfiguration is in a worse financial position as a result of the reconfiguration. These results are shown in the table that follows.

		Annual Cost Reduction/(increase) Compared to Do Minimum 2016/17						
Option	Hospital with UCS	Queens Hospital	King George	Whipps Cross	Homerton	Newham	Barts and the London	Total
Do Minimum	No Change	£0m	£0m	£0m	£0m	£0m	£0m	£0m
Option 2	King George	£18m	-£3m	£3m	£0m	£3m	-£0m	£21m
Option 3	Homerton	£1m	£0m	£4m	-£3m	£3m	£11m	£15m
Option 4	Newham	£11m	£7m	£6m	£7m	-£13m	£12m	£30m

As the table illustrates, each option benefits individual hospitals differently with *Option 2* and *Option 4* providing most benefits to BHRUT (shown as Queen's and King George), the trust experiencing the most significant financial difficulties in 2009/10.

7.3 CONCLUSION

As the selection of recommended options has been clinically, rather than financially, driven, Option 2 can be recommended on the basis of being the highest-scoring option from the non-financial appraisal process. Given that Option 2 also provides financial benefit, to the overall health economy of north east London, and especially to BHRUT (the trust currently

experiencing most severe financial challenges), Option 2 is a particularly strong recommendation.

Modelling shows that option 4, which also scored highly in the non-financial appraisal, can deliver greater savings than Option 2 (£30million compared to £21 million). However the additional £9million savings do not outweigh the benefits that Option 2 can deliver beyond that of Option 4 in terms of clinical quality, safety and workforce; capacity; access; and deliverability.

Taking this into consideration, the Programme Board recommended that Option 2 (five hospitals with A&E and King George a hospital with UCS) provides the greatest overall benefit to north east London.

7.4 THE RECOMMENDATION

The recommendations made by the CRG to the Programme Board and in turn by the Programme Board to the JCPCTs are set out below. These are subject to public consultation.

- An endorsement of the principle of 'care closer to home' including:
    - the continued development of primary care led urgent care provision at the front end of all A&E departments and within polyclinics, with the ambition to deliver a minimum of 40% of current A&E activity in this way in future.
    - new integrated, primary and community based models of care that reduce by approximately 60% current outpatient activity.
- That the Royal London and Queen's are designated major acute hospitals for north east London.
- That, in addition to the two major acute hospitals, three hospitals with A&E are required and one hospital with UCS.
- That the population of north east London will be served best by hospitals with A&E at Homerton, Newham and Whipps Cross and a hospital with UCS at King George (see *Chapter 8* for further exploration of the proposed services models for King George).
- That, as a recognition of the need for continued improvements to clinical quality and financial viability, Homerton, Newham and Whipps Cross should actively pursue opportunities to work together closely.

8. THE CLINICAL PROPOSALS FOR CHANGE

This chapter sets out the detail of the proposed service delivery models for north east London. The chapter is structured into four sections:

- **Section 8.1** provides a summary of the changes
- **Section 8.2** reviews the current configuration of services
- **Section 8.3** describes the proposed service configuration for north east London
- **Sections 8.4 – 8.7** examine the proposed service configuration for major acute hospitals, hospitals with A&E and hospitals with UCS
- **Section 8.8** looks at the benefits of the clinical proposals

As part of the clinical proposals two options are set out for the future service configuration of King George: the 'core' configuration and the 'enhanced' configuration. These options will be tested during public consultation.

8.1 SUMMARY OF CHANGES

In summary, the changes can be characterised as follows:

1. That there are programmes and activities that have already been agreed and form part of the 'do minimum' scenario – see *section 5.1.3* for further detail. At the core of this work is the shift of services from hospital to community-settings. The detail of the work comprises:

   - Implementation of **Urgent Care Services (UCS)** model that absorbs a minimum of 40% of all A&E attendances
   - **Polysystems** established throughout north east London with polyclinics as their hub
   - Primary care-led **clinical pathway transformation** programme enables reductions in hospital activity levels
   - **Quality and productivity improvements** at all hospitals and in primary and community care services
   - **Paediatric Assessment and Treatment services (PATS)** operational at all hospitals with A&E services

   These five areas of work are referred to as 'enabling milestones' for the purposes of transition and implementation, as they support the implementation of the reconfiguration proposals.

2. That the major acute hospital model set out by *Healthcare for London* will be developed in north east London with specialist services, currently being provided by

most hospitals in the sector, being consolidated at the two designated major acute hospitals – the Royal London Hospital and Queen's Hospital.

3. That, in addition to the two major acute hospitals, there will continue to be four hospitals with three (Homerton, Newham and Whipps Cross) providing A&E, critical care, obstetric and gynaecology and other acute services.

4. That King George Hospital will be re-shaped to provide urgent and planned care services. There are two proposed options for service configuration at King George, plus a set of additional services that could be located at King George with either reconfiguration option. These are summarised below (the detail of which is set out in *section 8.7.1*).

   - '**Core' service configuration ~** services would comprise round the clock urgent care services, an on-site polyclinic, outpatient services and diagnostics, planned surgery[18], stroke rehabilitation and other rehabilitation and intermediate care beds, community services for children, adults and older people. It is expected that this model would enable the UCS to undertake a minimum of 40% of current A&E activity.

   - **'Enhanced' service configuration ~** services would comprise the 'core' configuration plus next-day outpatient clinics for urgent specialist assessment and treatment, increased planned surgery activity including transfer of non-complex activity from Queen's. It is expected that this model would enable the UCS to undertake between 60% and 75% of current A&E activity as a result of rapid access to specialist advice and enhanced diagnostics.

   - **Other services located at King George ~** compatible with either the 'core' or 'enhanced' configuration, is the proposal to relocate services from elsewhere to the King George site. These services could include renal dialysis and child health development services.

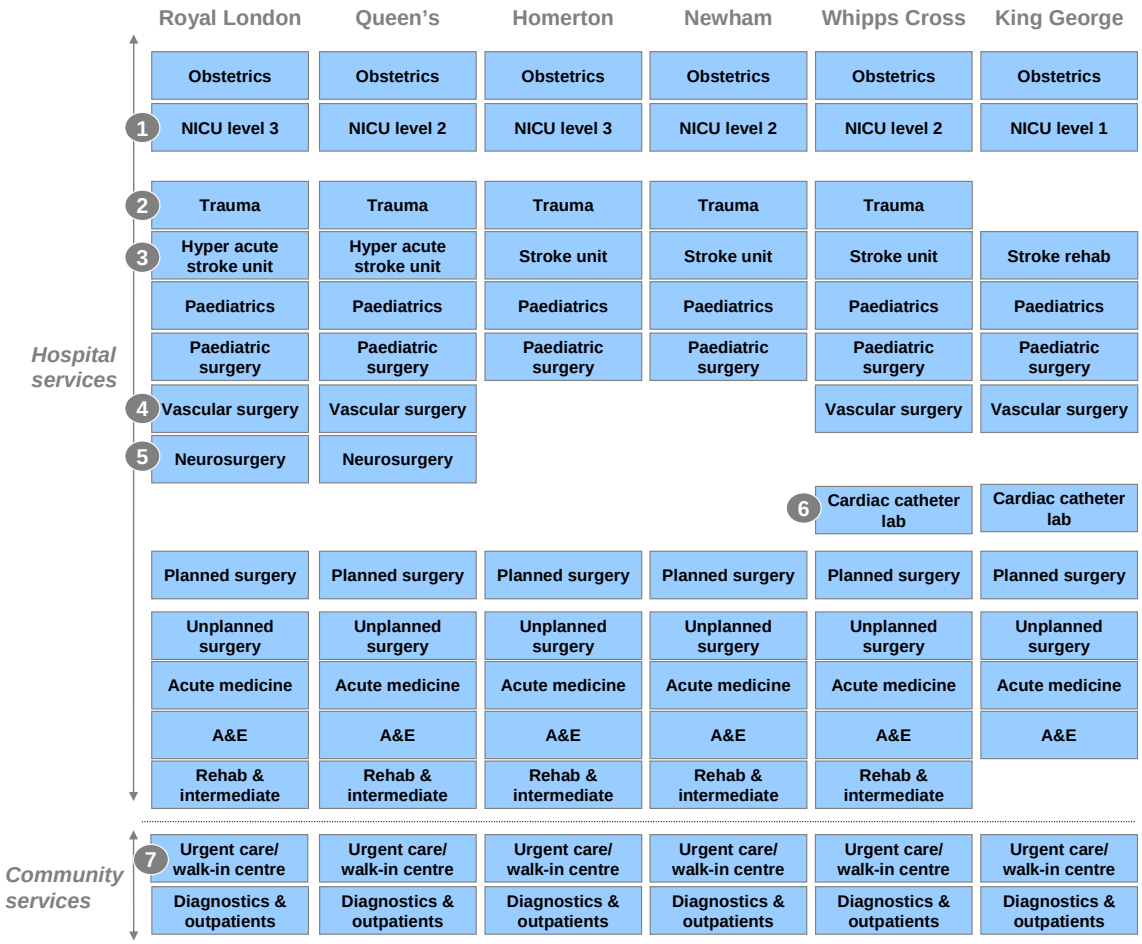
5. That, across north east London, planned care pathways will be separated as far as is possible from urgent care pathways.

The above changes are examined in detail in *section 8.7.1.*

8.2 THE CURRENT CONFIGURATION OF SERVICES

The figure below shows a high-level view of the services provided at each site, within the current configuration.

[18] Planned surgery comprises activity currently undertaken on the King George site including the Independent Sector Treatment Centre (ISTC)



As shown in the diagram above, there are few differences in the services provided at each hospital site in north east London. Most services are provided at all hospital sites, with the following exceptions:

1. **Neonatal intensive care (NICU) ~** NICU Level 3 is provided at the Royal London and Homerton. Level 2 is provided at Queen's, Newham and Whipps Cross. Level 1 is provided at King George.

2. **Trauma ~** all hospitals other than King George have trauma units. Royal London is the designated major trauma centre for north east London.

3. **Stroke services ~** all hospital sites have acute stroke units, except King George which has a stroke rehabilitation centre. Royal London and Queen's provide hyper-acute stroke units for north east London.

4. **Paediatric high dependency unit (HDU) ~** is provided only at the Royal London.

5. **Vascular surgery** is provided at the Royal London, Queen's, Whipps Cross and King George, but not at Homerton or Newham.

6. **Neurosurgery** is provided only at The Royal London and Queen's.

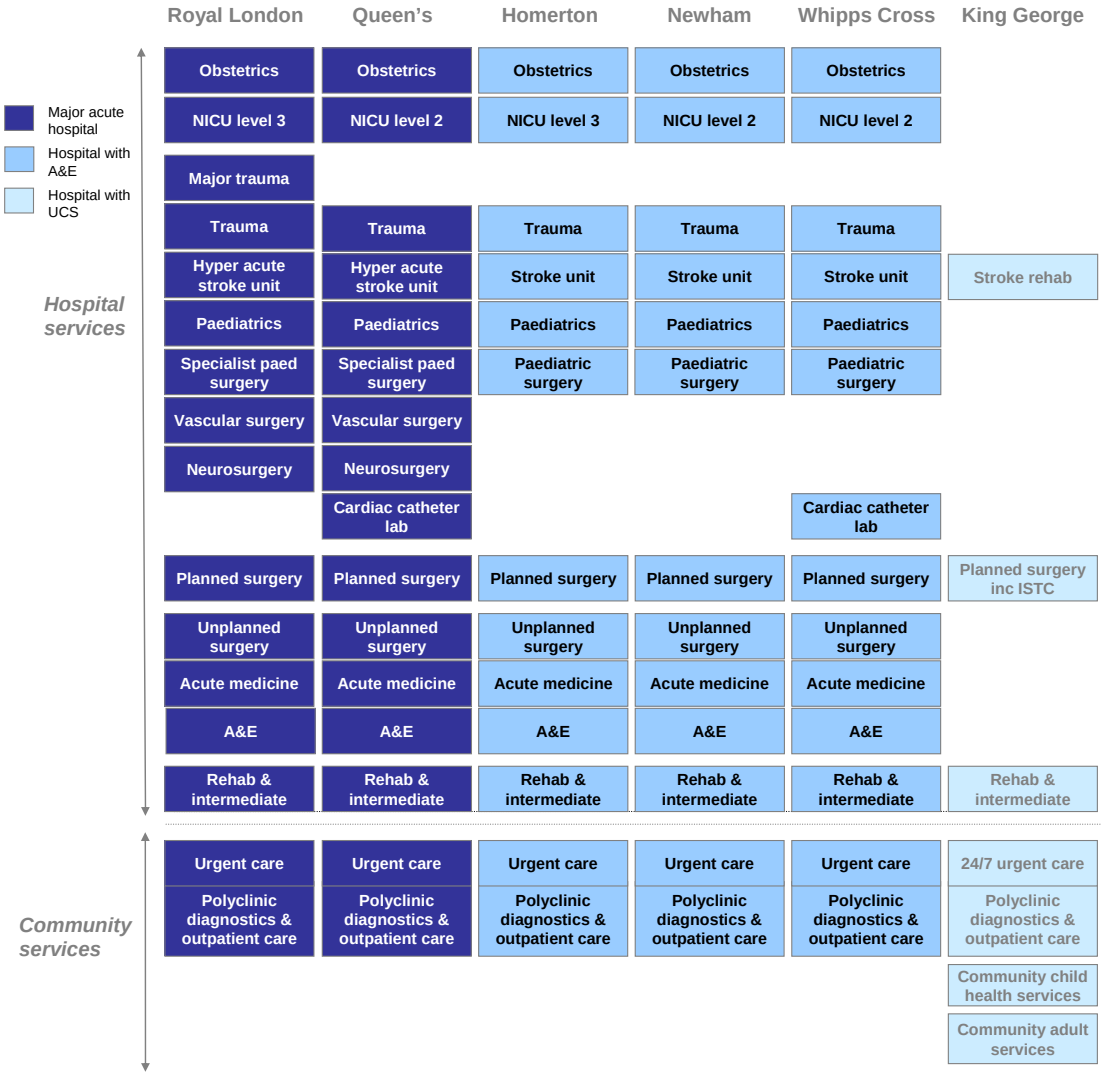
7. **Cardiac catheter labs** are provided at Whipps Cross and King George (as well as at the London Chest Hospital, Mile End - part of Barts and the Royal London NHS Trust).

8. **Urgent care centres and walk-in centres ~** whilst each hospital has either an urgent care centre or a walk-in centre, the model of care for each currently differs.

As Barts is out of scope for *Health for North East London*, it is not included in the diagram above. However, it is noteworthy that there is a cardiac catheter lab located at the London Chest Hospital, Mile End, which is part of Barts and the London NHS Trust. The pan London review of cardiac services is expected to conclude that this service should continue to be provided by Barts and the London Trust.

8.3 PROPOSED SERVICE CONFIGURATION

The figure below shows a high-level view of the services, under the proposed changes, will be delivered at each hospital site. This picture is relevant to both options for King George Hospital.



By comparing the two diagrams, the following proposed changes can be seen:

Major acute hospitals ~ as the major acute hospitals for north east London it is proposed that the Royal London and Queen's will deliver a similar range of hospital services to each other, with a few exceptions. The detail of this proposed service configuration is as follows:

- Vascular services will be consolidated at the Royal London and Queen's.
- All specialised paediatric services will be consolidated at the Royal London and Queen's. All paediatric surgery for under twos and all surgery that is urgent or complex for children over two years old will be undertaken at the Royal London.
- Hyper-acute stroke units will be provided at the Royal London and Queen's.
- The Royal London will provide major trauma services for north east London.
- The Royal London will have a NICU level 3 and Queen's will have a NICU level 2.
- The Royal London and Queen's will have round the clock GP-led urgent care services as a front-door to A&E and an on-site polyclinic with diagnostics and outpatient care.

Hospitals with A&E ~ it is proposed that Homerton, Newham and Whipps Cross will provide a similar range of services to one another. The detail of this proposed service configuration is as follows:

- Homerton, Newham and Whipps Cross will continue to provide A&E, urgent medicine and urgent surgery, critical care, obstetric and gynaecology and other acute services.
- Homerton, Newham and Whipps Cross will continue to provide stroke unit.
- Whipps Cross will continue to provide a cardiac catheter lab. Queen's will provide the cardiac catheter service currently located at King George.
- Queen's will increase its maternity capacity, with the current inpatient service at King George being re-provided at Queen's, with an emphasis on reaching 40% of births in midwifery-led units.
- Homerton, Newham and Whipps Cross Hospitals will have round the clock GP-led urgent care services as a front-door to A&E and an on-site polyclinic with diagnostics and outpatient care.

Hospitals with UCS ~ it is proposed that King George Hospital will undertake between 40% and 75% of current A&E activity in a round the clock urgent care service. The site will also provide a range of children's, adult's and older people's services. There are two proposed options for the future service configuration of King George (this can be seen in more detail in *section 8.7.1*), and the following points are relevant for both proposed options.

- King George will have round the clock GP-led urgent care services and an on-site polyclinic with diagnostics and outpatient care.
- It is anticipated that patients with serious illnesses or injuries, who require an A&E service rather than an urgent care service, will access Queen's, Newham or Whipps Cross A&E department, as these are the closest geographically. LAS protocols will be updated to reflect agreed changes, therefore, patients transported

by ambulance to A&E or UCS, will be conveyed to the most appropriate setting for their condition.

- King George will provide stroke rehabilitation services.
- Planned surgery will be undertaken at King George.
- Additional services at King George could include community child health and adult rehabilitation and intermediate care services.

8.4 DEVELOPMENT OF THE MAJOR ACUTE MODEL IN NORTH EAST LONDON

The major acute hospital model set out by *Healthcare for London* would be developed in north east London with the Royal London and Queen's as the two major acute hospitals. These hospitals will have a dual role: to provide local hospital services to their catchment population and to act as centres for specialist services, where there is benefit from consolidating the service to fewer sites. The key changes to clinical services, in relation to the development of the major acute hospitals, are set out below by each clinical working group area (with the exception of planned care which is reviewed separately in *section 8.6*).

a. MAJOR ACUTE HOSPITALS: CHILDREN'S SERVICES

In addition to the implementation of Paediatric Assessment and Treatment Services (PATS) at all hospitals, major acute and local, with A&E departments, major acute hospitals will provide specialist paediatric services for children with complex or acute clinical needs.

Paediatric medicine ~ for children who require a more specialised inpatient environment, such as a High-Dependency Unit (HDU) or a longer length of stay than can be provided by the PATS model, it is proposed that patients are stabilised and transferred to specialist inpatient services at the Royal London and Queen's.

Paediatric surgery ~ all surgery for children under two years (other than surgery requiring a tertiary children's hospital such as Great Ormond Street) will be consolidated at the Royal London and Queen's. All surgery that is urgent or complex for children aged 15 or less will be undertaken by Royal London and Queen's hospitals.

A clear journey will need to be mapped as to how a safe, high quality specialist service can be developed on the Queen's hospital site. The proposal is to link the surgery service to Barts and the London to assure availability of experienced paediatric surgeons and support teams to enable high quality care and clinical outcomes.

b. MAJOR ACUTE HOSPITALS: URGENT MEDICINE

In line with *Healthcare for London's* vision of major acute hospitals, the Royal London and Queen's will provide A&E services. The A&E department will have an Urgent Care Service (UCS) as a front-door which is expected to operate round the clock and absorb a minimum of 40% of current A&E attendances. This will mean that access and continuity of care for minor injuries and illnesses is improved and only patients with serious or life threatening conditions need to be treated within the acute hospital setting of the A&E department.

At the 'back end' of the urgent medicine pathway, specialist-led Acute Assessment Units (AAUs) at both major acute hospitals will reduce admissions and length of stay and increase quality of care and improve clinical outcomes.

The major acute hospital model for north east London includes on-site access to the full range of clinical support services such as diagnostics and laboratory services as well as clinical specialities including urgent surgery and obstetrics and gynaecology.

c. MAJOR ACUTE HOSPITALS: URGENT SURGERY

Urgent surgery services will continue to be available on site at major acute hospitals. For specialist vascular surgery see *section 8.4.e.*

d. MAJOR ACUTE HOSPITALS: MATERNITY AND NEWBORN CARE

Maternity services ~ it is proposed that the Royal London and Queen's maintain their current co-located obstetric services, with an increasing emphasis on midwifery-led care where appropriate. In addition to providing a local hospital service to their catchment population the expectation is that women with complex medical histories or serious co-morbidities that cannot be managed in non-major acute hospitals would be referred to these units. Activity from King George's co-located obstetric service will transfer to Queen's, to ensure continued co=location with A&E and supporting clinical services and specialist practitioners. The new midwifery-led unit opening at Barking Hospital in 2011 will provide an alternative care setting choice for low risk women currently using the King George service.

Newborn care ~ no change to the configuration of current neonatal provision in the sector is envisaged; however additional capacity will be required in both Level 2 and Level 3 units to meet rising demand related to growth in births. The Royal London and Homerton already have plans in place to develop additional Level 3 cots.

If the number of newborns requiring NICU Level 3 care in outer north east London rises beyond expected levels in the future (for instance, due to changing demographics) this position may need to be reviewed.

e. MAJOR ACUTE HOSPITALS: SPECIALIST SERVICES

Stroke and major trauma ~ following the *Healthcare for London* consultation for stroke and major trauma, the decisions taken by the London JCPCT included:

- Designation of the Royal London as the site for major trauma for north east London.
- Designation of the Royal London and Queen's as providers of hyper-acute stroke services.

As these decisions were taken following a separate consultation they do not form part of the Health for North East London *consultation, but are included in the description of the proposals for change for completeness.*

Vascular surgery ~ it is recommended that urgent and complex vascular surgery will be consolidated from four to two sites. It is proposed that the current provision at King George and Whipps Cross is consolidated at Queen's and the Royal London respectively. This consolidation will be supported by a network delivery model with outpatients and routine planned procedures undertaken on all sites by accredited vascular surgeons in partnership with local services.

Cardiac catheterisation services ~ whilst cardiac services across north east London are part of the pan-London review of cardiac services (from which it is anticipated that either Barts or the Royal London will provide a cardiac catheterisation service), one change to cardiac services forms part of the proposals for consultation. As part of the wider move to consolidate specialist services at major acute hospitals, it is recommended that the diagnostic cardiac catheter laboratory currently situated at King George will be relocated to Queen's.

8.5 PROVIDING HOSPITAL SERVICES AT HOMERTON, NEWHAM, AND WHIPPS CROSS

The reconfiguration proposals are that, in addition to the two major acute hospitals, there will continue to be four hospitals in north east London. Three (Homerton, Newham and Whipps Cross) would provide a similar range of hospital services to one another, with King George being re-shaped to focus on provision of urgent care and planned care services.

As we have seen in *Section 8.4.e* some specialist services will be consolidated at the two major acute hospitals. Where these are currently provided at non-major acute hospitals the effect will be a migration of that service to the major acute. For example, vascular surgery is currently performed at Whipps Cross and King George as well as the two major acute hospitals. The proposals therefore include the migration of vascular surgery from Whipps Cross to the Royal London and from King George to Queen's.

The key changes to clinical services, in relation to the hospital provision at Homerton, Newham, and Whipps Cross, are set out below by each clinical working group area (with the exception of planned care which is reviewed separately in *section 8.6*).

a. HOSPITALS WITH A&E: CHILDREN'S SERVICES

All hospitals with an A&E department will provide a Paediatric Assessment and Treatment Services (PATS) which will play a key role in supporting the A&E department with paediatric specialists, and stabilising children who need to be transferred to a major acute hospital for more specialist treatment.

Paediatric medicine ~ for children who require a more specialised inpatient environment, such as a High-Dependency Unit (HDU) or a longer length of stay than can be provided by the PATS model, it is proposed that patients are stabilised and transferred to the Royal London paediatric department with potential for Queen's to be developed to fulfil this role for its local population in the future.

Paediatric surgery ~ as all urgent and complex paediatric surgery will be consolidated at the Royal London and Queen's hospitals it will be the role of PATS at Homerton, Newham and Whipps Cross to stabilise and transfer patients requiring this service to the major acute hospital. For non-urgent and non-complex surgery a paediatric surgical network will be developed whereby accreditation will be given to surgeons suitably trained and experienced

to operate on children and young people (aged 15 or less) at non-major acute hospital settings.

b. HOSPITALS WITH A&E: URGENT MEDICINE

It is proposed that Homerton, Newham and Whipps Cross provide A&E services. As in the model for major acute hospitals, all north east London hospitals will have an Urgent Care Service (UCS) as a front-door which is expected to operate round the clock and absorb a minimum of 40% of current A&E attendances. This will mean that only patients with serious or life threatening conditions need to be treated in the A&E department.

Hospitals with A&E will also maintain specialist-led Acute Assessment Units (AAUs) at the 'back-end' of the urgent medicine pathway that will reduce admissions and length of stay and increase quality of care and improve clinical outcomes. Hospitals with A&E will also have on-site access to the full range of clinical support services such as diagnostics and laboratory services as well as clinical specialities including urgent surgery and obstetrics and gynaecology.

c. HOSPITALS WITH A&E: URGENT SURGERY

The proposals have no change to clinical service configuration for urgent surgery at Homerton, Newham and Whipps Cross, with relocation of urgent surgery from King George to Queen's hospital in line with the movement of all urgent services.

It is anticipated that one of the positive impacts of consolidation from six sites to five will be increased capacity at the five remaining sites for management of all urgent surgical admissions within recommended time periods. Consequently, night-time operating can be kept to an absolute minimum, and authorised only by specialist clinicians when clinically appropriate.

Opportunities for networks and joint rotas to support urgent surgery at five sites are to be further explored in the future. The sustainability of all five hospitals with A&E providing the full range of urgent surgery will need to be kept under review.

d. HOSPITALS WITH A&E: MATERNITY AND NEWBORN CARE

Maternity services ~ for Homerton, Newham and Whipps Cross there is no proposed change to the current configuration of co-located obstetric services at each site. However, the vision for the future is to increase the proportion of women following midwifery-led pathways, with the majority giving birth in midwife-led units that are located in close proximity to obstetric led services and an increase in the number of women supported to give birth at home or in (standalone) community based midwifery led units.

Newborn care ~ no change to current neonatal provision in the sector is envisaged at this stage. Neonatal Intensive Care Unit (NICU) Level 3 provision will be retained at Homerton with Level 2 provision at Newham and Whipps Cross. Under the proposals there will be no NICU Level 2 at the King George site as all maternity and newborn care services will move to Queen's.

e. HOSPITALS WITH A&E: SPECIALIST SERVICES

Stroke and trauma services ~ as part of *Healthcare for London's* review of stroke and trauma services Whipps Cross, Newham and Homerton have been accredited to provide acute stroke and trauma centre care in support of the designated hyper-acute stroke units at Royal London and Queen's and the major trauma centre at Royal London. There is no change for King George which does not currently provide either acute stroke or trauma services, and will continue to provide stroke rehabilitation services.

Vascular surgery ~ as it is proposed to consolidate urgent and complex vascular surgery at the two major acute services, this means that the current provision at King George will be consolidated at Queen's and current provision at Whipps Cross will be consolidated at the Royal London. This consolidation will be supported by a network delivery model with outpatients and routine planned procedures undertaken on all major acute and other hospital sites by accredited vascular surgeons in partnership with local services.

Cardiac catheterisation services ~ whilst cardiac services across north east London are part of the pan-London review of cardiac services, one change to cardiac services forms part of the proposals for consultation. As part of the wider move to consolidate specialist services at major acute hospitals, the diagnostic cardiac catheter laboratory currently situated at King George will be relocated to Queen's hospital. The cardiac catheterisation service provided at Whipps Cross will be unchanged.

8.6 PLANNED CARE SERVICES

Clinical recommendations are for as much separation of urgent care pathways and planned care pathways as possible. If capacity allows, ideally this is through separate facilities, but separation can also be achieved on co-located facilities. Separation of pathways in this way reduces rates of infection for both sets of patients because planned care patients can be screened and treated in advance for any infections, and patients are not sharing the same wards. Levels of patient satisfaction are also higher when this separation is achieved.

The reconfiguration proposals go some way to achieving separation between urgent and planned care pathways. It is proposed that all urgent inpatient activity moves from King George to Queen's consequently allowing greater focus on planned care services at King George. Some of the other hospitals have also developed separate planned care facilities or have plans to do so (Newham and Barts and Royal London).

Immediate proposals for change include movement of some planned care from Queen's to King George and there is potential for the future to increase activity further on the King George site. In the longer term *Health for North East London* will consider the potential for more specialisation in planned surgical care with King George becoming a centre that specialises in one or several non-complex and high-throughput procedures such as orthopaedics, ophthalmology, or general surgery, on behalf of the whole sector. There may also be opportunity for other sites, as well as King George, to specialise in one or more case types. An elective commissioning strategy will be developed during 2010/11 with the full range of options considered.

8.7 CLINICAL SERVICES TO BE PROVIDED AT KING GEORGE

The recommendation from the Clinical Reference Group was that five A&E departments, backed-up by the full range of supporting clinical services (such as urgent medicine, urgent surgery and obstetrics) was the best configuration to meet the needs of the local population in north east London (at least in the short to medium term). The option appraisal process, as described in *Chapter 5*, identified that remodelling King George into a hospital with a focus on urgent and planned care services would provide the best overall pattern of services for north east London.

A key clinical reason for selecting King George as a hospital with UCS is because its current configuration is furthest away from the desired model for a hospital with A&E, as it does not provide trauma, acute stroke or orthopaedics services, and therefore requires least changes to operate as a hospital with UCS.

The vision for King George is a hospital providing round the clock urgent care along with a range of enhanced polyclinic and planned care services to the local community. It will provide a viable alternative to A&E for the vast majority of people who attend A&E with a minor injury or illness rather than a life-threatening or serious condition, with access to a wide range of diagnostics as well as on-site next day treatment clinics. Currently 85% of A&E attendees at King George do not require hospital admission; the task of the urgent care service will be to manage as many of these patients as possible. This will mean that access and continuity of care for minor injuries and illnesses is significantly improved.

8.7.1 Options for reconfiguration of King George hospital

There are two reconfiguration options for King George. These set out a number of clinical services proposed for location at King George, either existing services, new services, or services that proposed to be relocated from another site. The two options will form part of the formal consultation; stakeholders and members of the public will be asked for their view on the changes contained in each option. The detail of these options is set out in paragraphs that follow.

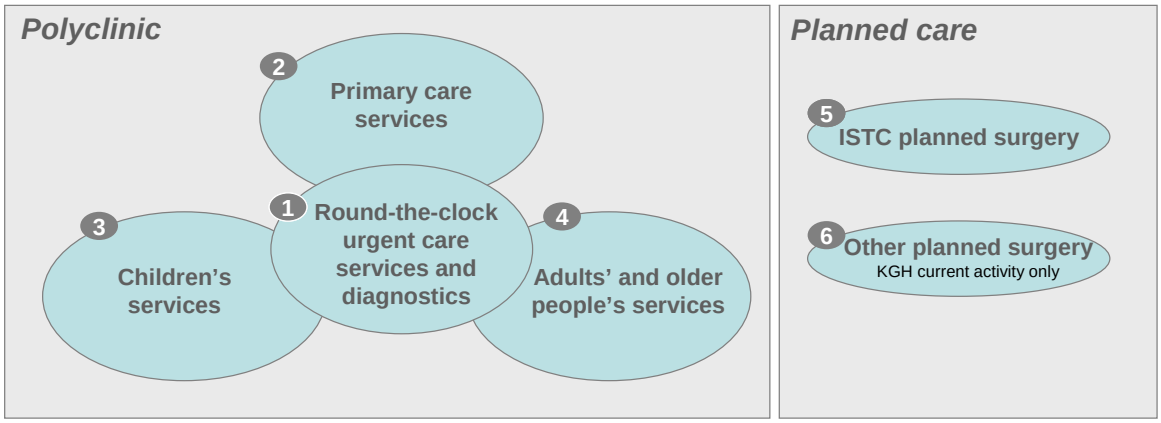
The PCBC has been modelled, in terms of activity and financial impact, on the ‘core’ configuration option. The ‘enhanced’ option has been identified more recently, as a result of pre-consultation engagement, therefore activity and financial impact modelling will be undertaken during consultation.

It should be noted that part of the proposals for consultation includes the development of a commissioning strategy for the services that will be located at the King George site. This strategy will review the commissioning arrangements for the services, including the providers of the services at King George. The description of proposed service models that follows therefore covers what services will be provided, but not which provider will deliver the service.

a. THE ‘CORE’ CONFIGURATION OF SERVICES AT KING GEORGE

The diagram and text that follows provides a high-level view of the services to be provided at King George within the ‘core’ configuration of proposals for change.

'Core' configuration: services to be provided at King George



Polyclinic services within the 'core' configuration

The polyclinic services proposed for location at King George are described below:

1. **Round the clock urgent care services ~** whilst all hospitals in the sector will have a primary care-led UCS as the front-door, the service at King George will be provided on an enhanced level, with a greater range of specifically targeted diagnostic and urgent care support services available on-site than elsewhere; these are detailed in the paragraphs that follow. Continuity of care will also be supported through the on-site availability of primary care services.

   Diagnostics are expected to include ECG, pulse oximetry, spirometry, x-ray, ultrasound, vascular doppler, colonoscopy, and standard haematology, microbiology and pathology. Further work is being undertaken to determine whether there is a case for providing MRI and CT in some polyclinics.

2. **Primary care services ~** within the polyclinic setting, primary care services such as GP services, proactive management of long-term conditions, ante-natal and post-natal care will be available.

3. **Children's services ~** the proposals include a focus for King George on providing non-acute children's services, enabling co-location of several inter-linked service areas and specialist practitioners, to support child well-being, prevent A&E hospital attendances and inpatient admissions, and support families to provide care for their child at home. A key aspect of this service area will be close links to care outside hospital services such a paediatric homecare teams. These services are likely to comprise:

   - Specialist children's nursing support to the urgent care service
   - Children's outpatient clinics including ongoing management of long term conditions
   - Child and Adolescent Mental Health Services (CAMHS), relocated from Loxford
   - Child protection and safeguarding services including child protection medical assessments

4. **Adults' and older people's services ~** the re-modelling of King George enables a specialised focus on providing services for adults and older people, with a particular

emphasis on effective proactive management of long term conditions in the community. Within this service area, the following services are proposed:

- Specialist adult and older people nursing support to urgent care services
- Outpatient clinics including ongoing management of long term conditions
- Multidisciplinary rehabilitation and intermediate care services, provided on an outpatient basis
- Rehabilitation and intermediate care beds (approximately 50 beds), relocated from Heronwood and Galleon in Wanstead.
- Stroke rehabilitation service, with specialist unit including inpatient beds, including relocation of twelve stroke rehabilitation beds from Grays Court in Barking and Dagenham
- Community mental health services for adults and older people
- Chemotherapy services: the Cedar Unit

Planned care services

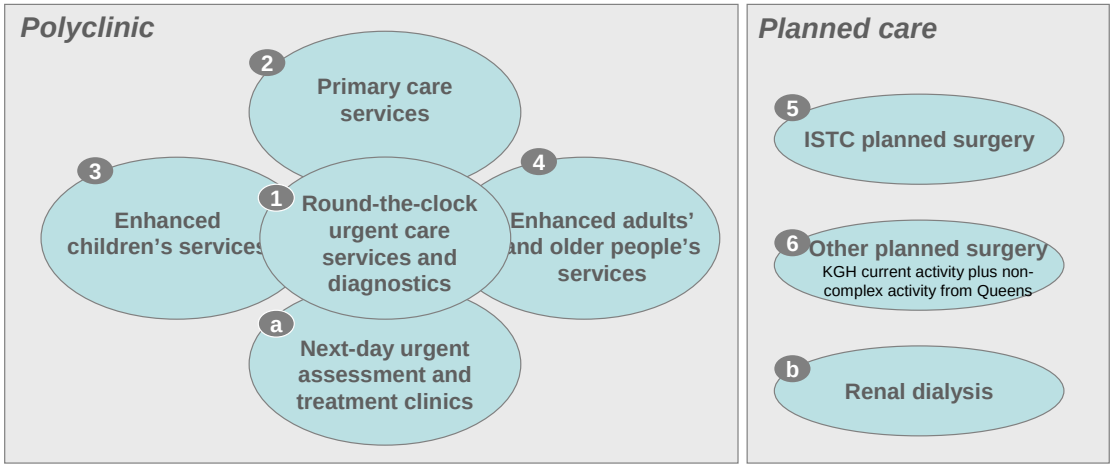
5. **Independent Sector Treatment centre (ISTC)** ~ the ISTC currently located at King George is expected to continue to operate; the proposed changes provide an opportunity to review the levels of case mix and activity and ensure the right level of capacity is available to meet projected demand.

6. **Other planned surgery** ~ within the 'core' configuration option, the proposal is for the current level of planned surgery activity undertaken at King George to remain.

b. THE 'ENHANCED' CONFIGURATION OF SERVICES AT KING GEORGE

The diagram and text that follows provides a high-level view of the services to be provided at King George within the 'enhanced' configuration of proposals for change.

'Enhanced' configuration': services to be provided at King George



Polyclinic services within the 'enhanced' configuration

The polyclinic services proposed for location at King George are described as 'enhanced' because they exceed the standard offering of the polyclinic model being implemented elsewhere in north east London. The additional services proposed to be located at King George within the 'enhanced' model are described below:

- Children's urgent (within 24 hours) outpatient clinics for specialist assessment and treatment.

- Adult and older people's urgent (within 24 hours) outpatient clinics for specialist assessment and treatment.

Planned care services

In addition to the services described in the 'core' option, the following services form part of the 'enhanced' option:

- **Other planned surgery** ~ within the 'enhanced' option, the proposal is for a considerable volume of planned surgery activity to transfer from Queen's to King George. In the longer term, as described in *section 8.6*, there is potential for King George to develop into a centre specialising in one or several non-complex and high-throughput cases of planned surgery such as orthopaedics, ophthalmology, or general surgery, on behalf of the whole sector.

- **High dependency unit ~** within the 'enhanced' option, a high dependency unit (HDU) will be required to support the higher volume of planed surgery taking place on King George site.

c. OTHER SERVICES PROPOSED FOR LOCATION AT KING GEORGE

In addition to the proposed 'core' and 'enhanced' configurations for King George, there are a number of services which are proposed for relocation from an existing site to King George hospital.

- **Renal dialysis ~** it is proposed that 24 renal haemodialysis stations are located at King George from current locations at Barts and Whipps Cross hospitals. This will provide significant benefit for patients in Barking and Dagenham and southern Redbridge who currently have to travel long distances from home for dialysis.

- **Community child health services** ~ multidisciplinary services such as children's neuro-developmental assessments could be relocated from an existing base at the Kenwood Child Development centre to the King George site. The service would greatly benefit from co-location with other children's services such as CAMHS and children's outpatient clinics and the concentration of child health specialists at one site. In addition, the fabric of the building at Kenwood is below ideal standards, and better facilities are available at King George.

8.8 BENEFITS OF THE CLINICAL PROPOSALS FOR CHANGE

As we saw in *Chapter 3*, benefits from reconfiguration have been identified and grouped for patients and for staff.

The table below shows a high level view of the extent to which the clinical proposals for change as described in this chapter deliver the identified benefits. These benefits are relevant for both 'core' and 'enhanced' reconfiguration options.

Benefits to patients

Benefit	Extent to which clinical proposals for change can deliver benefit
Patients are more likely to have input from a senior clinician, with a high level of experience in treating the condition type, earlier in their pathway.	▪ By reducing the number of sites with A&E, urgent medicine, urgent surgery, obstetrics and some specialist services, the existing workforce can be consolidated to ensure sustainable rotas and fully-resources teams. ▪ Networks of care across hospitals will provide ease of access to specialist opinion and enable early senior decision-making.
The most seriously ill patients will be treated by the most highly skilled staff and in facilities that are designed for treating that condition.	▪ Consolidation of A&E and supporting clinical services to fewer sites enables staff to treat higher volumes of a richer case mix. This means staff develop greater expertise in this case mix. ▪ Consolidation of specialist services to fewer sites means patients will only be treated at hospitals where the most skilled staff are based, with access to the most appropriate facilities and supporting clinical services. ▪ The urgent care services model will absorb a high proportion of patients with minor injuries and illnesses, enabling A&E departments to focus on patients with life-threatening and serious conditions.
More children can be cared for within north east London and the need for transfer to central London tertiary hospitals is reduced.	▪ The PATS model plus development of Royal London and Queen's as centres of excellence for paediatrics, means pathways for children will ensure wherever possible, patients are cared for within the sector, and transfers to out-of-sector tertiary centers will be minimised.
Patients undergoing planned care are less likely to have their surgery or treatment cancelled.	▪ Separation of emergency and planned care through concentration of planned care at King George, and re-provision of King George emergency activity at Queen's, significantly reduces the diversion of resources, beds and theatres from planned to emergency cases.
The likelihood of patients contracting healthcare acquired infections is reduced.	▪ Separation of emergency and planned care through concentration of planned care at King George, and re-provision of King George emergency activity at Queen's, means screening

	and treatment of planned care patients in the community can reduce infection rates because planned and emergency patients do not share the same facilities.

Benefits to staff

Benefit	Extent to which clinical proposals for change can deliver benefit
Opportunities for sub-specialisation for all clinical professions and broadening of non-medical career pathways, for example the development of nurse practitioner roles.	▪ The development of major acute hospitals, operating as centres of excellence and the separation of emergency and planned care pathways, will provide opportunities for staff to sub-specialise and take on enhanced roles. ▪ Clinical staff look for opportunities where they can sub-specialise and where there is a greater range of career options to pursue.
Improved opportunities for training and supervision of clinical staff in training.	▪ By reducing the number of sites with A&E, urgent medicine, urgent surgery, obstetrics and some specialist services, the existing workforce can be consolidated to ensure sustainable rotas and fully-resources teams. This will provide greater opportunity for senior clinician-led supervision of staff in training. ▪ Networks of care across hospitals will provide ease of access to specialist opinion and enable early senior decision-making. In this way staff in training will have greater access to a wider range of specialists for enhanced training opportunities.
Advantages of working in a fully-resourced team with sustainable rotas, including support from increased senior clinician input and decision-making.	▪ By reducing the number of sites with A&E, urgent medicine, urgent surgery, obstetrics and some specialist services, the existing workforce can be consolidated to ensure sustainable rotas and fully-resources teams. ▪ Networks of care across hospitals will provide ease of access to specialist opinion and enable early senior decision-making.
Greater throughput of patients per team provides clinicians with increased levels of experience and expertise.	▪ Consolidation of A&E and supporting clinical services to fewer sites enables staff to treat higher volumes of a richer case mix. This means staff develop greater expertise in this case mix.

9. FINANCIAL ANALYSIS OF THE CLINICAL PROPOSALS FOR CHANGE

9.1 REVENUE CONSEQUENCES TO PROVIDERS

The table below shows the forecast income and expenditure position of each trust in 2016/17 as a consequence of implementing the proposals for change. These are based on the "core" configuration as described in *section 8.7.1a*.

This now brings together:

- The income assumptions discussed in *Chapter 4* together with the cost consequences
- The aggressive cost savings discussed in *Chapter 4*
- The effect of the savings from the reconfiguration of King George discussed in *Chapter 6*.

Appendix M shows a fuller breakdown of each trust including the phasing of income and cost changes.

Forecast Income and Expenditure 2016/17 (£m)

Income	BHRUT	BLT	Newham	Whipps Cross	Homerton	NEL
2007/08 Income	366.2	583.8	159.0	196.0	158.7	1,463.7
Growth & Centralisation	50.7	75.8	60.4	-11.6	12.8	188.1
Site Reconfiguration	-26.9	-0.9	8.7	16.4	0.5	-2.2
Shifts in Settings of Care	-85.7	-95.2	-45.9	-33.0	-38.5	-298.3
Net Tariff deflation	-54.1	-100.2	-32.4	-29.8	-23.7	-240.3
Forecast Income	250.2	463.3	149.7	138.0	109.8	1,111.1
Expenditure						
2007/08 Cost	389.4	577.9	162.7	195.7	150.9	1,476.7
New PFI Scheme		40.0				40.0
Changes in Activity	39.2	55.1	44.2	-9.0	11.5	140.9
Shifts in Settings of Care	-62.2	-68.8	-33.6	-26.2	-29.3	-220.0
Site Reconfiguration	-41.3	-0.6	6.3	13.1	0.4	-22.2
Healthcare cost inflation	41.2	70.5	22.5	23.1	18.1	175.4
Productivity Gains	-123.4	-216.0	-63.8	-60.6	-47.5	-511.4
Expenditure	243.0	458.1	138.4	136.0	104.0	1,079.4
Surplus	7.3	5.2	11.4	2.0	5.8	31.7
Surplus Margin	2.9%	1.1%	7.6%	1.5%	5.2%	2.9%

The table demonstrates that the proposed option would improve the financial viability of Barking, Havering and Redbridge University Hospitals Trust (BHRUHT), Newham and Whipps Cross Trust. There is no impact on Barts and the London (BLT) or Homerton. Implementation of the proposals would see BHRUT move from being £8.0m in deficit in 2009/10 to £7.3m in surplus in 2016/17.

9.1.1 Savings accruing from the reconfiguration

In general the cost model predicts changes in the following way:

- For *any* shift in activity:
    - Costs increase at sites with an A&E department based on the cost structure adopted for sites with an A&E
    - Costs decrease at sites with no A&E department based on the cost structure adopted for sites without an A&E
    - Cost scaling assumptions are applied to reflect economies of scale
- If cost structures are identical across sites, the net effect is no change in overall costs
- Where there is a major reconfiguration (i.e. at KGH in this instance), an additional reduction in indirect costs has been assumed, because large changes in activity render indirect costs highly variable
- Reconfiguration therefore allows economies of scale to be captured at remaining sites with an A&E department without being offset by reduced economies of scale at cold sites
- None of these reallocations is a productivity gain, and therefore there is no double counting

The table below shows how savings totalling £21.4m accrue to the health economy from the changes proposed, where *Option 1* is the do minimum scenario and where *Option 2* recommends two major acute hospitals, three hospitals with A&E and King George as a hospital with UCS.

	Income and expenses	2007/08	2016/17 Option 1	2016/17 Option 2	Difference
King George Site	**Income**	124	112	50	(63)
	Expenditure	132	104	58	(46)
	Total Direct	90	72	37	(35)
	Total Indirect	35	28	21	(7)
	PFI	-	-	-	-
	Non Clinical	7	4		(4)
	Additional savings	-	-	14	14
	Surplus (before PDC)	(8)	8	6	(2)

	Income and expenses	2007/08	2016/17 Option 1	2016/17 Option 2	Difference
Queen's Site	**Income**	221	159	201	42
	Expenditure	255	168	191	24
	Total Direct	163	89	106	17
	Total Indirect	64	38	42	3
	PFI	15	34	34	()
	Non Clinical	13	6	10	4
	Additional savings	-	-	-	-
	Surplus (before PDC)	(34)	(8)	9	18

	Income and expenses	2007/08	2016/17 Option 1	2016/17 Option 2	Difference
Other NEL Sites	**Income**	1185	839	861	21
	Expenditure	1138	801	816	15
	Total Direct	593	390	402	12
	Total Indirect	323	227	230	3
	PFI	84	102	102	
	Non Clinical	138	82	82	-
	Additional savings	-	-	-	-
	Surplus (before PDC)	47	39	45	6

9.1.2 Financial viability at Barking, Havering & Redbridge University Hospitals Trust

BHRUHT are currently in deficit. In a parallel process the Trust management is preparing an application for funding support from the Challenged Trust Board (CTB) for London. For this it is necessary to demonstrate that the Trust can return to financial viability. BHRUHT and *Health for North East London* have made every effort to ensure that both exercises use common assumptions for activity, income and phasing of the reconfiguration of King George. The cost modelling undertaken by the Trust is more sophisticated than that used by *Health for North East London*. The initial conclusions of the Trust are broadly the same as those presented here:

- That the Trust can return to financial viability
- That a challenging programme of cost reductions will be required
- That the reconfiguration of services at King George aids this process.

The CTB is undertaking independent verification of the Trust's application.

9.1.3 Financial effect of King George reconfiguration on commissioners

The general assumption made is that there is no financial effect on commissioners in the long-term; the volume of activity commissioned from acute hospitals and from community providers will ultimately be the same regardless of the configuration of providers. However the reconfiguration of King George, and the creation of new community facilities on the site will provide a major impetus towards delivering the ambitious savings for the outer north east London sector outlined in *Chapter 4*.

9.2 SPACE UTILISATION ON THE KING GEORGE SITE

The table below shows the initial projections of the space required on the King George site following the reconfiguration of services. This has been done as a desk-top exercise and will need to be developed in the full business case. *Appendix Q* shows the full workings.

Space Utilisation King George Site
Core Service Configuration

	Current m2	Core Configuration m2	Change m2
Clinical Areas			
A&E, WIC, UCC	1,245	1,245	0
Clinical - Ward	12,314	2,900	-9,414
Clinical - Clinics, Outpatients	2,578	2,428	-150
Clinical - Diagnostics	1,064	1,064	0
Clinical - Theatres	1,245	1,245	0
Clinical - Treatment & Therapy	3,582	2,528	-1,054
Pathology	976	0	-976
Pharmacy	607	407	-200
Sub-total	23,611	11,817	-11,794
Non-Clinical Areas			
Facilities	5,338	3,696	-1,642
Administration	2,056	1,456	-600
Common Area	2,509	1,759	-750
Sub-Total	9,903	6,911	-2,992
Total	33,514	18,728	-14,786
Site retained		55.9%	

This is based on the following assumptions:

- Ward space reduced significantly to two wards for elective surgery
- Outpatients and ante-natal clinic space has been reduced by 150 m^2.
- No change to operating theatres
- No change to A&E and the Walk-in Centre although this becomes polyclinic space for the urgent care service
- Pathology services centralised to Queen's Hospital
- Pharmacy space reduced

- Therapy space reduced
- 1,200 m^2 has been added for rehabilitation and intermediate care: equivalent to two wards
- 30% reduction to space for administrative, facilities and common areas

In total the reduction of space is 14,786 m^2 which equates to 44% of the total space on the site.

The table below shows the space utilisation on the site by the types of provider.

Space Utilisation on King George Site by Type of Provider

	Current		Core Configuration	
	m2	%	m2	%
Acute Services	18,479	55.1%	5,135	15.3%
Community Services	1,062	3.2%	2,262	6.7%
Primary Care Services	1,245	3.7%	2,095	6.3%
Shared Space	12,728	38.0%	9,236	27.6%
Surplus Space	0	0.0%	14,786	44.1%
Grand Total	33,514	100.0%	33,514	100.0%

The cost analysis described in *section 9.1* is concerned with the cost of the acute providers: in this case BHRUHT. The forecast is for £24.7m of indirect and overhead costs to be saved on the King George site through a combination of activity reductions and the site reconfigurations. Whilst the direct costs associated with a site, and the volume of space used, are not the same, there should be a relatively close alignment between the two as many of the direct costs relate to the estate.

The table below shows that the finance model has 70% of the indirect costs saved. On the space utilisation estimates the acute unit will use 66% less of the site.

Cost Saving and Space Utilisation at King George

	Indirect and overhead costs	Acute services site utilisation	Add: proportion of shared space	Total acute services space utilisation
2007-8	£35.3m	18,479 m2	11,315 m2	29,794 m2
2016-17	£10.6m	5,135 m2	4,997 m2	10,132 m2
Saving	£24.7m			19,663 m2
% Saved	69.9%			66.0%

The delivery of the savings forecast for this PCBC will require a rationalisation of the KGH site to make sure that the space vacated by the acute unit is either used productively for an alternative use, or decommissioned such that the running costs are saved. There will need to be an Estate rationalisation plan developed as part of the full business case that brings together:

- The parts of the KGH site and buildings that can be decommissioned and mothballed

- The parts of the KGH site and buildings that can be decommissioned cleared and sold.
- Rationalisation between KGH and mental health facilities on the Goodmayes site.
- Rationalisation between KGH and other PCT properties.

9.3 ENHANCED CONFIGURATION OF SERVICES AT KING GEORGE

Section 8.7.1b describes a set of enhanced services that could be added to the King George site. The effect on costs has been modelled and the table below shows the results. The principal effect is that because of the increase of elective inpatient activity on the King George site over the core configuration there is less saving to the health economy as a whole and to Queen's Hospital in particular. The overall gain to the health economy shifts from a gain of £21m for the core configuration to £14m in the enhanced option. The analysis shows the financial situation at Queen's just slipping into deficit in 2016/17.

Comparison of "Core" and "Enhanced" Configuration of Services at King George Hospital

	Do Minimum Option	Core Configuration		Enhanced Configuration	
		Suplus/ Deficit	Gain/Cost	Suplus/ Deficit	Gain/Cost
Queens Hospital	-£13.4m	£4.5m	£17.9m	-£2.3m	£11.1m
King George Hospital	£5.5m	£2.7m	-£2.7m	£3.7m	-£1.8m
Sub-Total BHRUT	-£7.9m	£7.3m	£15.2m	£1.4m	£9.3m
Whipps Cross	-£1.5m	£2.0m	£3.5m	£0.9m	£2.3m
Homerton	£5.5m	£5.8m	£0.2m	£5.6m	£0.1m
Newham	£8.9m	£11.4m	£2.5m	£10.8m	£1.9m
Barts and the London	£5.5m	£5.2m	-£0.3m	£5.8m	£0.3m
NEL Total	£10.5m	£31.7m	£21.1m	£24.4m	£13.9m

The variant reduces the financial benefits from the reconfiguration as well as putting Queen's financial position in jeopardy. Before this variant could be adopted, the health economy would need to demonstrate how this could be made to be financially viable for Queen's Hospital and that the overall financial gains given up are justified by other benefits arising.

9.4 TRANSITIONAL COSTS OF RECONFIGURATION

Transition Costs (£m)

	2011/12	2012/13	2013/14	2014/15	2015/16	Total
Reconifguration deployment and programme management	3.0	3.0	3.0	3.0		11.9
Reconfiguration double running	1.4	6.4	5.0			12.8
Total	4.4	9.4	8.0	3.0	0.0	24.8

Transitional costs have been assumed for the reconfiguration as follows:

- Deployment and project management relates to transfer of acute services at a total cost of £11.9m spread over three years. This includes a £6m provision for redundancy costs relating to staff reductions associated with the reconfiguration of King George. The assumption is that given the very high turnover of staff at BHRUT and the fact that most of the services are transferring, staff redundancies will be kept to an absolute minimum.

- The assumption has been made that any savings associated with the release of overheads on the King George site will be delayed for two years after the changes to services. This is to give time for any release of buildings and rationalisation of the site.

- There will be an impairment of buildings on the King George site. The current value of buildings on the King George site is £62m. Up to 50% of the site will no longer be required following implementation of the reconfiguration proposals. Potentially buildings to the value of £30m will need to be written-off as an impairment. The full value of the impairment will depend upon:

    - The actual buildings to be lost, their value and any revaluations that may have taken place in the past
    - Any resale value of the buildings or alternative use that the NHS can put to these buildings; the full impairment would only come into play if the buildings are disposed of as having no value

  At this time the cost of impairment has not been included in the forecasts as it cannot be estimated with any certainty until the site development plan is more developed that will be done for the full business case. The assumption is made that the cost of impairment, as it is not a cash cost, can be financed centrally.

The PCTs are already financing the project management of additional community and primary care services so this is not seen as a new marginal cost.

The cost of any transitional costs associated with the productivity gains described in chapter 3 is not related to the changes that form the basis of this consultation and these have not been included above.

9.5 CAPITAL COSTS

9.5.1 Capital costs and receipts directly related to the option

Preliminary estimates of the capital consequences of the proposed reconfiguration of King George have been made. The table below shows the capital consequences of the proposals that are directly related to the services transferring from King George. Investment will be needed to increase capacity at Queens and Whipps Cross. All the amounts below are preliminary estimates. Cost estimates have been shown as a range with the high range built around the risk that further capacity will be needed than that forecast.

Direct Capital Consequences of the Reconfiguration of Acute Services

Trust/Site	Description	Range of Costs		Year
		Low £m	High £m	
Queen's Hospital	New Cardiac Catheter Laboratory	£2.3m	£3.4m	2010/11
	Maternity: Increase capacity through new delivery rooms, obstetric theatre and centralising neonatal cots.	£3.8m	£5.6m	2010/11
	Accident & Emergency/Urgent Care: investment in the A&E department to increase capacity and to introduce discrete Urgent Care Centre.	£6.0m	£9.0m	2010/11
	Create new clinical capacity from current administrative space		£3.0m	2010/11
Sub-Total Queen's		£12.0m	£21.0m	
Whipps Cross	Increase Intensive Care Unit capacity by 6 beds	£2.2m	£3.3m	2010/11
	Increase Special Care Baby Unit capacity by 5 beds	£0.6m	£0.9m	2010/11
	New Endoscopy Suite	£0.8m	£1.6m	2011/12
	Additional Inpatient capacity		£2.3m	2011/12
Sub-Total Whipps Cross		£3.6m	£8.1m	
King Georges Hospital	Site redevelopment and rationalisation	£4.0m	£8.0m	From 2011/12
Total Capital Cost		£19.6m	£37.1m	

To set against this there should be a capital receipt relating to the disposal of part of the King George site. The value of a receipt will depend upon the size of the site to be disposed of and the state of the market at the time. Based on the current book value of land, a receipt of £8m could be secured.

9.5.2 Return on Investment

The capital investment required offers a good return on investment:

Capital Expenditure	£19.6m
Total Transitional costs	£24.3m
Total One-Off Costs	£43.9m
Annual Forecast Saving	£21.6m
Payback in 2 years	

9.5.3 Financing Capital Costs

The north east London health economy expects that the capital costs will be managed in the following way:

- Costs will be kept at or below the “low estimates” of cost.
- Costs at Queen’s hospital will be met as additions to the PFI contract.

- Costs at Whipps Cross and King George Hospital will be met by the receipt from the sale of some of the KGH site. However, the timing of expenditure and receipts will require the negotiation of brokerage between years with the Department of Health.

9.5.4 Other capital costs: Newham hospital

At Newham there are no direct capital consequences of the proposed changes at King George although there are other capital costs that should be taken into account. All forecasts at Newham (except the option where Newham becomes a hospital with UCS) indicate that increasing demand, particularly in maternity, paediatrics and A&E will put pressure on capacity that will require capital investment.

The new maternity unit that has already been approved as a capital scheme will increase capacity to 6,500 births however the forecasts indicate that the potential number of births will increase to 8,250 (7,557 without the closure of the King George maternity unit) by 2016/17. Newham has a second phase of the maternity scheme that would increase capacity to 9,000 births at a cost of £16.5m. However a decision on this would not need to be taken prior to the proposed King George change.

Newham Trust is developing plans with Newham PCT to redevelop the A&E department and to expand paediatrics at a cost of £8m. This project is not dependent upon the changes proposed in this PCBC.

See *Appendix N*.

9.5.5 Other capital costs: Whipps Cross Hospital

Whipps Cross has already planned for a redevelopment of the A&E department including an extension to the Emergency Medical Centre (subject to Full Business Case approval) to introduce an urgent care service onto the site. Capital funding has already been allocated for this.

Whipps Cross has undertaken a study of the capital requirements until 2016/17 (see *Appendix O*). The conclusion reached by the Trust Board is that all equipment and maintenance costs can be met from the existing capital sources. This will maintain the quality of the estate at an acceptable standard. There are no significant backlog issues relating to single-sex accommodation, main fabric of buildings, medical gases, utilities or heating that will require major investment in this time period.

The one proviso relates to information technology. The Trust will need to upgrade its information systems to match the Cerner Millennium system installed in Homerton and Newham Hospitals. The assumption made is that if this is to be done the costs will be a charge to revenue.

9.5.6 Other capital costs: Homerton Hospital

Homerton anticipates that the existing rolling programme of maintenance and investment in ward refurbishment will maintain the quality of estate. The only material investment that is being considered during this time period is replacement of the boilers that would require around £2m of investment. The Trust is planning to refurbish the East Wing when it is vacated by North East London NHS Foundation Trust.

See *Appendix P*.

9.5.7 Other capital costs: polyclinics

Section 2.3.1 describes the range of service changes being introduced to community and primary care services that will underpin the transformational changes proposed to health services. These will require investment into estate:

- Some expansion of existing General Practitioner premises to accommodate extended services such as outpatient clinics or urgent care services.
- Development of polyclinics, some of which will be new buildings and some will be expansion or refurbishment of existing buildings.

The cost of this capital investment will be a mixture of:

- Projects financed through the LIFT initiative
- New capital investment
- Investment by third parties, usually the providers of community or primary care services, including GPs
- Joint ventures with other organisations such as Local Authorities

The PCTs in the sector fully understand the difficulty of raising capital through Government and the revenue cost of financing new capital. Investment will be kept as low as possible by using imaginative ways of attracting finance, re-using existing estate wherever possible and re-investing capital receipts wisely.

9.5.8 Conclusions: capital

The direct capital cost of the proposed changes is estimated to be £19.6m, although risks surrounding space requirements could push this up. At this level the cost of the scheme could be met from capital receipts and an extension to the PFI contract at Queen's hospital. This represents a good investment with a fast payback.

10. ACTIVITY ANALYSIS OF THE CLINICAL PROPOSALS FOR CHANGE

This chapter sets out the activity flows that have been used to underpin the financial and capacity modelling. Unless other wise stated all the forecasts relate to the core configuration assumptions.

10.1 FORECASTS OF MOVEMENTS OF ACTIVITY

Within the proposals for change, some of the activity currently undertaken at King George will be transferred elsewhere. A proportion of this shift has already been agreed as part of the care outside hospital strategy, leading on from decisions following *Healthcare for London's Consulting the Capital*. In summary, the current activity will be spread between care outside hospital, Queen's, Whipps Cross and Newham. Analysis takes into account increasing demand due to demographic change and patterns of ill health, and decreases as a result of quality and productivity improvements, demand management strategies and shifts of care from hospitals to community-based settings.

The tables that follow detail the volumes of activity that providers can expect and the bed capacity that will be required, including forecast movements for:

- Growth in demand due to population and other growth
- Demand management
- Shifts in the setting of care to polysystems
- Shifts in the settings for care between hospitals. The modelling of HRGs indicates that the designations of hospitals as local and major will change the mix of activity with some changes to the volume of inpatient activity and bed capacity.
- Activity that is displaced as a result of the reconfiguration of King George Hospital
- Productivity gains (bed capacity only).

The movement due to the displacement of King George activity is also shown as a diagram.

10.2 INPATIENT ACTIVITY

10.2.1 Inpatient activity for the core configuration of services

Elective Inpatient Activity Movements (Spells)

	King George Hospital	Queen's Hospital	Whipps Cross Hospital	Newham Hospital	Barts & the London Hospitals	Homerton Hospitals	Net NEL Movement
2007/08 Baseline	15,338	28,645	32,540	14,239	40,467	13,497	144,726
Demand Growth	2,233	3,127	4,495	4,284	9,336	1,978	25,453
Demand Management	-779	-2,006	-2,524	-858	-1,845	-1,159	-9,172
Shifts in the Settings of Care to Polysystems	-2,678	-4,111	-4,586	-1,977	-3,907	-2,176	-19,434
Do Minimum Scenario	14,115	25,654	29,926	15,688	44,051	12,140	141,573
Shifts in the Settings of Care to Other Hospitals	9,578	-12,471	-3,469	1,351	-3,276	1,765	-6,522
Reconfiguration	-5,490	3,210	1,576	627	3	75	0
Forecast Activity 2016/17	18,203	16,392	28,032	17,666	40,777	13,980	135,051

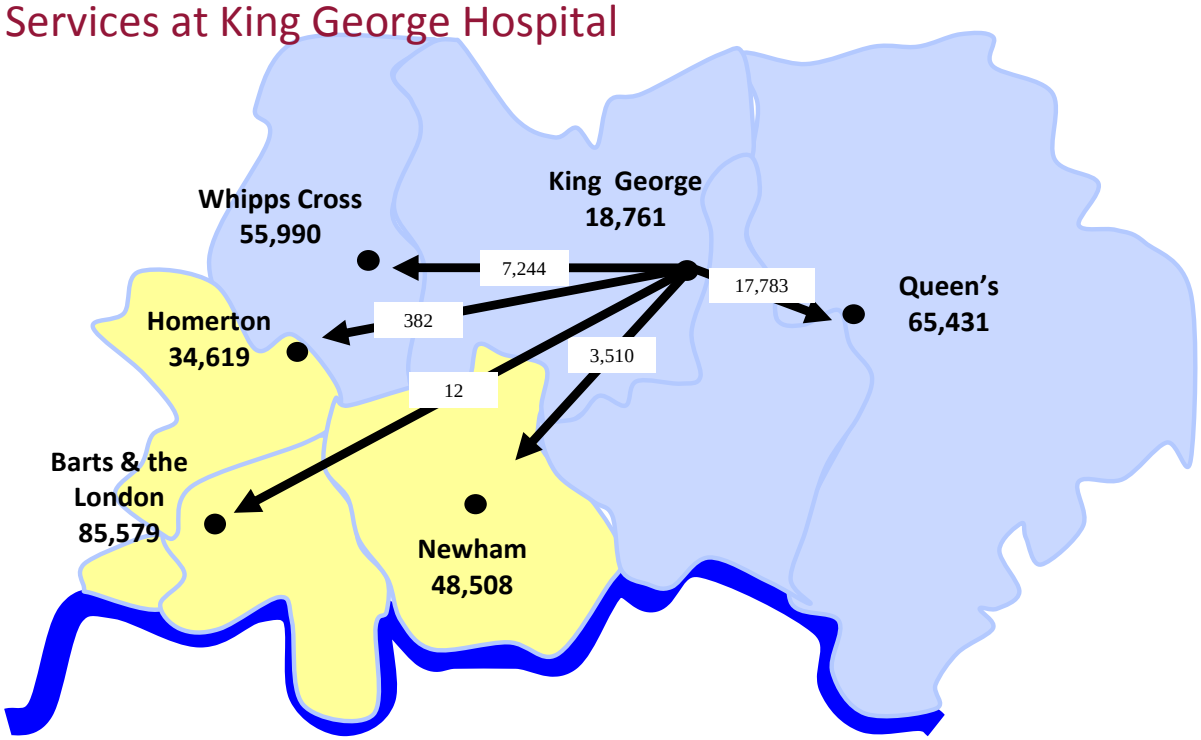
Non-Elective Inpatient Activity Movements (Spells)

	King George Hospital	Queen's Hospital	Whipps Cross Hospital	Newham Hospital	Barts & the London Hospitals	Homerton Hospitals	Net NEL Movement
2007/08 Baseline	22,995	28,938	25,057	20,165	37,010	17,168	151,333
Demand Growth	4,109	3,869	3,637	6,058	8,923	2,809	29,406
Demand Management	-2	-5	-7	-3	-11	-3	-30
Shifts in the Settings of Care to Polysystems	-428	-590	-539	-404	-848	-343	-3,152
Do Minimum Scenario	26,674	32,212	28,149	25,816	45,074	19,631	177,556
Shifts in the Settings of Care to Other Hospitals	-2,676	2,253	-5,859	2,142	-282	701	-3,720
Reconfiguration	-23,440	14,573	5,667	2,884	9	307	0
Forecast Activity 2016/17	558	49,038	27,957	30,842	44,802	20,639	173,836

Total Inpatient Activity Movements (Spells)

	King George Hospital	Queen's Hospital	Whipps Cross Hospital	Newham Hospital	Barts & the London Hospitals	Homerton Hospitals	Net NEL Movement
2007/08 Baseline	38,333	57,582	57,598	34,403	77,477	30,665	296,059
Demand Growth	6,343	6,996	8,133	10,342	18,259	4,787	54,859
Demand Management	-781	-2,011	-2,531	-861	-1,856	-1,162	-9,202
Shifts in the Settings of Care to Polysystems	-3,105	-4,701	-5,125	-2,380	-4,755	-2,520	-22,586
Do Minimum Scenario	40,789	57,866	58,074	41,504	89,125	31,771	319,129
Shifts in the Settings of Care to Other Hospitals	6,902	-10,218	-9,328	3,494	-3,558	2,466	-10,242
Reconfiguration	-28,930	17,783	7,244	3,510	12	382	0
Forecast Activity 2016/17	18,761	65,431	55,990	48,508	85,579	34,619	-10,242

Inpatient Activity Displaced by Reconfiguration of Services at King George Hospital



10.2.2 Inpatient activity for the enhanced configuration of services

Under the enhanced configuration of services a significant proportion of elective surgery at Queen's Hospital would transfer to King George Hospital creating a larger elective treatment centre. For modelling purposes all inpatient activity designated by the Clinical Reference Group (CRG) as relating to local hospital services is moved to King George from Queen's with the following result.

Elective Inpatient Activity Movements (Spells)
Enhanced Configuration of Services at King George Hospital

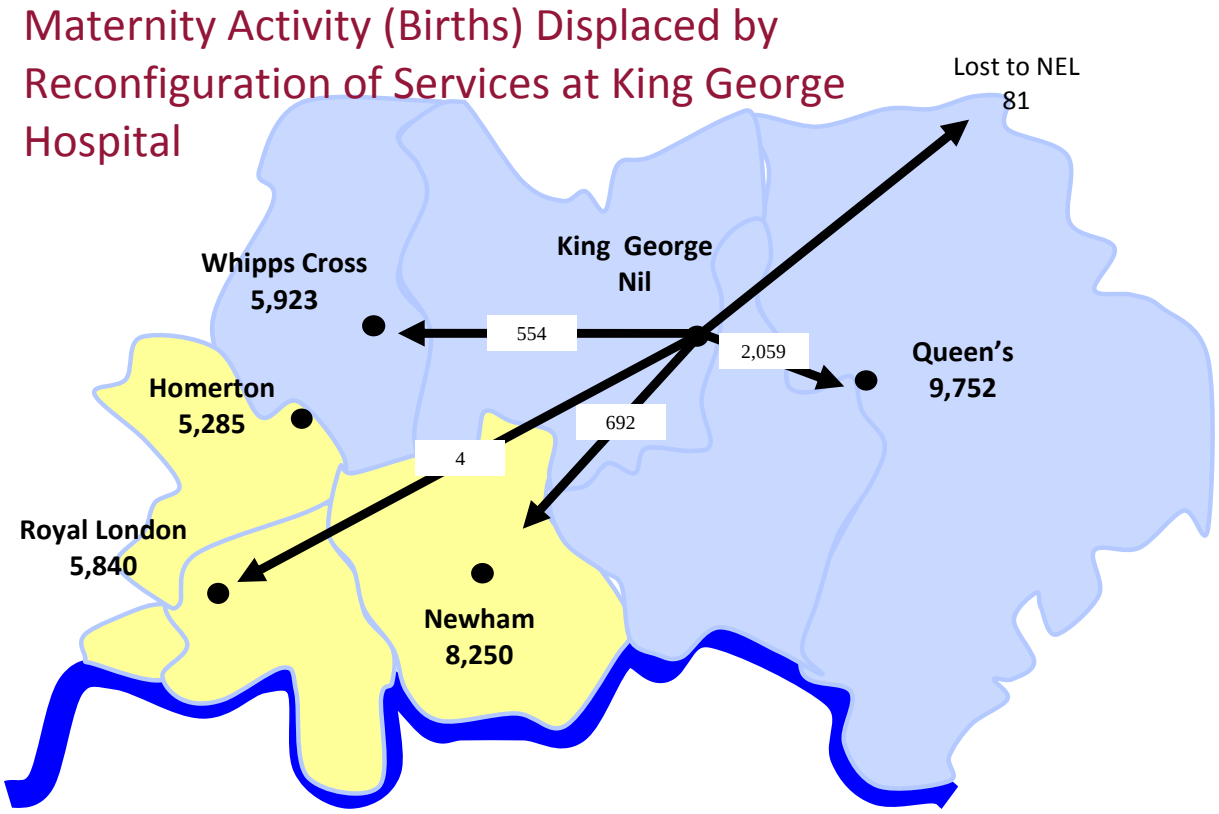
	King George Hospital	Queen's Hospital	Whipps Cross Hospital	Newham Hospital	Barts & the London Hospitals	Homerton Hospitals	Net NEL Movement
2007/08 Baseline	15,338	28,645	32,540	14,239	40,467	13,497	144,726
Demand Growth	2,233	3,127	4,495	4,284	9,336	1,978	25,453
Demand Management	-779	-2,006	-2,524	-858	-1,845	-1,159	-9,172
Shifts in the Settings of Care to Polysystems	-2,678	-4,111	-4,586	-1,977	-3,907	-2,176	-19,434
Do Minimum Scenario	14,115	25,654	29,926	15,688	44,051	12,140	141,573
Shifts in the Settings of Care to Other Hospitals	9,578	-12,471	-3,469	1,351	-3,276	1,765	-6,522
Reconfiguration	6,590	-6,590	0	0	0	0	0
Forecast Activity 2016/17	30,284	6,592	26,456	17,039	40,774	13,905	135,051

10.3 MATERNITY

Forecasts of the numbers of births are described in *section 5.4.2b.* The modelling indicates that the number of births in the sector is set to continue to grow, which will put pressure on all maternity units. The assumption has been made that the number of births at home and at community based midwife units will increase.

Maternity Deliveries (Births)

	King George Hospital	Queen's Hospital	Whipps Cross Hospital	Newham Hospital	Barts & the London Hospitals	Homerton Hospitals	Net NEL Movement
2007/08 Baseline	3,186	5,476	4,878	5,246	4,137	4,801	27,724
Demand Growth	387	2,629	779	2,716	2,012	767	9,290
Increase in Home Births to 5%	-182	-412	-288	-405	-313	-283	-1,883
Do Minimum Scenario	3,391	7,692	5,369	7,557	5,836	5,285	35,131
Reconfiguration	-3,391	2,059	554	692	4	0	-81
Forecast Activity 2016/17	0	9,752	5,923	8,250	5,840	5,285	35,049

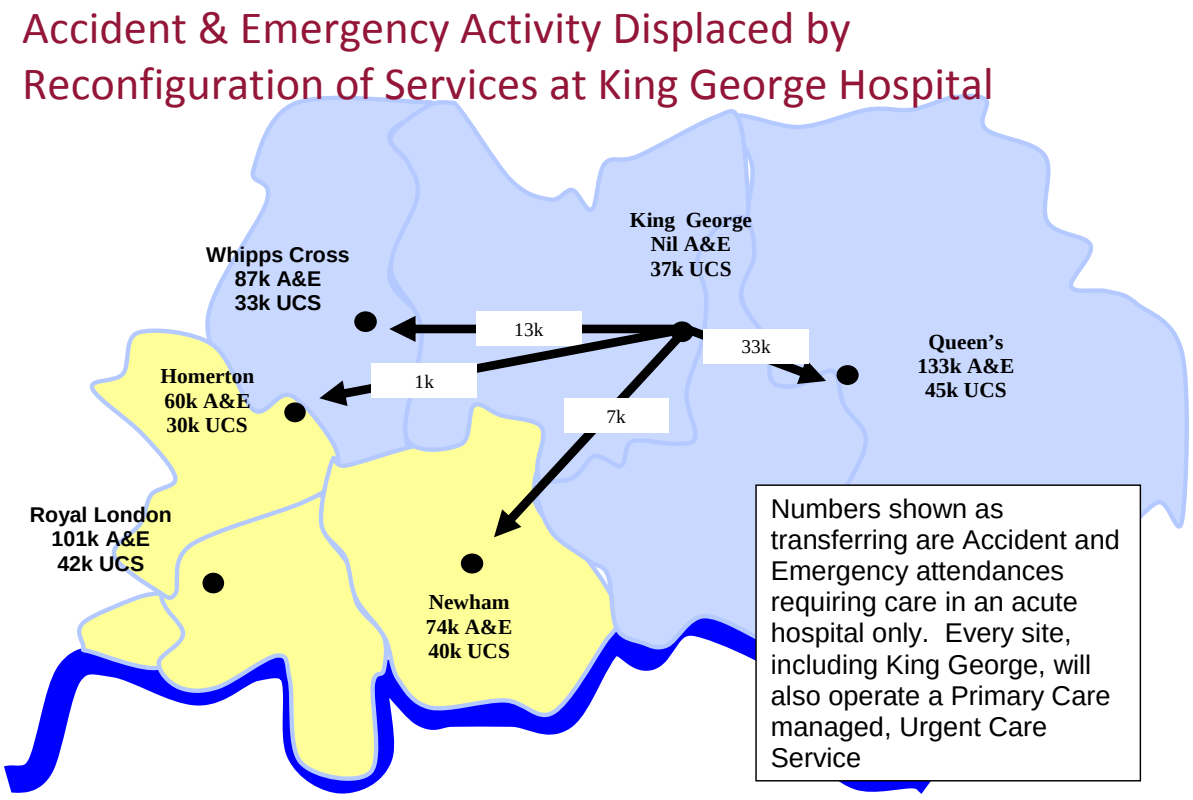


10.4 A&E AND URGENT CARE SERVICE ACTIVITY

10.4.1 A&E and urgent care service activity for core configuration of services at King George Hospital

Accident & Emergency Activity Movements (Attendances)

	King George Hospital	Queen's Hospital	Whipps Cross Hospital	Newham Hospital	Barts & the London Hospitals	Homerton Hospitals	Net NEL Movement
2007/08 Baseline	94,792	148,889	111,805	100,571	134,344	91,629	682,029
Demand Growth	7,296	11,460	5,680	20,259	22,444	7,242	74,382
Shift to UCS in community	-12,279	-14,964	-10,888	-13,385	-14,041	-9,959	-75,517
Shift to UCS co-located in acute site	-36,837	-44,892	-32,663	-40,156	-42,123	-29,878	-226,550
Do Minimum Scenario	52,971	100,492	73,934	67,288	100,624	59,034	454,345
Reconfiguration	-52,971	32,527	12,781	6,985	8	671	0
Forecast Acute Activity 2016/17	0	133,019	86,715	74,273	100,632	59,705	454,345
Retained Urgent Care Activity (Primary Care)	36,837	44,892	32,663	40,156	42,123	29,878	226,550

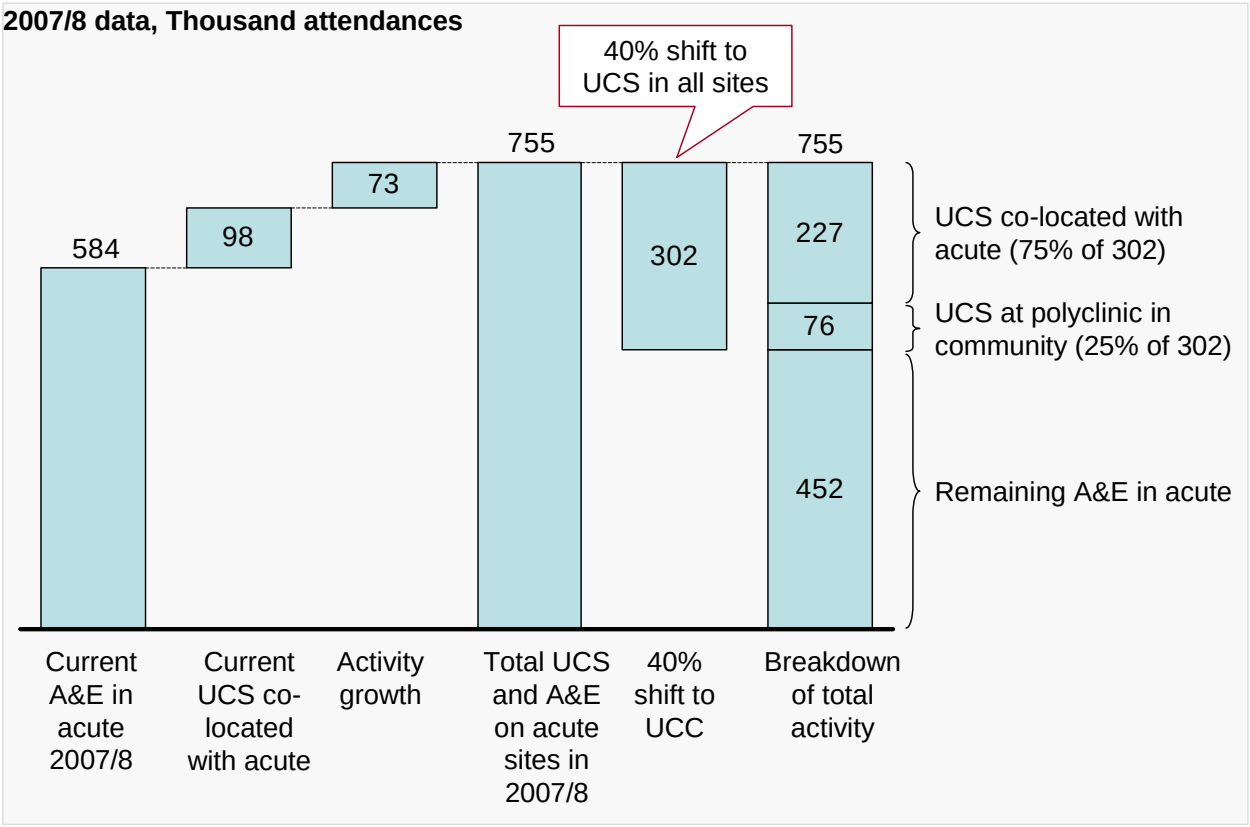


The table below shows A&E activity and urgent care services activity together. In the base year (2007/08) there were 584,000 attendances at A&E departments managed by acute hospitals and recorded as data on the Hospital Episodes System (HES) database. In addition there were 98,000 attendances recorded in walk-in centres and urgent care centres. The assumption is that by 2016/17:

- Total activity will have increased by 74,000 giving total activity of 755,000

- 40% of this activity (302,000) will be seen in a primary care setting
- Of this 40%, 75% (227,000) will be seen in urgent care services co-located on one of the current hospital sites and 25% (76,000) will be seen in alternative primary care settings including polyclinics and GP-led health centres.

Movement of A&E and UCS activity in north east London



10.4.2 A&E and urgent care service activity for enhanced configuration of services at King George Hospital

For the enhanced configuration of services at the King George Hospital the aim is to keep 75% of activity at KGH through supplementing the UCS with outpatient clinics available for urgent consultations. The changes to A&E activity forecasts that result are seen in the table below.

Accident & Emergency Activity Movements (Attendances)
Enhanced Configuration of Services at King George Hospital

	King George Hospital	Queen's Hospital	Whipps Cross Hospital	Newham Hospital	Barts & the London Hospitals	Homerton Hospitals	Net NEL Movement
2007/08 Baseline	94,792	148,889	111,805	100,571	134,344	91,629	682,029
Demand Growth	7,296	11,460	5,680	20,259	22,444	7,242	74,382
Shift to UCS in community	-12,279	-14,964	-10,888	-13,385	-14,041	-9,959	-75,517
Shift to UCS co-located in acute site	-63,323	-44,892	-32,663	-40,156	-42,123	-29,878	-253,035
Do Minimum Scenario	26,486	100,492	73,934	67,288	100,624	59,034	427,859
Reconfiguration	-26,486	16,264	6,391	3,493	4	335	0
Forecast Acute Activity 2016/17	0	116,756	80,325	70,781	100,628	59,370	427,859
Retained Urgent Care Activity (Primary Care)	63,323	44,892	32,663	40,156	42,123	29,878	253,035

10.5 OUTPATIENT ACTIVITY

Outpatient Activity Movements (Attendances)

	King George Hospital	Queen's Hospital	Whipps Cross Hospital	Newham Hospital	Barts & the London Hospitals	Homerton Hospitals	Net NEL Movement
2007/08 Baseline	182,868	345,780	251,326	193,464	479,564	183,027	1,636,029
Demand Growth	17,531	22,012	21,038	48,427	88,076	18,070	215,155
Demand Management	-33,160	-62,994	-49,577	-37,117	-102,066	-34,523	-319,436
Shifts in the Settings of Care to Polysystems	-89,455	-162,167	-119,473	-127,535	-178,403	-100,217	-777,251
Do Minimum Scenario	77,784	142,631	103,314	77,239	287,172	66,358	754,497
Shifts in the Settings of Care to Other Hospitals	-3,445	-2,720	14,823	9,645	-52,272	22,133	-11,836
Reconfiguration	0	0	0	0	0	0	0
Forecast Activity 2016/17	74,338	139,911	118,137	86,885	234,900	88,491	742,661

The effect of shifts in the location of care and demand management is most significant for outpatients with more than one million acute outpatient attendances forecast to be shifted from acute hospitals. Outpatient activity will be retained at King George so there is no shift shown for the proposed reconfiguration.

10.6 VOLUMES OF ACTIVITY FOR KING GEORGE

The current and projected levels of activity for hospital services at King George are shown in the table that follows. This shows how projected activity increases due to demographic and non-demographic growth, is managed down through demand management and the move to care outside hospital and the shift to other providers. The hospital will continue to have outpatient clinics. The table does not show the activity that will be managed by primary care providers operating from the site that will include an urgent care service seeing around 37,000 people a year.

King George Hospital (Core Configuration of Services)

	Accident & Emergency Attendances	Elective Inpatients Spells	Non-Elective Inpatients Spells	Outpatient Attendances	Maternity Births
Activity 2007/08	94,792	15,338	22,995	182,868	3,186
Demand Growth	7,296	2,233	4,109	17,531	387
Demand Management	0	-779	-2	-33,160	0
Shifts in the Settings of Care to Polysystems	-49,117	-2,678	-428	-89,455	-182
Do Minimum Forecast Activity 2016/17	52,971	14,115	26,674	77,784	3,391
Shifts in the Settings of Care to Other Hospitals	0	9,578	-2,676	-3,445	0
Shifts relating to King George Reorginisation					
Queens Hospital	-32,527	-3,210	-14,573	0	-2,059
Whipps Cross Hospital	-12,781	-1,576	-5,667	0	-554
Newham Hospital	-6,985	-627	-2,884	0	-692
Homerton Hospital	-671	-75	-307	0	0
Barts & London Hospitals	-8	-3	-9	0	-4
Other Hospitals	0	0	0	0	-81
Acute Activity remaining at King George	0	18,203	558	74,338	0

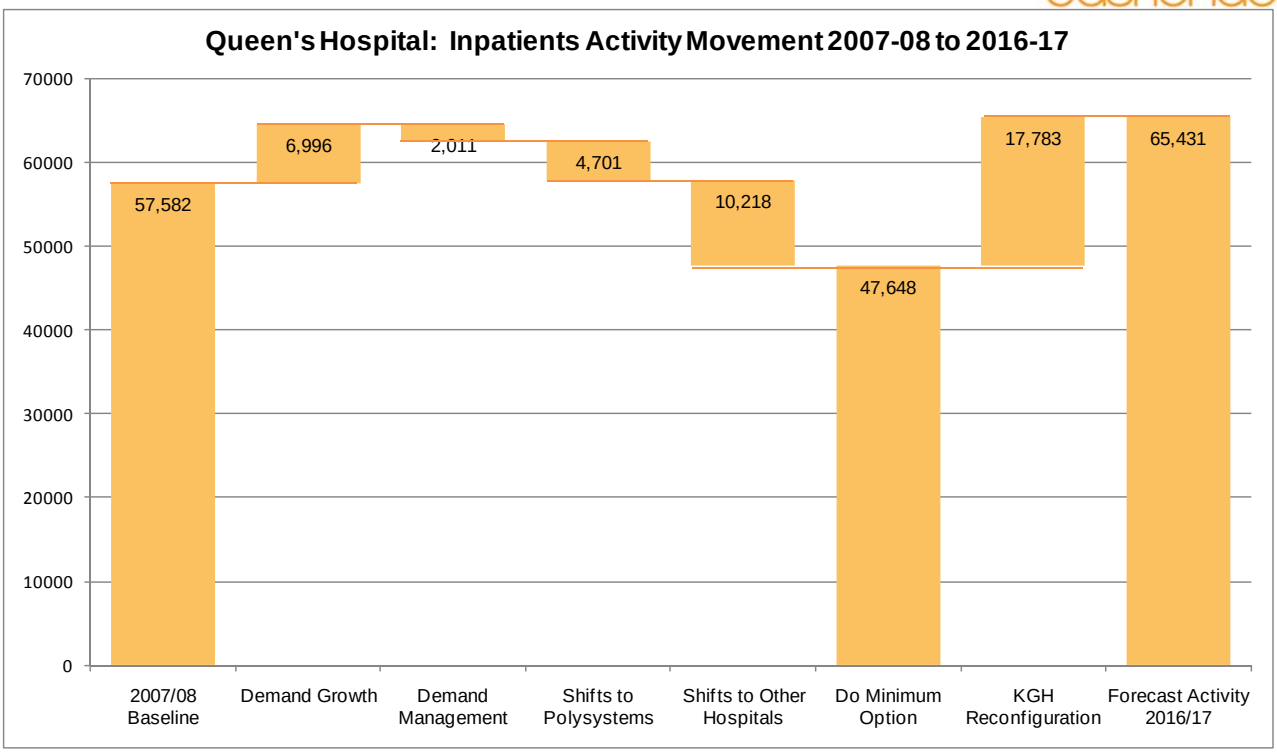
10.7 VOLUMES OF ACTIVITY FOR QUEENS HOSPITAL

The table below shows a similar analysis for Queen's, detailing how projected activity increases due to demographic and non-demographic growth, is managed down through demand management and the move to community settings, the impact of quality and productivity and the shift to Queen's.

Queens Hospital

	Accident & Emergency Attendances	Elective Inpatients Spells	Non-Elective Inpatients Spells	Outpatient Attendances	Maternity Births
Activity 2007/08	148,889	28,645	28,938	345,780	5,476
Demand Growth	11,460	3,127	3,869	22,012	2,629
Demand Management	0	-2,006	-5	-62,994	0
Shifts in the Settings of Care to Polysystems	-59,856	-4,111	-590	-162,167	-412
Do Minimum Forecast Activity 2016/17	100,492	25,654	32,212	142,631	7,692
Shifts in the Settings of Care to Other Hospitals	0	-12,471	2,253	-2,720	0
Shifts relating to King George Reorginisation	32,527	3,210	14,573	0	2,059
Acute Activity remaining	133,019	16,392	49,038	139,911	9,752

The diagram below shows the movement of Inpatient activity at Queen's Hospital.



10.8 VOLUMES OF ACTIVITY FOR WHIPPS CROSS HOSPITAL

The table below shows a similar analysis from Whipps Cross, showing the impact of demographic and non-demographic growth, demand management and the move to community based care, less improvements from quality and productivity, and the shift of activity from King George to Whipps Cross.

Whipps Cross Hopsital Hospital

	Accident & Emergency Attendances	Elective Inpatients Spells	Non-Elective Inpatients Spells	Outpatient Attendances	Maternity Births
Activity 2007/08	111,805	32,540	25,057	251,326	4,878
Demand Growth	5,680	4,495	3,637	21,038	779
Demand Management	0	-2,524	-7	-49,577	0
Shifts in the Settings of Care to Polysystems	-43,551	-4,586	-539	-119,473	-288
Do Minimum Forecast Activity 2016/17	73,934	29,926	28,149	103,314	5,369
Shifts in the Settings of Care to Other Hospitals	0	-3,469	-5,859	14,823	0
Shifts relating to King George Reorginisation	12,781	1,576	5,667	0	554
Acute Activity remaining	86,715	28,032	27,957	118,137	5,923

10.9 VOLUMES OF ACTIVITY FOR NEWHAM HOSPITAL

The table below shows a similar analysis from Newham, showing the impact of demographic and non-demographic growth, demand management and the move to community based care, less improvements from quality and productivity, and the shift of activity from King George to Newham.

Newham Hospital

	Accident & Emergency Attendances	Elective Inpatients Spells	Non-Elective Inpatients Spells	Outpatient Attendances	Maternity Births
Activity 2007/08	100,571	14,239	20,165	193,464	5,246
Demand Growth	20,259	4,284	6,058	48,427	2,716
Demand Management	0	-858	-3	-37,117	0
Shifts in the Settings of Care to Polysystems	-53,542	-1,977	-404	-127,535	-405
Do Minimum Forecast Activity 2016/17	67,288	15,688	25,816	77,239	7,557
Shifts in the Settings of Care to Other Hospitals	0	1,351	2,142	9,645	0
Shifts relating to King George Reorginisation	6,985	627	2,884	0	692
Acute Activity remaining	74,273	17,666	30,842	86,885	8,250

10.10 VOLUMES OF ACTIVITY FOR BARTS AND THE LONDON

The table below shows a similar analysis for Barts and the London, showing the impact of demographic and non-demographic growth, demand management and the move to community based care, and the shift of activity from King George to Barts and the London.

Barts and the London Hospitals

	Accident & Emergency Attendances	Elective Inpatients Spells	Non-Elective Inpatients Spells	Outpatient Attendances	Maternity Births
Activity 2007/08	134,344	40,467	37,010	479,564	4,137
Demand Growth	22,444	9,336	8,923	88,076	2,012
Demand Management	0	-1,845	-11	-102,066	0
Shifts in the Settings of Care to Polysystems	-56,164	-3,907	-848	-178,403	-313
Do Minimum Forecast Activity 2016/17	100,624	44,051	45,074	287,172	5,836
Shifts in the Settings of Care to Other Hospitals	0	-3,276	-282	-52,272	0
Shifts relating to King George Reorginisation	8	3	9	0	4
Acute Activity remaining	100,632	40,777	44,802	234,900	5,840

10.11 VOLUMES OF ACTIVITY FOR HOMERTON HOSPITAL

The table below shows a similar analysis for Homerton showing the impact of demographic and non-demographic growth, demand management and the move to community based care, and the shift of activity from King George to Homerton.

Homerton Hospital

	Accident & Emergency Attendances	Elective Inpatients Spells	Non-Elective Inpatients Spells	Outpatient Attendances	Maternity Births
Activity 2007/08	91,629	13,497	17,168	183,027	4,801
Demand Growth	7,242	1,978	2,809	18,070	767
Demand Management	0	-1,159	-3	-34,523	0
Shifts in the Settings of Care to Polysystems	-39,837	-2,176	-343	-100,217	-283
Do Minimum Forecast Activity 2016/17	59,034	12,140	19,631	66,358	5,285
Shifts in the Settings of Care to Other Hospitals	0	1,765	701	22,133	0
Shifts relating to King George Reorginisation	671	75	307	0	0
Acute Activity remaining	59,705	13,980	20,639	88,491	5,285

10.12 BED CAPACITY

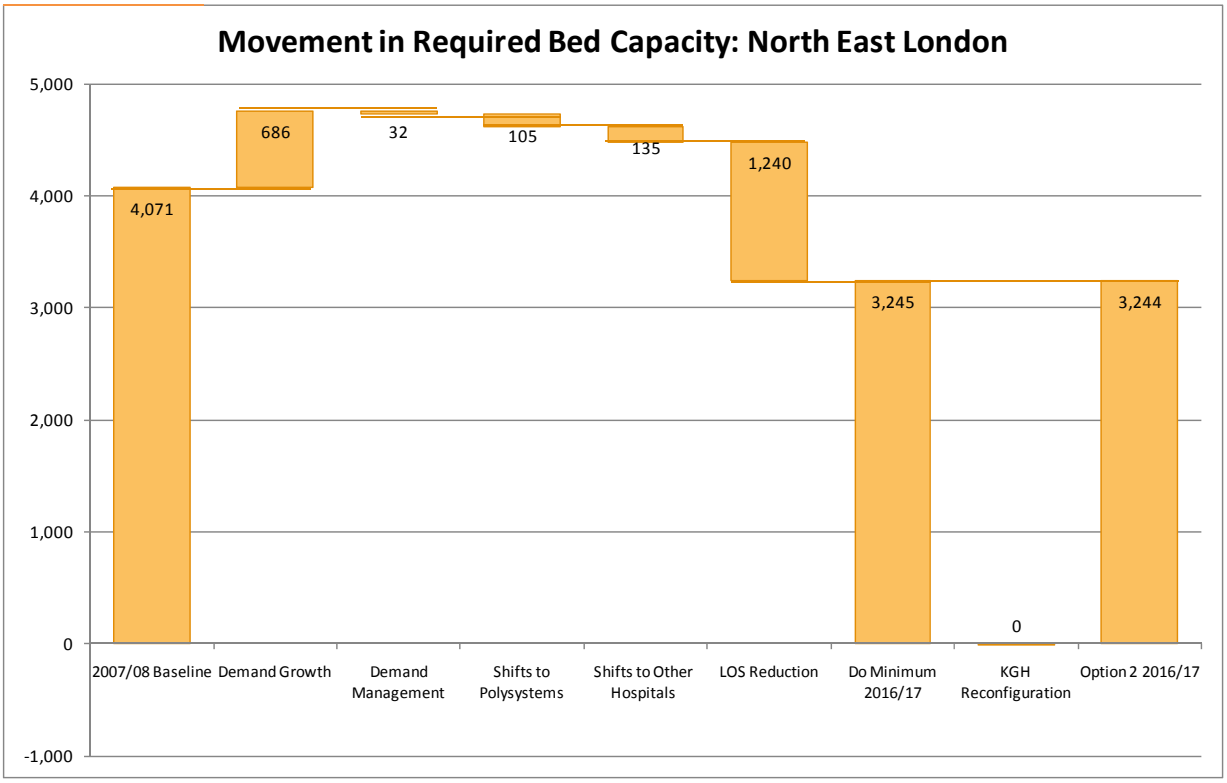
10.12.1 Bed Capacity for the Core Configuration of services at King George Hospital

The table below shows the forecast movement in bed capacity.

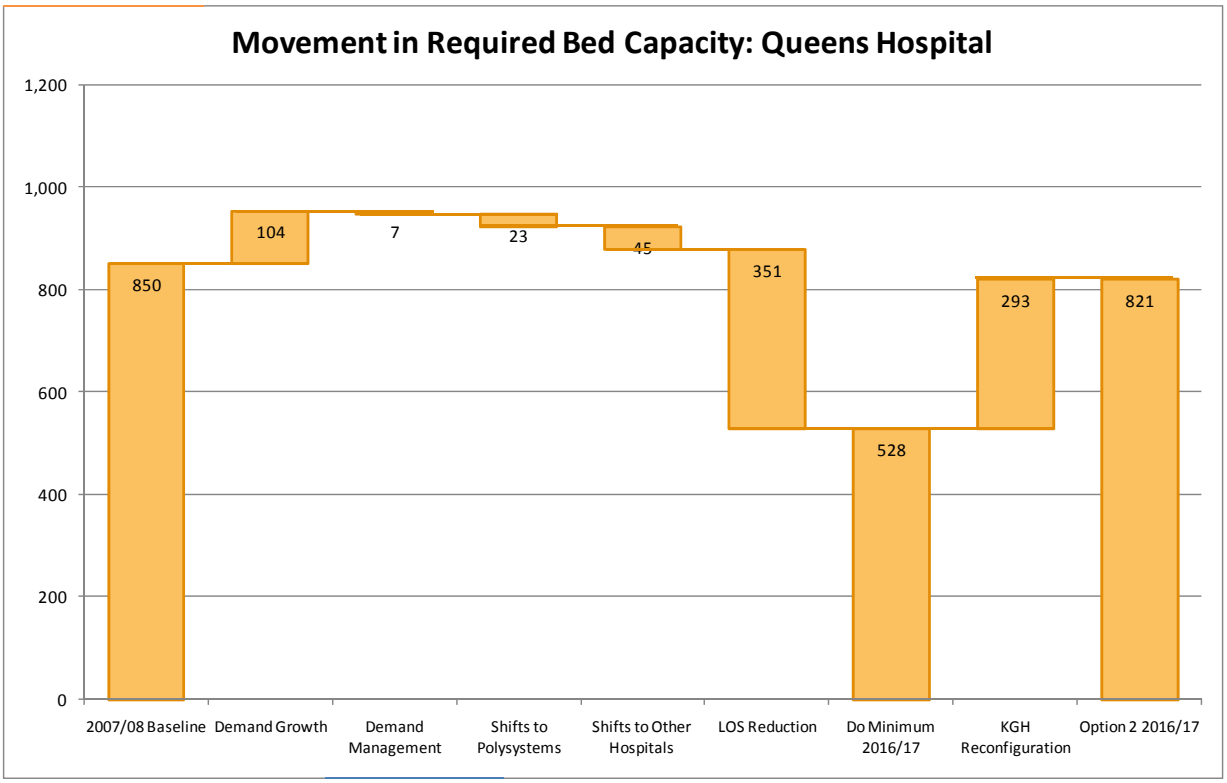
Movement in Bed Capacity

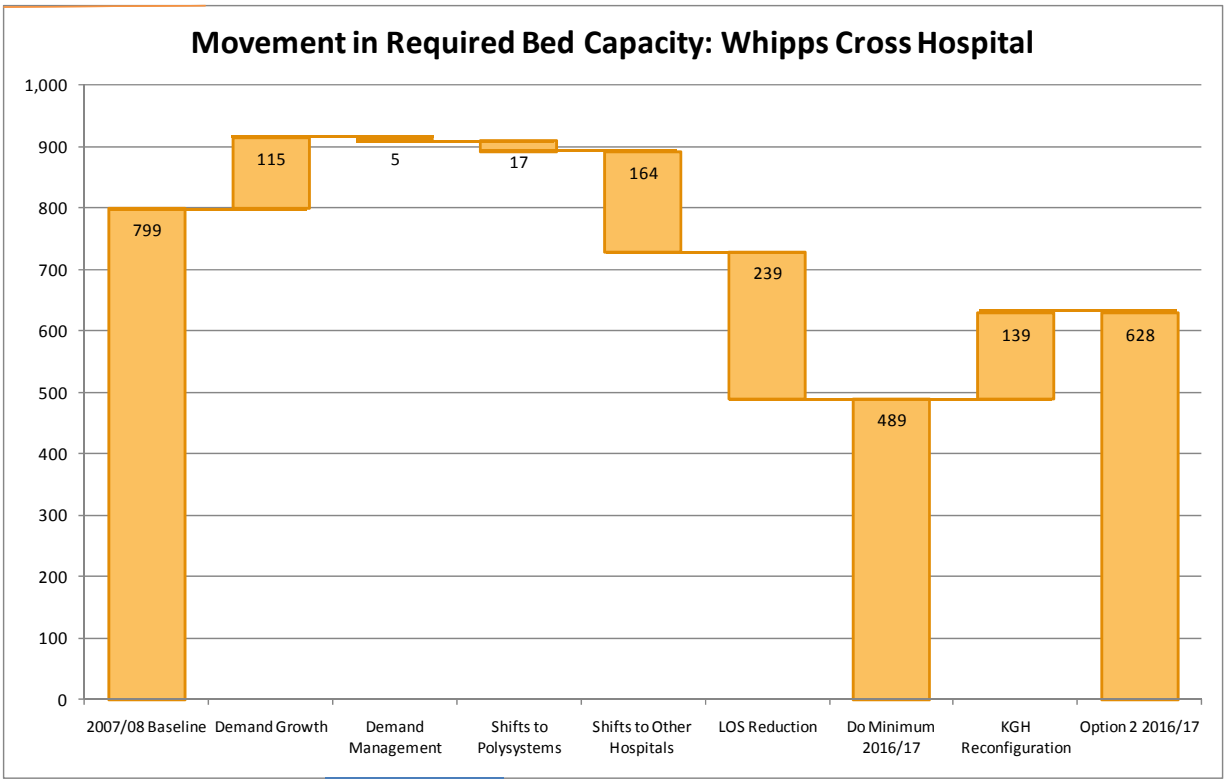
Site	King George Hospital	Queen's Hospital	Whipps Cross University Hospital	Newham General Hospital	Bart's and the London	Homerton University Hospital	Total
2007/08 Baseline	496	850	799	390	1,036	500	4,071
Demand Growth	83	104	115	121	177	86	686
Demand Management	-3	-7	-5	-3	-8	-6	-32
Shifts in the Settings of Care to Polysystems	-13	-23	-17	-10	-25	-17	-105
Shifts in the Settings of Care to Other Hospitals	-9	-45	-164	90	-62	53	-135
No Reconfiguration 2016/17	554	879	728	588	1,119	616	4,484
Reconfiguration Option 1 to Option 2	-490	293	139	50	0	7	0
Option 2 2016/17	65	1,172	867	638	1,119	624	4,484
LOS Reduction (Option 2)	-13	-351	-239	-119	-317	-201	-1,240
Option 2 2016/17 post LoS reduction	52	874	653	528	802	424	3,244
Net Movement	-444	24	-146	138	-234	-76	-827

In total the two sectors will reduce the total bed capacity by 827 beds over the period. The shift in activity to polysystems and the demand management initiatives are predominately focused on outpatients and will have only a small impact on inpatient bed requirements. There are more significant movements created by the growth in demand and the shifts in activity between hospitals. Improvements in inpatient length of stay, that form a major plank of the financial savings discussed in *Chapter 4* are also crucial to freeing-up bed capacity necessary to allow for the reconfiguration of inpatient services on the King George site. This is illustrated by the diagram below.



At Queen's the reduced demand for beds achieved from reduced inpatient length of stay will free-up capacity that is required to support the reconfiguration of King George capacity.





10.12.2 Bed Capacity for the Enhanced Configuration of services at King George Hospital

Under the enhanced configuration of services on the King George site the shift in elective activity from Queen's to King George has the following effect on the required bed capacity.

Movement in Bed Capacity
Enhanced Configuration of Services on the King George Hospital Site

Site	King George Hospital	Queen's Hospital	Whipps Cross University Hospital	Newham General Hospital	Bart's and the London	Homerton University Hospital	Total
2007/08 Baseline	496	850	799	390	1,036	500	4,071
Demand Growth	83	104	115	121	177	86	686
Demand Management	-3	-7	-5	-3	-8	-6	-32
Shifts in the Settings of Care to Polysystems	-13	-23	-17	-10	-25	-17	-105
Shifts in the Settings of Care to Other Hospitals	-9	-45	-164	90	-62	53	-135
No Reconfiguration 2016/17	554	879	728	588	1,119	616	4,484
Reconfiguration Do Minimum to Option 2a	-423	231	135	49	0	7	0
Option 2 2016/17	131	1,110	863	637	1,119	623	4,484
LOS Reduction (Option 2)	-25	-332	-239	-119	-317	-201	-1,233
Option 2 2016/17 post LoS reduction	106	778	625	518	802	423	3,250
Net Movement	-390	-72	-174	128	-234	-77	-821

This shows a net effect of around 50 fewer beds at Queen's Hospital.

10.12.3 Management of Risk Associated with Bed Capacity on the Queen's Hospital Site

The release of bed capacity from reduced length of stay at Queens Hospital is understood to be a risk in the delivery of the programme. A number of actions are being considered that could reduce pressure on beds if this becomes necessary:

- The enhanced configuration of services on the King George Hospital site would move some elective activity. This would reduce the bed requirement on the Queen's site by 50 beds.

- Further review of the acute and rehabilitation care pathways to maximise capacity in other settings including for example, St George's (Havering), Barking Hospital (B&D) as well as a further review of the balance of bed based provision across KGH and Queens Hospital.

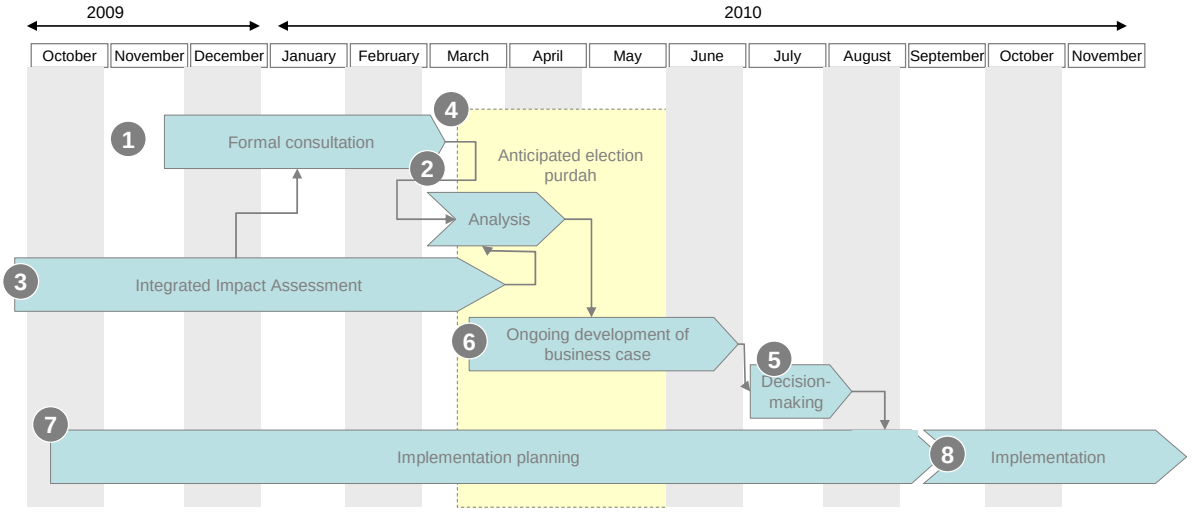
11. TRANSITION AND IMPLEMENTATION

Health for North East London is aiming to complete the transition to the new settings of care in the next three years. This chapter of the PCBC gives an overview of the activity that needs to happen to deliver the changes described for the reconfiguration proposals and associated changes.

Following a post-consultation decision by the JCPCTs with regard to the proposed reconfiguration, there will be a period of transition when the agreed changes to services will be planned in detail, in readiness for full implementation. PCTs, NHS and Foundation Trusts (acute and mental health), primary care and ambulance services will need to work closely together to ensure that plans are developed to implement the JCPCTs decisions. This implementation process will be clinically-led and will involve clinical professions from all backgrounds and organisations. Patients and members of the public will be invited to participate in the transition and implementation planning.

11.1 DECISION-MAKING PROCESS FOLLOWING CONSULTATION

Prior to reaching the transition and implementation phase, a number of key activities must take place. The critical path to implementation is shown in the figure that follows.



1. **Formal consultation ~** the consultation is planned to run from Monday 30th November to Monday 8th March. This is a 14-week period, two weeks longer than the usual 12-week duration. Additional time has been included because the Christmas holidays fall within the time period for the consultation. Further detail about the consultation process can be found in *Chapter 13*.

2. **Analysis of the consultation ~** during this phase responses to consultation will be analysed and a report produced containing the findings from this analysis. This report will be provided to the JHOSCs and made available to the public.

3. **Integrated impact assessment (IIA) ~** in parallel to the consultation process there are a set of detailed analyses that need to be carried out on the proposals for consultation. Impact assessments of the proposals will be required for: travel times and accessibility, equality and environmental impact. The outputs from the IIA need to be provided to the JHOSCs prior to finalisation of their responses to the consultation.

4. **Anticipated election purdah ~** a general election must be called by May 2010, therefore a period of 'purdah' (the period between the announcement of an election and the date that election is held) is anticipated. During this time no activity that could be perceived to give electoral advantage must be undertaken. Hence, this period of purdah is built into the timeline leading up to implementation.

5. **Decision-making ~** this phase concludes with the formal decision-making by the JCPCTs. It includes refinement of the pre-consultation non-financial options appraisal framework and criteria post consultation, taking account of the output from the consultation including the integrated impact assessment; updating of the benefits models to ensure that the benefits proposed in the options can be measured and monitored effectively; identification of variant options arising out of the consultation, and advice from the Clinical Reference Group to identify those that are clinically viable; use of the non-financial options appraisal framework to assess consulted proposals and clinically viable options. This process will enable the joint SROs to make a recommendation for consideration and decision by the JCPCTs.

6. **Ongoing development of the business case ~** following JCPCT decision-making the pre-consultation business case must be further developed to take into account the full benefits model and non-financial options appraisal framework, together with all the detailed analysis carried out in support of them. In particular, the business case will set out the strategic and clinical case for the selected option; the financial assessment of the selected option including investments required and cash releasing benefits and confirmation of affordability; and an assessment of the risks and how these will be managed. Approval of the business case by the JCPCTs marks the start of implementation, and should be used as the baseline against which costs and benefits should be monitored.

7. **Implementation planning ~** planning for implementation has commenced as part of the preparation of the PCBC in order to be ready for shortly after the end of the consultation period. This will enable the programme to commence implementation at the earliest opportunity and ensure that benefits can be realised as soon as possible. This planning cannot be completed in detail until the outcome of the consultation is known and a decision is taken to go ahead with a particular option. Indeed, the outcomes may be that the preference is for a variant of option or hybrid of options. Nonetheless, there are two key implementation planning activities that should occur throughout the consultation phase: firstly, detailed implementation planning for those elements applicable to all options for change; and secondly, additional planning for the variant between the options which can then be adapted once the outcome of the consultation in known and a decision in taken. Implementation planning is reviewed in more detail in *section 11.4*.

8. **Implementation ~** the implementation phase begins following approval by the JCPCTs of business case, and is responsible for delivering on the selected options and realising the promised benefits. The work will be organised into workstreams to be identified in the implementation planning phase and will cover all elements of activity identified in the planning. It is expected that implementation will commence in September 2010 and continue until early 2013. Some activities will be implemented prior to this period as they are not dependent on post-consultation decision-making. These activities include quality and productivity improvement programmes and the development of urgent care systems across the sector. These activities have been identified as 'enabling milestones' to the reconfiguration proposals and are reviewed in more detail in *section 11.2*.

11.2 MILESTONES FOR IMPLEMENTATION

To achieve the new configuration of services, enabling milestones and reconfiguration milestones have been identified. These are set out in the two tables that follow.

- **Enabling milestones** are programmes and activities already agreed and underway that will support the implementation of the reconfiguration proposals, including both 'core' and 'enhanced' reconfiguration proposals for King George Hospital. These are not dependent on post-consultation decision-making and planning, and in some cases implementation is already underway.

- **Reconfiguration milestones** are key activities within the reconfiguration proposals that require separate planning and consideration for implementation. All milestones are relevant for the 'core' configuration option and those relevant for the 'enhanced' configuration are highlighted. Dependencies are identified that each milestone is contingent upon. Most of these milestones are dependent on a post-consultation decision-making process before detailed implementation plans will be developed.

#	Enabling milestones	Support to reconfiguration proposals	Clinical dependencies
E1	Implementation of urgent care services (UCS) model that absorbs a minimum of 40% of all A&E attendances	Reduction in A&E attendances. Improved continuity of care supports *demand management* and *quality and productivity improvements*.	Round the clock UCS model at all A&E sites operating as 'front door' to A&E department.
E2	Polyclinics established throughout north east London	Reduction in hospital activity levels leading to availability of capacity to support reconfiguration proposals. Improved continuity of care supports *demand management* and *quality and productivity improvements*.	
E3	Clinical pathway transformation programme to introduce effective demand management and enable reductions in hospital activity levels	Reduction in hospital activity levels leading to availability of capacity to support reconfiguration proposals.	Provision of sufficient capacity and capability in primary care and community settings. Improvements in self-care.
E4	Quality and productivity improvements at north east London hospitals	Availability of capacity to support reconfiguration proposals. Clinical and financial viability of services.	
E5	Paediatric Assessment and Treatment services (PATS) operational	Clinical and workforce viability of paediatric services across sector. Releases capacity for complex paediatric admissions at Royal London and Queen's.	Round the clock PATS provision is needed at Queen's, Royal London and Whipps Cross at early stage to enable treat and transfer from 12-hour PATS at King George

#	Reconfiguration milestones	Dependent on post-consultation decision-making?	Other clinical dependencies
R1	Vascular services move from Whipps Cross to Royal London and from King George to Queen's	Yes	Capacity available at Queen's and Royal London to absorb vascular services.
R2	King George PATS operates 12-hours a day with a treat-and-transfer service to Queen's	Yes	Capacity available at Queen's and Whipps Cross to receive transfers from King George Capacity at Whipps Cross is dependent on capacity and complex paediatrics service availability at Royal London
R3	King George polyclinic is operational	No	
R4	Cardiac catheter laboratory moves from King George to Queen's	Yes	Capacity available at Queen's, including capital development to absorb cardiac catheter lab and service
R5	Urgent surgery moves from King George to Queen's.	Yes	Capacity available at Queen's to absorb urgent surgery.
	Planned surgery moves from Queen's to King George ***'Enhanced' configuration option only***	Yes	Capacity available at King George to absorb planned surgery.
R6	Obstetrics services move from King George to Queen's	Yes	Capacity available at Queen's, including capital development to absorb obstetrics service.
R7	Rehab and intermediate care moves from Wanstead to King George	No	Capacity available at King George to absorb rehab and intermediate care.
R8	Barking Community Hospital midwifery-led unit opens	No	
R9	King George A&E operates without ambulance blue calls and is medically-admitting only	Yes	A&E capacity available at Queen's and Whipps Cross to absorb additional blue calls and associated acute admissions.
R10	All King George A&E re-provided by Queen's and Whipps Cross	Yes	A&E capacity available at Queen's and Whipps Cross to absorb additional A&E attendances.
R11	Additional services move to King George	TBC (some services have already been consulted on)	Determination of additional services to be provided at King George

11.3 DEPENDENCIES

The tables above identify dependencies associated with each milestone. There are two key dependencies relating to the phasing of activities that have been taken into consideration in scheduling the identified milestones to implement the proposed reconfiguration. Firstly, the impact of the five enabling milestones (identified above) in reducing the level of demand for some services; and secondly, the availability of capacity, in particular availability of appropriate clinical space, at hospital sites absorbing services from another site.

11.3.1 The impact of the five enabling milestones

The five improvement programmes identified above are set to deliver significant improvements in healthcare services that will mean a reduction in the level of hospital activity and demand for hospital-based services. For instance, clinically viable re-provision of King George A&E services at Queen's and Whipps Cross, without significant capital investment, is dependent on reductions in A&E attendances from fully functioning urgent care services or improved demand management of patients with long term conditions. Reductions in A&E attendance are expected to be incremental throughout the three-year programme duration; with a critical threshold to enable clinically viable re-provision of A&E activity expected to be reached at 2.5 years (early 2012).

1.3.2 Availability of capacity

Where services are being transferred from one hospital to another, the new location will need to be ready, in terms of availability of beds, theatres and other physical facilities. Appropriate clinical and support staff (either existing, or transferring with the clinical service) will also need to be available, as well as access to the required clinical support services (such as radiology and laboratories).

Within the reconfiguration proposals, as identified in *section 9.5.1,* additional investment will be needed to increase capacity at Queen's and Whipps Cross. Queen's will require a new cardiac catheter laboratory (most likely transferred from King George), additional delivery rooms and obstetric theatre, and an increase in space in the A&E department. Whipps Cross needs an additional six beds in ICU, an additional five beds in NICU, a new endoscopy suite and an increase in inpatient beds. Whilst Whipps Cross has mothballed clinical space to expand into, Queen's has far less flexibility on its site.

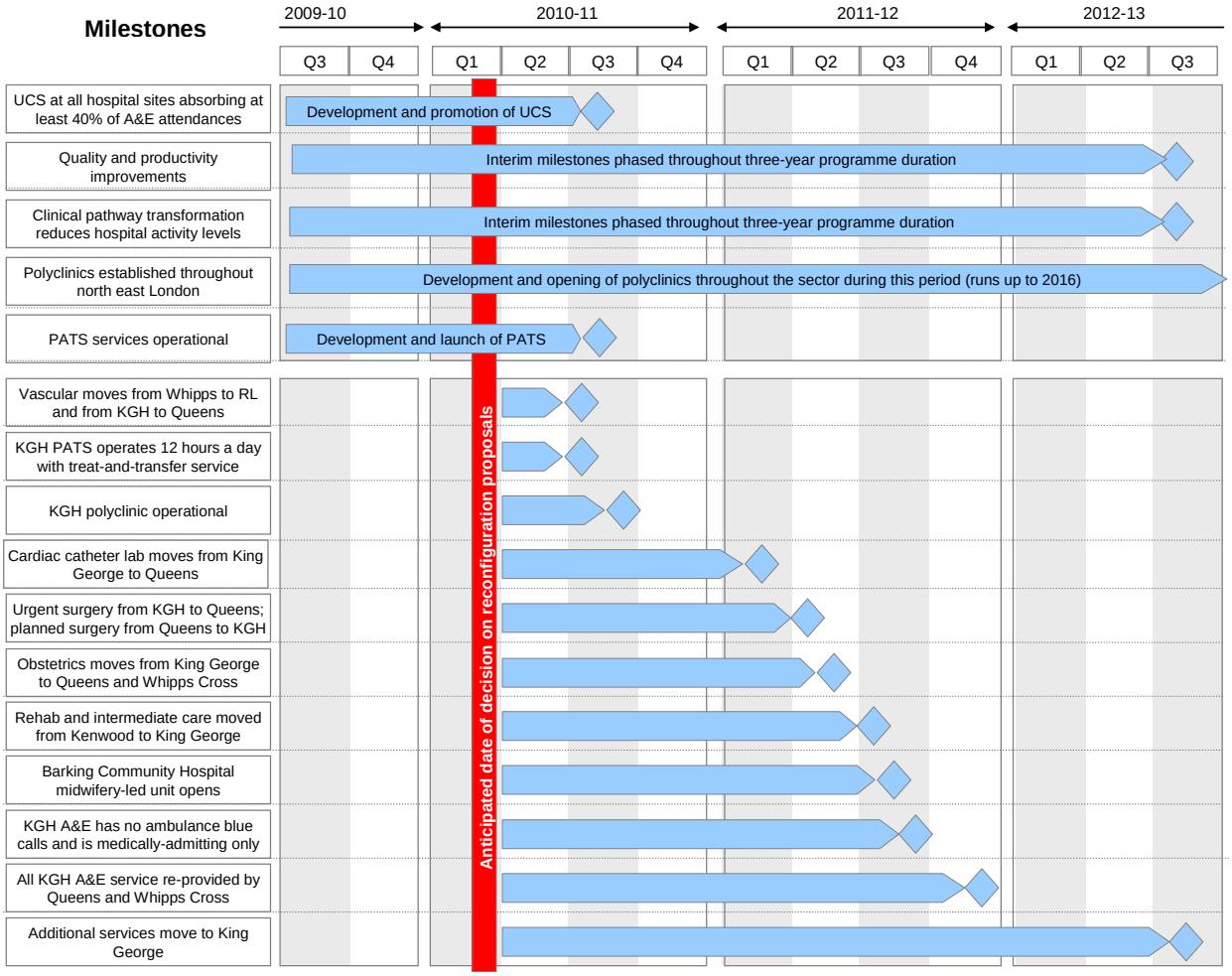
Many of the reconfiguration milestones identified for the proposals involve movement of services between King George and Queen's hospitals. Planned care services, such as elective surgery are proposed to move from Queen's to King George (under the 'enhanced' reconfiguration option), and urgent care services, such as A&E, from King George to Queen's. Each site must have the required capacity to absorb each service as it moves, ensuring no gap in service provision. This is particularly pertinent for the Queen's site because of their space constraints.

BHRUT has been focusing on reducing patients' average length of stay (ALOS) so that it is closer in line with national averages. BHRUT's modelling shows that by reducing the ALOS for planned care pathways by less than one day (from 5.2 to 4.5 days) several wards will no longer be required. This will enable more flexibility on the Queen's site to absorb services transferring from other hospitals.

For this reason, scheduling of reconfiguration milestones has been done in conjunction with BHRUT's planning for reductions in length of stay. This schedule can be seen in the high-level implementation plan below.

11.4 HIGH-LEVEL IMPLEMENTATION PLAN

The proposed timescales for implementation are shown in the diagram that follows:



11.5 IMPLEMENTATION PLANNING

As we saw in *section 11.1* planning for implementation has started as part of the development of the PCBC, and will run concurrent with the consultation period to enable the programme to commence implementation at the earliest opportunity and ensure that benefits can be realised as soon as possible. This implementation planning will be restricted to elements applicable to all options for change, and for the variants between the options which can then be adapted once the outcome of the consultation in known and a decision in taken.

The first stage will be planning preparation to agree the following:

- The workstreams for this phase;
- Responsibility for undertaking the work;
- Key milestones for the planning phase;
- How the plans will be challenged and signed off.

A critical success factor for implementation will be the clear allocation of accountability during this phase for realisation of each line of benefit defined in the benefits model.

The workstreams included in the implementation planning phase will include:

- **Clinical workstreams ~** many of the benefits that need to be derived from this programme are clinical in nature and to deliver will need strong leadership from the clinicians. It is envisaged that there will be a range of clinical workstreams to focus on the service changes needed. These will be agreed by the CRG when the implementation plan is being prepared, and are currently identified as unscheduled care, scheduled care, maternity and newborn and children's services. There will also be clinical workstreams focussing on community care including long term care and planned care, care outside hospital, end of life care and mental health.

  Each working group and workstream will be responsible for planning the service transformation including the service reconfiguration to enable services to move sites.

  The plans will be dependent on the Implementation Plans and, in particular, the timing of service set-up, expansion and contraction of the services site by site, and including the development of out of hospital care.

- **Non-clinical workstreams** ~ there will be three non-clinical workstreams to support the clinical workstreams. These will be workforce, education and training, and research and development. These workstreams will be critical in supporting the clinical workstreams to make the necessary workforce transformation.

- **Detailed implementation planning** ~ this purpose of this workstream is to tie together the clinical requirements of the plan produced by the clinical workstreams, the safe re-shaping and movement of services between sites in NEL and the financial requirements. Key deliverables will the project plans and a register of any risks, issues, contingencies and dependencies.

- **Staff transition management set-up ~** the Implementation Plan will need to detail the approach to how staff changes during Implementation will be managed as the impact on staffing numbers and structures is potentially one of the most complex areas for transition. Preparatory activities will include collecting complete data about existing staff in the areas likely to be affected, including their current terms and conditions, lengths of service. This information will be needed for any staff that may be TUPEd to other organisations if a service is to be transferred, or for staff asking to retire early as part of the process. Policies for staff transition will need to be developed and communicated effectively. There will also be implications for staff skills. Changes in service delivery models may mean that staff require additional training or further development of existing skills.

- **Estates planning** ~ these changes in service configuration will have implications for the estate. There will be elements of the estate that need to be changed to accommodate expansion in services or change of use of areas of the Hospital (e.g. from bed-space to theatres). This will need to be planned in detail prior to the implementation phase so that lead-in times for changes to configurations are understood, and the full scope of activities are built into the implementation plan (design, planning, defining and awarding contracts, oversight of delivery, commissioning the new/ refurbished buildings, completion and snagging). There will also be elements of the estate that may become redundant and need to be closed down and disposed of. Given the expected expansion in out of hospital care, estates planning will need to cover these requirements as well as the acute Trusts. The

planning for this workstream will need to include planning for the management of transition between arrangements**.**

- **Clinical Support Services ~** changes in service configuration will have implications for the provision of clinical support services including diagnostics, theatres and similar.

- **Facilities Management planning ~** similarly, changes in service configuration will have implications for the facilities needed in the hospitals including cleaning, catering, ICT.

- **Supplier Engagement** ~ there will need to be a workstream that focuses on existing external suppliers. This will need to include collecting information on relationships and contracts with external suppliers so that services are not compromised during the transition. The relationships will consequently need to be managed to ensure that contracts can be extended if required to maintain safe delivery of services during transition and to keep suppliers informed of future opportunities.

- **Informatics ~** there will need to be a workstream that focuses on the informatics infrastructure and resources needed in the health community to support the new models of care.

- **Legal** ~ in reality the legal work will contribute across the workstreams, but is identified as a separate workstream, as the programme will need to call on legal resources throughout the process. Advice from the legal team will include:

  - Continued advice on the lawfulness of the consultation and implementation programmes as they are developed;

  - Staff consultation advice and advice on TUPE if it applies;

  - Advice on existing and future contracts.

- **Communications ~** the communications and media handling activities will be critical during implementation. It will be key to ensuring that communications are continued during the planning phase – to maintain engagement, particularly with clinicians, and ensuring that there is a coherent communications plan in place to underpin implementation.

- **Travel and patient transport ~** depending on the option selected, there may well be significant action needed to change or enhance travel arrangements. These cover public transport, patient transport and blue light services. This will require coordination with key stakeholders including Transport for London, patient transport providers, and London Ambulance Service.

11.6 BENEFITS REALISATION

The benefits specified in *Chapter 3* of this business case are underpinned by a comprehensive benefits framework, which is attached at *Appendix C*. The benefits framework will be used throughout implementation to monitor success of the programme, both the reconfiguration elements and the wider productivity programme. Benefits realisation will be embedded within the programme of change.

The next stage for development of the benefits framework is to develop detailed metrics for measurement, and to determine the baseline against which future performance will be compared.

12. APPROVAL PROCESS

In line with the programme governance arrangements (see *Chapter 1*), the approval process for confirming the reconfiguration proposals for formal consultation can be summarised as follows:

- Recommendations made by the Clinical Reference Group to Programme Board
- Recommendations made by Programme Board to the Joint Committees of PCTs (JCPCTs)
- Consideration and decision-making by the JCPCTs

12.1 RECOMMENDATIONS MADE BY CLINICAL REFERENCE GROUP (CRG)

The role of the CRG was to lead the non-financial options appraisal process and, based on the results of this process, made recommendations to the Programme Board of what should be taken to public consultation.

The CRG's recommendation was a five-site configuration with significant reshaping of King George Hospital as a hospital with UCS.

The CRG noted that there may be a need for further consolidation of hospital provision in the longer term to deliver optimum clinical quality and financial sustainability.

12.2 RECOMMENDATION MADE BY PROGRAMME BOARD

The role of the Programme Board was to consider the recommendations from CRG and subsequently, to make recommendations to the JCPCTs of what should be taken to public consultation.

The Programme Board endorsed the decision of the CRG to recommend the option of a five-site configuration with significant reshaping of King George Hospital to become a hospital with UCS.

12.3 APPROVAL BY THE JOINT COMMITTEES OF PCTS

In July 2009 the two JCPCTs met to consider the development of options for reconfiguration and the process for options appraisal. The JCPCTs gave approval of the following:

- The proposed short listing process;
- The hierarchy of decisions as set out in the decision tree to inform the development of a shortlist of options;

- The decision criteria, subject to any final amendments made by the expert groups.

In September 2009 the two JCPCTs met and approved the following.

- A report on the outcomes of the option appraisal process;
- The development of this pre-consultation business case;

In November 2009, the two JCPCTs met to consider the recommendation to go to public consultation on the clinical proposals for change, with the option of a five-site configuration with significant reshaping of King George Hospital to become a hospital with UCS.

The JCPCTs endorsed the recommendation from Programme Board to go public consultation on the option of a five-site configuration with significant reshaping of King George Hospital to become a hospital with UCS.

13. PREPARING FOR CONSULTATION AND ENGAGEMENT

This chapter sets out the purpose of undertaking consultation and engagement and the plans for how *Health for North East London* will conduct this process.

13.1 PURPOSE OF UNDERTAKING CONSULTATION AND ENGAGEMENT

Health for North East London is consulting members of the public and stakeholders in the local community about the reconfiguration proposals for change in line with its statutory responsibilities (see *section 13.2*)

The purpose of undertaking this consultation and engagement is to gain a greater understanding of the views of the local community and to enable the JCPCT to take these views fully into account when making decisions. Intelligence gained through consultation will also support the *Health for North East London* programme team in developing implementation plans and making the transition to the new state.

The more comprehensive and meaningful the consultation the better the chances of a successful implementation into the local community. Guidance from the Department of Health[19] strongly suggests that:

- Patients and the public are entitled to be involved wherever decisions are taken about care in the NHS;
- The involvement of patients and the public must be embedded in the structures of the NHS and permeate all aspects of healthcare;
- The public and patients should have access to relevant information;
- Healthcare professional must be partners in the process of involving the public and patients;
- There must be honesty about the scope of the public's and patient's involvement, since some decisions cannot be made by the public;
- There must be transparency and openness in the procedures for involving the public and patients;
- The mechanisms for involvement should be evaluated for their effectiveness;
- The public should be represented by a wide range of individuals and groups and not by particular 'patient groups'.

Health for North East London is committed to translating these principles into an operational set of consultation arrangements, which balance the value added through consultation and engagement, with the clinical recommendations contained in the programme and the strategic responsibilities of NHS leaders to ensure the clinical and financial sustainability of north east London.

[19] Real Involvement, Department of Health (2008)

The process of consultation and engagement will help to define the potential scope of the impact of the proposals, and give a qualitative understanding of how this impact might occur, and in what circumstances. In parallel the Integrated Impact Assessment (see *section 1.9*) will flesh out this analysis in quantitative terms and will feed into the consultation process as the work progresses.

13.2 REQUIREMENTS TO CONSULT AND ACCOUNTABILITY FOR CONSULTATION

The process of consultation and engagement on *Health for North East London* reconfiguration proposals is governed by Sections 242 and 244 National Health Service Act, 2006.

The established practice to comply with the relevant sections of the National Health Service Act, 2006 is first to consult with the relevant Overview and Scrutiny Committees (OSCs) under Section 244. The consultation with the OSCs will help inform and guide the *Health for North East London* programme in the development of the proposals and will help to determine whether, and if so how, any wider engagement envisaged by Section 242 should be undertaken.

13.2.1 Scope of consultation period

Planning for formal public consultation on the reconfiguration proposals for change started with a series of meetings with the relevant OSCs. It was determined that two Joint Health Overview and Scrutiny Committees (JHOSC) should be formed for the purpose of the *Health for North East London* reconfiguration proposals.

The JHOSCs agreed to oversee a 14-week consultation process starting in November 2009 and ending March 2010. An additional two weeks in addition to the standard period of 12 weeks was agreed to take account of the Christmas holiday period during the consultation timeframe. This was accepted as an appropriate consultation period which would both influence key decisions prior to final definition of acute service reconfiguration and would identify the impact on the local health economy in order to enable action to be taken by those within it.

13.2.2 Governance arrangements for undertaking consultation and engagement in north east London

Accountability for undertaking consultation and engagement on acute reconfiguration proposals is with the seven north east London PCTs, but with a significant co-ordination role from the *Health for North East London* programme communications team. Both PCTs and acute trusts will fully brief their staff about the consultation.

The *Health for North East London* programme team provides consultation and engagement materials such as the consultation document, presentation packs and FAQs and acts as a central point of contact for further information requests. These materials may often require tailoring by individual PCTs to reflect the priorities and concerns of the local public and stakeholder groups specific to the PCT area, but all materials will be generated centrally to ensure consistency across the seven PCTs.

Health for North East London is also responsible for delivery of regular briefings to the two Joint Health Overview and Scrutiny Committees, and for the co-ordination of the key engaged public focus groups: the People's Platform (see *section 1.7.2*).

PCTs are accountable for delivery of consultation and engagement activities. Activities to engage with the public and stakeholders include widespread distribution of consultation materials, convening public meetings and ensuring effective plans are in place to include seldom heard groups such as travelling communities and homeless people. PCTs are expected to use their usual channels of communication with the general public, engaged public and wider stakeholder groups to ensure effective engagement prior and during the consultation period. PCTs must also undertake staff consultation with their own staff and ensure acute trusts are equipped to deliver their own staff consultation and engagement processes.

PCTs agreed to share their plans for pre-consultation engagement and public consultation with the *Health for North East London* programme team (individual PCT plans are available separately). These plans include an assessment of the various groups of stakeholders likely to have interest or influence in the reconfiguration proposals and plans to engage with these stakeholders through methods such as public meetings, road shows, focus groups and one-to-one meetings.

Fortnightly communications lead meetings are held between the *Health for North East London* communications team and communications and engagement leads from the seven PCTs and five acute trusts in the sector. The purpose of these meetings is to ensure PCTs are equipped with the materials, capacity and expertise to undertake consultation and engagement activities effectively and to identify any areas of concern that can be tackled as a group.

13.3 CONSULTATION QUESTIONS

13.3.1 Scope of consultation questions

This consultation should be seen as the next step of consultation subsequent to the decisions made by the London JCPCT following the London-wide consultation by *Healthcare for London: Consulting the Capital*. This consulted on settings of care and established significant clinical and public support for the principle of *localisation where possible, centralisation where necessary.*

The scope of this consultation therefore builds on the principles established in *A Framework for Action* and how they should be applied to the north east London context.

The recommendations following the non-financial options appraisal and financial assessment identified clinical proposals for change with two options for the future of King George. Consequently, the scope of the consultation questions needs to be focused on three key areas of proposed service change:

- Designation of the Royal London and Queen's as major acute hospitals and consolidation of specialist services, such as paediatric surgery and vascular surgery, on these sites.
- Reducing variation in quality of care and making the best care commonplace by ensuring the right services are available at each hospital site.
- Delivering better care closer to home by moving services out of hospitals into the community and through revised configuration of services at the King George site.

13.3.2 Proposed questions for consultation

The final version of questions for stakeholders is set out as part of the *Health for North East London* consultation document which is published in mid-November 2009. A full consultation document and summary version will be published in hard copy (for onward distribution) and on a consultation website.

Given that a single document is being produced, rather than one for NHS family and one for public/ patients, it has been decided that a single set of questions should be asked in public consultation rather than tailoring questions to different stakeholders. However, it is anticipated that a wide variety of questions will be asked and responded to through both public meetings and within more detailed discussion with stakeholder groups, such as the People's Platform as well as with NHS organisations and individuals.

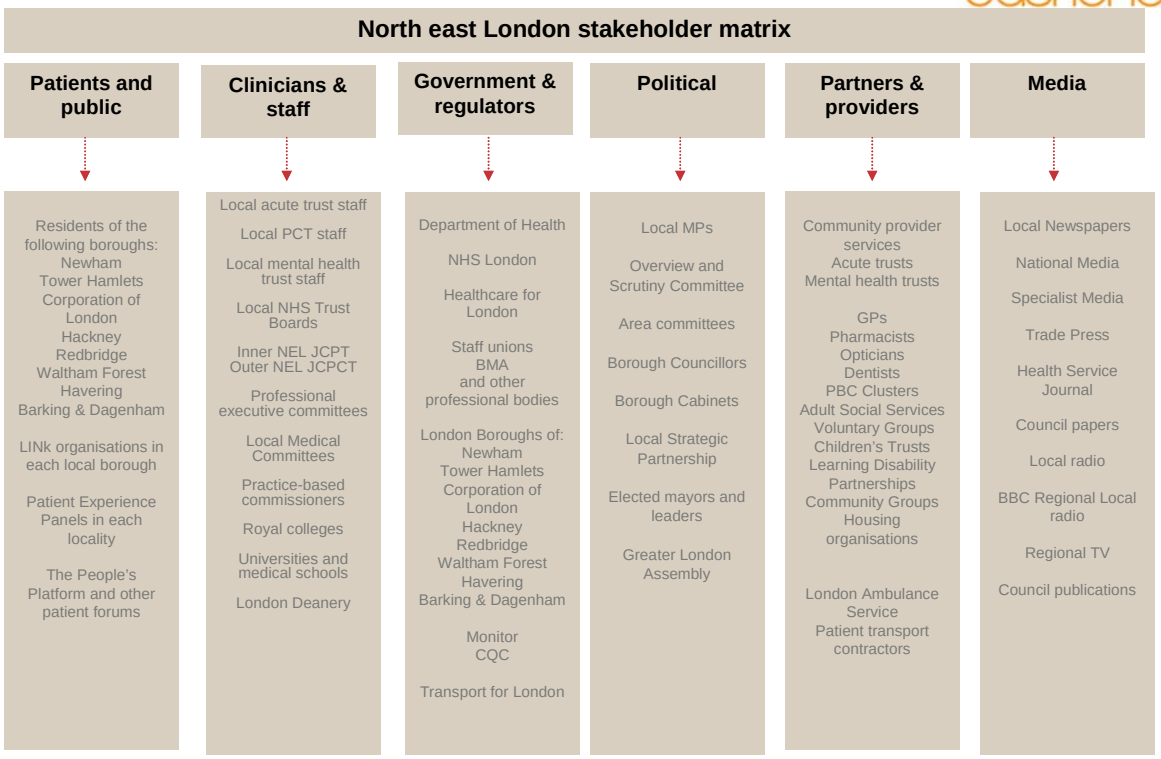
13.3.3 External assurance of the consultation questions

Ipsos MORI have been commissioned by Health for North East London to undertake the analysis of the consultation. They have established response mechanisms (email, mail, telephone and online) and have set up methods of analysis for all responses. In addition, Ipsos Mori has worked with the programme team to ensure the accurate development of the questionnaire and also independently assessed and critiqued the communications process. Ipsos Mori will provide the programme office with a full analysis of the results and also breakdown by borough and PCT.

One of the roles of the People's Platforms is to review the consultation materials, including the consultation document and questionnaire and provide views and advice.

13.4 ENGAGING WITH STAKEHOLDERS

The stakeholder analysis shown in the figure below indicates the range of stakeholders anticipated to have an interest, or influence, in the *Health for North East London* reconfiguration proposals. Stakeholders have been grouped into six groups and a strategy for engaging for each group is set out in the text that follows the diagram.



Patients and the public ~ as key users of the health services, patients and the public are a source of valuable feedback. They are also key players in determining 'demand' for health services and, if adequately engaged, can make appropriate decisions about their use of some services such as A&E. This stakeholder group consists of multiple forums, with wide-ranging and varied views and priorities. Via the consultation exercise adequate information must be made available to patients and the public to enable understanding of the change, and assurance must be given that access to care when patients need it will not be compromised. There must also be effective communication with the public to inform them of the opportunity to contribute and influence proposals. Key engagement mechanisms include public meetings in local and accessible locations, specific meetings for groups (e.g. local voluntary groups), media releases, website and the consultation document.

Clinicians and staff ~ clinicians and other NHS staff can be powerful advocates or adversaries of change. They can be highly influential, particularly with patients and the public and can provide essential insight on patient needs and concerns. Wider clinical views can come from the involvement of groups such as Royal Colleges and the BMA. It is important to be aware of staff concerns about their personal futures, and ensure sufficient information is available and engagement is undertaken regarding this. Regular communications are imperative to keep clinicians and other staff informed and on board. Engagement mechanisms such as staff meetings and forums, staff-specific briefings and specially convened meetings, for instance, for the LMCs, should be used to enable this regular two-way consultation.

Government and regulators ~ this stakeholder group has a regional or national remit and influence. Their interest in the reconfiguration proposals is likely to focus on seeking assurance that processes and timescales are being followed, that proposals are in line with national priorities and that progress is being made to meeting targets and legislation. Regular progress updates will be required to provide this assurance and specially convened meetings or one-to-one meetings will be most useful.

Political ~ political stakeholders priorities will be to protect the interests of their constituents, especially from any perceived 'closures' of local services. There will also be an acute

awareness of the upcoming general election and consequently, the fit of consultation proposals with party policies and likely manifesto promises will be of key importance. Political stakeholders are in frequent contact with the media and are often first in line for comment on changes to local services. Engagement activities should be focussed on the OSC engagement process plus one-to-one meetings as required with elected officials.

Partners and providers ~ there is a need to work closely, and in partnership, with this stakeholder group to deliver successful change proposals. They are likely to have a very good understanding of the impact of proposals with specific knowledge and experience and, as such, are highly valuable contributors within the consultation process. Frequent and close engagement is essential to ensure stakeholders are on board, particularly given the potential for confusion with mixed messages, given the public perception of 'one NHS'. Road shows, one-to-one and specially convened meetings will be a key part of this engagement.

Media ~ the local media is key to promoting messages about the consultation proposals as well as raising the profile of the consultation to the public and other stakeholders which in turn increases the likelihood of wide participation. However, careful handling of the meeting is imperative as there is potential for coverage to be one-sided, sources to be inaccurate and information to be misrepresented in the interests of getting 'a good story'. Media releases and ensuring key spokespeople, especially senior clinicians, are available for interviews must be part of this media relationship, and use should be made of the local media for paid advertising.

13.4.1 Staff consultation

The *Health for North East London* programme team and PCTs recognise that NHS staff members, particular those employed at acute trusts affected by the proposals for reconfiguration, are likely to have different questions and concerns about the reconfiguration proposals from those expressed by members of the public and key stakeholder groups.

The programme team are developing a staff briefing pack for use by PCTs and acute trusts in staff consultation, which will reflect the anticipated concerns of NHS staff members.

13.4.2 Engaging with seldom heard groups

The *Health for North East London* programme recognises that for an effective consultation exercise to take place, special efforts must be made to engage with 'seldom heard' groups within the local community. These groups may include travelling communities, offenders, homeless people, refugees and asylum seekers.

PCTs have established mechanisms for engaging with hard-to-reach groups, such as working with providers of services to those with learning disabilities to help develop and deliver easy read consultation documents. PCTs will make use of these channels as part of pre-consultation engagement and the formal consultation process to ensure the views of all sections of the local community are heard and can be incorporated into the decision-making process.

The *Health for North East L*ondon programme will commission an external agency to help ensure that engagement activity with seldom heard groups is extensive throughout north east London.

13.5 CONSULTATION AND MATERIALS

13.5.1 Consultation methods

Below is set out a full range of practicable consultation methods along with an assessment of whether the *Health for North East London* programme believes the method should be pursued and the assumptions which would underpin their implementation, the consultation methods are listed from broadest to narrowest reach.

Consultation method	Implementation assumptions
General publicity – paid advertising (to ensure accuracy) in local media, as well as publicity via NHS organisations and established stakeholder channels such as LINks and local voluntary group networks.	Programme team to coordinate pan sector publicity; PCTs responsible for promoting publicity through usual channels. Measures should be taken to ensure accuracy of publicity.
Public meetings – an effective way of engaging with a wide range of interested parties in the local health economy as well as patients and general public.	Need to consider geographical spread. Ideally one per PCT area. Organised and managed by local PCT. Advertised through LINks and key NHS stakeholders. Ensure suitably credible speakers available and briefed.
Road shows – to provide an opportunity for detailed conversations with local acute trusts (with a possibility to extend to other groups) about their specific priorities and interests.	At least one per acute trust prior to consultation and during consultation.
Focus groups for the engaged public – via the People's Platform detailed engagement on the proposals and their impact on local people.	Two People's Platforms are being set up – for inner and outer north east London.
One-to-one meetings – for key individual stakeholders such as MPs and OSC leads.	Specific meetings to be scheduled and existing PCT to stakeholder one-to-one sessions to be used.
Website/online media – for all stakeholders to access for information and provide further background information.	Stakeholders will be able to ask questions of the programme office and complete the consultation questionnaire via this mechanism. The website www.healthfornel.nhs.uk is now established

Telephone and freepost – the programme team will be directly accessible via telephone and post mechanisms in addition to online contact information	Programme office telephone contacts established and freepost applications underway

13.5.2 Consultation materials

The consultation methods listed above give rise to some common consultation materials. These are defined below. The materials will be developed by the *Health for North East London* programme team and given to PCT communications teams and should be tailored to suit local needs – this tailoring should be limited to the extent necessary. Some materials will also require translation into languages other than English (see *section 13.5.4*).

Consultation material	Audience
Consultation document – full and summary versions	All public and stakeholders
Consultation website – central point for accessing documents	All public and stakeholders
Press releases – designed to inform local media of the consultation and its implications	Media
Public presentation – for use at all public engagement events	All public stakeholders, tailored and updated as required
Staff presentation – for use in all staff engagement	All staff, tailored and updated as required
JHOSC briefing – background brief on the purpose, features and benefits of the proposed changes	JHOSCs and available on website.
Staff briefing – description of proposals for change, purpose and benefits specifically aimed at staff	Existing NHS staff
Public notices/posters/banners and roadshow materials – to inform the local population of the consultation and how to give comments, signpost to public meetings	Public, tailored to locality
Consultation interim report – to inform JHOSCs of results of consultation midway through the period	All public and stakeholders
Consultation final report – to inform JHOSCs of the findings from consultation	All public and stakeholders

13.5.3 External assurance of the consultation materials

Where possible, all consultation material will be tested with the People's Platforms well in advance. The consultation document is subject to legal approval and is prepared in conjunction with Ipsos Mori, who has been commissioned to undertake the analysis of the consultation, for external validation.

Materials for seldom heard groups are also developed in conjunction with external providers, such as the commissioning of an easy read, and also with specialist translation service providers.

13.5.4 Translation of consultation materials

Given the ethnic diversity within north east London, it is imperative that consultation materials be provided in languages to reflect this ethnic profile ensuring widespread participation and response to the consultation. The consultation document will be available in approximately ten international languages as well as formats including Braille and large print. The consultation document will also be prepared as an easy read version for those with learning difficulties.

13.5.5 Managing consultation responses

Ipsos MORI have been commissioned to undertake the management of the response to the consultation on behalf of the *Health for North East London* programme. This process includes co-ordinating the receipt and collation of all responses (responses received from key stakeholders will be flagged to the programme team on receipt) and an analysis of the findings and presentation of these findings in a report that will be shared with key stakeholders and made available to the public.

Based on the proportion of responses to population numbers from similar consultation exercises, it is anticipated that somewhere in the region of 10,000 – 14,000 responses will be received for *Health for North East London.* It is also expected that between 1-3,000 telephone calls and emails will also be received, which will be fielded by the *Health for North East London* programme team.

13.6 SCHEDULE OF ACTIVITIES FOR THE CONSULTATION PERIOD

A schedule comprising PCT and *Health for North East London* programme team consultation and engagement activities will be developed prior to commencement of the consultation period.