**"Options for future organisational arrangements for Ealing and North West London Hospitals Trust" Progress Report**

## 1. Background

In January 2011 the Boards of Ealing Hospital NHS Trust (EHT) and North West London Hospitals NHS Trust (NWLHT) separately considered a series of options for future organisational configurations. These options had been developed over the period from October to December 2010 as a response to the challenges faced by the NHS in general and by the North West London health economy in particular.

The two Trust Boards independently agreed at their respective meetings in January 2011 to pursue the development of a "Strategic Outline Case (SOC) to investigate the benefits and feasibility of a merger between EHT (including the community service of Ealing, Brent and Harrow which become part of Ealing NHS Trust from 1 April 2011) and NWLHT" to potentially create a new NHS Trust in West London. This was recognised as providing an opportunity to create a strategic platform for change in order to improve healthcare for North West London and to provide the basis for a clear timetable for the new organisation to successfully achieve Foundation Trust (FT) authorisation.

As a result with, the support of the SHA, (and in line with NHS London's "Transaction guidance") an independent Chair (Peter Garland) and a Senior Responsible Officer (Simon Crawford) have been appointed. To assist with the development of this programme of work an "Organisational Futures Programme Board" has been established with membership from the 2 Trusts, each of the 3 GP Clusters, LINKs representation from the 3 boroughs as well as PCT, NHS London and NWL Cluster membership.

The milestones within the process are:

- SOC produced by the end of April 2011 and went to May 9th Trust Board
- Development of clinical vision and strategy by mid-June;
- OBC completion end of June and to July Trust Board;
- FBC completion by the end of October.

At its meeting on the 9th May 2011 the NWLHT Board approved the SOC and agreed to proceed to produce an OBC "to fully determine the benefits and financial viability of a merger between itself and EHT" (Ealing NHS Trusts Board also made the same decision at its Trusts Board on 11th May 2011). The SOC was submitted to NHS London for approval, and will go to the June Capital Investment Committee. In the meantime NHS London supports the on-going development of the OBC and the supporting work on clinical vision and strategy for a potential merger of the Trusts.

The SOC demonstrated; the future scale of challenge facing both organisations and the likely impact they would have as stand alone organisations as well as the potential range of patient, commissioner and Trust benefits of a merger including recognition that a merged organisation would have the potential to become a clinically viable and successful Foundation Trust. A copy of the SOC is available from the Trust websites at www.ealinghospital.nhs.uk and www.nwlh.nhs.uk.

## 2. Why are we looking at a potential merger? The context for change:

The current economic and political contexts are a challenge for both NWLHT and EHT. There are a number of external factors that drive the need for change in acute hospital provision that can be classified under three main headings;

### *National & local drive for improved quality*

- Increasing requirements for consultant provided services being set nationally and locally for emergency surgery, acute medicine, inpatient paediatrics and maternity services. The evidence is, consultant delivered services results in better outcome for patients.
- NHS London pursuing designation of specialist cancer and vascular services in addition to Cardiac, Stroke and Trauma; and likely for emergency surgery and acute medicine in the near future.
- Increasing recognition of the link between volume and quality for some services ie consultants need to do sufficient procedures to be expert (so even if you could afford to employ enough to staff rota's there would not be sufficient work in smaller centre to develop the expertise).

### *NHS wide system changes*

- Renewed focus across the NHS on improved prevention and out of hospital care to meet evolving health needs (chronic long-term conditions and care of the elderly) and ensure continued improvement in health status. Any potential for new investment is therefore targeted at community services rather than acute hospitals.
- The National "QIPP" challenge is leading to a reduction in acute sector activity and increasing expectation of productivity improvements.
- Increasing pressure to reach FT status which requires organisations to meet national quality standards and be able to demonstrate financial sustainability over a forward 5 year period.
- Ongoing tariff changes with introduction of new tariffs for emergency admissions and re-admissions and productivity requirements year on year. These mean acute Trusts will get paid less year on year for the same level of activity as the amount paid for each procedure is reduced and some will not be paid for at all or at very reduced rates.

***NWL sector wide changes***

- NWL sector is driving several 5 year initiatives in different pathway areas aimed at improving health and quality of care, transforming of primary and community care, and launching an integrated care pilot.
- NWL must close a £1bn financial gap by 2014/15 which requires £700m of savings from all NWL providers (including the impact of tariff changes).

## 3. Rational for this Potential Merger

Both Trusts have existing challenges that are only going to increase in the coming years. The reality is both will be faced with reducing levels of income, a need to improve staffing levels to meet new guidelines, a fairly fixed estate infrastructure and costs and so would either have to stop providing services, considerably overspend or risk providing them at less than the optimum standard. This is not a scenario either Trust Board wishes to countenance and hence the pro-active response to explore the merger as a means to secure the highest quality of care for the patients of North West London.

Background to the two Trusts:

- Ealing Hospital NHS Trust (EHT): Integrated Care Organisation
  - Small district general hospital (300 beds)
  - Community provider of services in Brent, Harrow and Ealing
  - Annual budget of £133million for EHT, community services adds another £96million
  - Sustained a surplus since 2005/6
  - Likely to lose 23% income over the next 5 years if sector QIPP plans are implemented
  - Concerns regarding minimum scale for clinical viability with changes to Royal College and National guidelines

- North West London Hospitals NHS Trust (NWLHT) – larger district general hospital (680 beds)
  - Two sites: Central Middlesex and Northwick Park with budget of £369million
  - Northwick Park also manages St Mark's Hospital – a specialist centre for diseases of the bowel and gut
  - Struggles to sustain break-even position
  - Significant level of historic debt
  - Likely to lose 24% income over the next 5 years if sector QIPP plans are delivered
  - Estate in need of renewal

Responding to the impact of these system wide changes underpins the clinical case for change, in that the tougher quality guidelines will place considerable pressure on smaller Trusts in particular because of the following:

- Meeting national quality standards will often require up to 24x7 consultant cover/presence
- For smaller hospitals this will require investment in additional staff/equipment
- Even if this were affordable, it would reduce the experience which individual staff need to train and to maintain specialist skills
- And may make it difficult to maintain training accreditation

Different options have been analysed in the past for both Trusts to reach financial and clinical viability and for North West London over the last year have included:

- Consolidation within Trust
- Transfer of one site to another Trust
- Divestment of unprofitable service lines
- Merger options with different Trusts in NWL

The first three were not seen to offer sufficient clinical and financial benefits in the long term hence a panel including membership of the Trusts, PCT's, NWL Cluster and NHS London, was established and used the following criteria to evaluate options:

- Acute clinical viability – could we provide 24/7 consultant cover?
- Integrated Care – could we link local and hospital services effectively?
- Geographic Proximity – would services be accessible?
- Strategic Fit – would it fit in with national and local expectations in changes in care?
- Do-ability – would it be acceptable and could it be delivered?

Eight options for the future of both Trusts were reviewed by the panel and evaluated to determine the likely benefits to patients and Commissioners. The panel determined that options that did not provide solutions to both EHT and the NWLHT would destabilise the local health economy with a negative effect on patients and clinicians at both Trusts. The quality of care delivered to local people would suffer. The panel did not consider it acceptable to allow one of the two Trusts to become clinically non viable.

The panel viewed integration between the two Trusts as the most promising option. A merger would enable improvement in the quality of care delivered because teams would have sufficient scale. It would allow more services to be delivered safely at local level in North West London and allow resources to be redirected from management and support to frontline services. A merger of EHT and the NWLHT will better position the Trusts to address the financial challenges and potentially be authorised as a Foundation Trust in due course, an outcome that seems unlikely under other scenarios. The merger would not significantly impact choice or competition because patients would still have the option to seek treatment at a large number of hospitals in North West London sector.

Overall the analysis concluded that a merger between NWLHT, EHT and its associated Community Services constituted the best option and which subsequently led to the production of the SOC in April 2011. Elements from the SOC are included below supporting the clinical and financial case for the potential merger.

### *3.1 Clinical case for Merger*

I. Both Trusts have an obligation to their local communities - a **"promise to patients"** to deliver safe, high quality care locally. Our clinicians tell us this promise will be impossible to deliver consistently in the coming years if we remain as separate organisations. In part this is due to improvements in medical science and in part to improvements in our understanding of what delivering the best quality care requires. To get the best clinical outcomes we need to have more time available from senior staff, particularly consultants, to see very sick patients when they arrive and we need to be able to get rapid access to the high-tech specialist and diagnostic and treatment services that our patients expect and deserve. This problem can only get more challenging for smaller hospitals with limited staff and other resources. We need larger, more specialised clinical teams, more care delivered by highly experienced staff (in particular hospital consultants) and more integrated working across primary, community and hospital based care.

II. There is a **rising expectation for quality** from patients, who quite rightly expect care from highly experienced clinical teams, increasingly stringent quality guidance from Royal Colleges, and more challenging clinical requirements from commissioners. "If you are admitted as an emergency with major internal bleeding then to get the best clinical outcome means that we need to have specialist endoscopists, radiologists **and surgeons available 24 hours a day, 365 days a year."**

III. **Achieving a greater size** would enable us to deliver on our promise as we can organise ourselves around larger, more senior and more specialised clinical teams and rotas – this enables us to meet the quality requirements to be a safe and effective provider of clinical services set by the various bodies including the medical Royal Colleges and the requirements of the Commissioner. Most importantly, this will ensure that appropriately qualified clinicians see local patients rapidly, based on clinical need. "Today when you go and see an orthopaedic surgeon you will see a specialist in your particular problem –knee, hip or ankle. It's the same for cancer – if you have breast cancer you will be seen by a breast surgeon not a general surgeon."

IV. **At the same time commissioner clinical plans** and Sector clinical strategies have been developed and tested with local stakeholders. They have concluded, in line with national policy, that continuing to deliver high quality care requires a shift of NHS resources from hospitals towards primary and preventative care. This shift of resources forces NHS Trusts like ours to address hospital services that risk becoming too small to be safe. The expectation of a reduction in income coming to traditional Hospitals means that we have to become much more efficient to maintain quality. Our commissioner's planning intentions mean that our hospitals cannot each plan to grow our services to meet the minimum safe scale that will be needed in the future.

### *3.2 Financial case for merger*

Overall NHS Spending in North West London is increasing in cash and real terms in the coming three years. However, hospital based income is falling as money is reallocated towards prevention and primary care. Reductions in hospital income of up to 23-24% are anticipated in PCT QIPP plans meaning EHT and NWLHT will need to manage an expected combined cost challenge of approximately £140m by 2014/15, based on current QIPP plans.

EXHIBIT 1

| **Required savings by 2014/15 (based on QIPP plans)** | |
|---|---|
| EHT - acute | £33 m |
| EHT - community | £14 m |
| NWLHT | £92 m |
| Total | £139 m |

On their own, the Trusts will have difficulties generating the efficiencies and savings required without impacting the safety and quality of services they deliver. Current forecasts suggest they may fall short of this target by £25-40m. Through a merger, by working together as a single entity, the Trusts will be able to use economies of scale to increase the scale of savings while minimising the impact of financial challenges on service delivery.

While the scale of resources that could be released to support front-line care will depend on the clinical strategy developed to support the integration, initial work suggests that those resources could go a significant way to closing the financial gap that will remain after the Trusts have planned savings efforts separately. The merger would clearly offer a range of savings opportunities over and above those available to the individual Trusts which would enable the maximum resource to be directed in front line patient care services. In the short and medium term, the incremental benefits are likely to come from:

- ***Reducing administrative costs and duplication*** in Boards and Board support as well as in the Finance, HR, and Procurement departments. High level estimates show potential savings in the order of £2-5m.

- ***Improving productivity to the best of the three sites –*** current productivity varies considerably across the three sites and there are opportunities to improve productivity in a number of areas – from procurement, to staff utilisation, to theatre throughput. A number of these opportunities could be captured through improved standardisation and adoption of best practice across the sites. High level estimates show potential savings in the order of £10-15m.

- ***Capturing the benefits of achieving the highest standards of clinical quality*** by improving throughput of support services or by consolidating teams, locations and rotas and moving some services to the most appropriate locations so that productivity improves to amongst the best in the country. High level estimates show potential savings in the order of £10-15m.

- ***Avoiding expensive admissions and reducing length of stay by developing community services –*** the integration of community services offers opportunities across a merged organisation to ensure patients are cared for in the most appropriate setting. The level of savings is still to be determined.

- ***Improving estate utilisation***
  - ***Optimising estate spend*** by increasing investments to develop those estates most appropriate to host consolidated clinical services and avoiding unnecessary capital spend on other estates. We believe a merged organisation will be in a better position to develop estate that is fit for purpose. The net level of savings or spend will largely depend on the merged Trusts clinical strategy and is still to be determined.
  - ***Fixed cost savings from estate rationalisation***: both Trusts can use the greater productivity of its combined resources by optimising the use of capacity in theatres and wards, etc and potentially reducing the physical footprint of the Trusts. High level estimates show potential savings in the order of £2-5m.
  - ***PFI optimisation*** In the longer-term (3+ years), the merged Trusts could lever their increased size to develop centres of expertise and use the potential of a cohesive medical brand to explore opportunities for growth in both clinical and non-clinical income.

- The ***clinical*** growth opportunities would be the result of serving broader patient populations and being able to develop more specialised, niche

services. Further, a cohesive commercial/private patient strategy across the sites could bring additional income for the integrated Trust.

- Furthermore, expansion of the ***non-clinical*** (primarily academic) platform could bring funding for research/teaching, support from commercial partners (e.g., donations, clinical trial revenue), and income from intellectual property.

Capturing the benefits from integration will be challenging from a managerial perspective. While theoretically at least some of these benefits could be realised through effective partnership working between the Trusts, the managerial challenges associated with working across organisational boundaries would likely be insurmountable. Working as an integrated organisation with a single governance structure would substantially reduce management challenges and increase the likelihood of benefit capture.

## 4. Way Forward

The next stage of the process following the SOC and currently being undertaken is to produce an Outline Business Case that will provide more detail than the SOC on the potential service changes, modelling and financial costing for the range of options identified.

### 4.1 Outline Base Case

Having completed the SOC, the Trusts are now developing the OBC which is due for completion by the end of June and will go to the respective Trust Bards in July. The NHS London Transaction guide sets out the key requirements of the OBC as follows:

- Integrated Business Plan (IBP) (similar to that required for an FT application)
  - Addresses the headline issues but incorporates less detail than the IBP required for FT assessment process and the structure is as follows:
    - Executive summary
    - Profile of the proposed new provider organisation
    - Strategy
    - High level market assessment
    - Prospective service developments
    - Financial evaluation
    - Risk
    - Leadership and workforce
    - Governance arrangements
  - Includes the following appendices
    - Long term financial forecast (5 years 2010/11 – 2015/16)
    - Governance rationale
    - Consultation plans

- Outline Organisation Development Strategy (ODS)
  - Key principles, time table and constituent parts of the strategy and the responsible officer for delivery
  - Includes a Board Development programme

- Post Merger Integration Blueprint
  - Including strategic rationale for the transaction, overview of key transaction objectives, key principles underpinning the approach to transaction, high level timeline

- Scope of the Due and Careful Enquiry
  - Is that superseded by the Due Diligence process of NWLHT Challenged Trust Board?

- Draft Heads of Terms agreed in principle but prior to execution by the parties
  - Including parties to the transaction, process and intended timeline, description of key documents (and summary of key issues) necessary to effect the transaction, liability issues, staffing and TUPE (Transfer of Undertakings /Protection of Employment) matters, property issues, cost and approval processes

The OBC will include:
- A do nothing scenario and show it provides future risk to compromising patient care standards and worsening finances so not an option
- A suite of benefits for the merger to include both clinical sustainability and financial benefits
- Finance linked to specific deliverables from the merger i.e.
  - Back office deliverable short term;
  - Shared rotas, driving up performance standards to the most efficient etc,
- Potential service re-configuration subject to consultation with a range of options.

### *4.2 Clinical Working Group (CWG)*

A key component of the IBP is the need for the Strategy and Vision of the new organisation. From the outset there has been a determination that this is clinically led and developed in the best interest of patients and staff. Running in parallel with the SOC production has been the establishment and work of the CWG. Membership of the CWG includes senior clinicians from across the two Trusts, three sites and key services as well as GP representation from each of the three Boroughs.

The Objectives for the Clinical Working Group are as follows:

- Develop a case for change - identifying specialties where current arrangements (critical mass, clinical expertise, training opportunities) are resulting in sub-optimal care and/or are unsustainable going forward

- Formulate and discuss hypotheses as to how care might be delivered in the future
  - Reviewing specific specialities
  - Identifying key co-dependent specialties
  - Agreeing optimal models for the delivery of care across the whole patient pathway
  - Developing a proposed clinical strategy for the individual hospitals within a merged NWLH-Ealing Trust

- Set out criteria for successful implementation – likely to include workforce considerations and operational factors which will need to be addressed
- Help engage clinical colleagues in the sector and the Trusts
- Promote and endorse the clinical strategy to a broad range of stakeholders as required
- Align with broader NWL sector strategy

To progress the work of the CWG four sub-groups have been created as follows:
- Maternity & Paediatrics
- Emergency surgery & med. (including emergency 'ologies'), critical care, A&E and UCCs
- Community and elderly care
- Specialist (e.g., cancer) and elective services (including elective 'ologies')

As the work of the CWG progresses it will lead to the development of a clinical vision for the new organisation and that will inevitably **lead to a range of options for clinical service configuration that will need to be modelled in the OBC but will need to be formally consulted upon.**

## 7. Potential Benefits of Merger

Both Trusts are committed to delivering the best possible care so staying as they are is not an option. Early indications from our clinical and financial modelling suggests the level of services available to local residents will be materially higher and better from a merged Trust and that the financial situation will be more manageable. This is because:

- Some services operated by separate Trusts will be sub-scale and therefore would be withdrawn as unsafe by commissioners, reducing local choice
- A merger enables greater cost savings from support services and infrastructure to be realised so the combined Trust can support higher levels of frontline spending on local residents

- Consolidating teams and specialist hospital skills should cost less
- Need to serve a large patient population to maximise the benefits of scale and critical mass
- A merger would join up acute and community care over the same geography, creating the potential for better integration of services and fewer hand overs for patients (particularly older patients with long term conditions.
- A merger and service re-organisation will offer incremental benefits in terms of:
  - Patient experience
  - Accessibility of high quality specialist care
  - Larger clinical teams
  - Potential to invest in medicine and equipment
  - Savings in shared management resources
  - Improved care pathways (less referrals)
  - Reduced duplication

## 6. Formal Consultation and Stakeholder engagement

At this stage the Trusts are still working through the potential range of service configurations and benefits of merger so no formal decisions have been made.

The engagement process has been started to build in stakeholder perspective:

- Clinicians from Trusts and GP consortia are participating in four Clinical Working Groups
- Patient Links and GP consortia leads are participating in the Organisational Futures Programme Board
- Public listening events are being arranged to refine the Trusts clinical strategy and the merger plans. The aim is to give key stakeholders in the localities of Ealing, Brent and Harrow the opportunity to:
  - understand the external factors that are and will continue to influence future clinical practice and the organization of service delivery,
  - understand the impact of these external factors on the two individual Trusts and recognize the need for change which will potentially bring real patient benefits,
  - identify and prioritise the key issues/ and factors to be considered as part of any design and re-organisation of clinical service delivery,
  - hear about the process so far and the timetable ahead,
  - give their views on how they would like to be involved as we move forward and how best to communicate with our local population.

The events have been organized on the following dates:

- Ealing: Thursday 26 May 2011 at 5.30pm to approx 8.30pm. In the Queen Hall, Ealing Town Hall, New Broadway, Ealing W5 2BY.

- Harrow: Monday 6 June 2011 at 5.30pm to approx 8.30pm. Committee Rooms 1 and 2, Harrow Town Hall, Harrow Council, Civic Centre, Station Road, Harrow HA1 2XY.

- Brent: Monday 13 June 2011 at 5.30pm to approx 8.30pm. The Stonebridge Centre, 6 Hillside, London NW10 8BN.

- Attendance at the local OSC's is planned for June as part of the early engagement process.

- Stakeholders such as MPs, Local Authorities and the Ambulance Services will be contacted formally and meetings are to be scheduled.

- The stakeholder engagement process is not formal consultation, any proposed changes to clinical service configuration will be subject to the normal formal consultation process.

Depending on the outcome of the potential options for clinical re-configuration and support for the Outline Business Case, Formal consultation is likely to commence some time in August 2011 and will run for a minimum of 14 weeks (allowing an extra 2 weeks due to the August start).

## 7 In Summary

A merger between the two Trusts appears to be the best way to ensure that the organisations are able to deliver a full range of high quality services to local people and patients. This will continue to be tested further during the on-going phases of work.

**Simon Crawford**
**SRO Programme Board**
May 2011