1 Introduction

The presentation of the full business case for the merger of Barts and The London NHS Trust (BLT), Newham University Hospital NHS Trust (NUHT) and Whipps Cross University Hospital NHS Trust (WCUHT) for board approval is a critical point in realising the ambition to create one of the most comprehensive NHS Trusts in England and catalyse profound improvements to the health and healthcare available to around one million people across east London.

This Full Business Case (FBC) represents a collective response by the Trusts to the significant health challenges faced by the NHS in east London, developed through close collaboration with key stakeholders, patients, the public and staff over the past 12 months. The conclusion that these challenges can only be met through a merger was recognised in the strategic outline case and subsequent outline business case approved by the Trust boards and NHS London earlier in the process. A merger will create the vehicle to create the new models of service delivery, effective clinical pathways and services needed to meet the needs of local patients in future.

Clinicians from the three organisations have worked together to create a vision of a more resilient, viable, clinically excellent and adaptable organisation that brings many benefits (both clinical and non-clinical). We are confident that this will lead to better services, a healthier population and fewer health inequalities. This merger is a once in a generation opportunity to transform the prospects of the three Trusts and the health of people in north east London.

Our intention is for the merged Trust to submit a Foundation Trust application to Monitor in May 2014, with the aim of full authorisation in December 2014.

Following on from the unanimous approval of the FBC by the merger project Integration Board on 30 November 2011, the boards of the three Trusts and of the sector commissioning clusters, for East London and the City and Outer North East London, are being asked to make substantive decisions on whether the FBC for merger should be approved. This decision will need to take account of the implications of proceeding or not proceeding with the merger, which are discussed in section 2 and the outcomes of the independent reviews of clinical and non-clinical risks that have been completed on the three Trusts.

An active programme of communication and engagement with internal and external stakeholders was launched at the onset of the merger project. Significant concerns raised during this process are addressed by the FBC.
Detailed planning of the integration of the three Trusts will continue at pace if the FBC is approved as described in chapter 9 of the FBC. Collaborative working in the period leading up to the merger will be underpinned by the Heads of Terms.

This navigator paper accompanies the suite of supporting documents that are being submitted to boards alongside the full business case. The remainder of this paper is structured as follows:

Section 2 What are the risks of proceeding and not proceeding with the merger?
Section 3 What were the findings of the clinical due diligence review?
Section 4 What were the findings of the due and careful enquiry?
Section 5 The ongoing The Cooperation and Competition Panel discussions and timetable
Section 6 How will the three Trusts operate in the period running up to the merger?
Section 7 What is the timescale and what next steps for the transaction?
Section 8 Have the concerns of stakeholders been addressed?
Section 9 What will the name of the new organisation be?
Section 10 What is the business case for merger?
Section 11 What are the conditions that need to be met prior to merger?
Section 12 Recommendations for the approval of the Board

2 Risks of not proceeding or proceeding with the merger

2.1 Risks of not proceeding

The FBC is based on the organisational configuration selected by each of the Trust boards as their preferred option for the future. In the case of NUHT and WCUHT it was identified as the only viable option offering the prospect of sustaining viable services on those sites.1 The immediate consequence if the merger is not approved is that all three Trusts will continue as stand-alone organisations.

Work on finding an alternative configuration would need to commence immediately for both NUHT and WCUHT, either individually or jointly. BLT could continue as a stand-alone organisation, but the size of its future CIP target would represent a substantial risk to a Foundation Trust application. To place the risk of a probably two-year delay to decision-making in context, the combined historic deficit at NUHT and WCUHT is forecast to increase by a further £12.1m over 2012/13 and £4.5m over 2013/14.2

Ultimately, all patients wherever they live in east London will benefit from the merger. It is in no-one’s interest if NUHT and WCUHT enter the failure regime. BLT too, as a major tertiary services provider, has a strong interest in ensuring that its partner district hospitals are financially sound, organisationally stable, and provide high quality clinical services.

2.2 Immediate consequences to the health economy of not proceeding

On top of the immediate imposition of a lengthy period of delay to determining the future of NUHT and WCUHT, the resulting financial consequences and/organisational uncertainty will have the following impacts:

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1 In the case of WCUHT the merger was also critical to securing essential capital investment to the site.
2 Against a historic deficit that is already expected to increase by £6m over 2011/12
the ability to contribute resources to programmes aimed at improving health and reducing health inequalities decreases as internal pressures take greater priority;

the future of local acute services, particularly in Newham and Waltham Forest, will become less secure;

the ability to improve quality and reduce variability of clinical outcomes, patient experience and operational performance will be compromised;

the absence of financial resilience will tend to undermine the delivery of Health for North East London and the commissioning strategies based upon it.

2.3 Review of alternative options for NUHT and WCUHT

Lessons learned from the current transaction and more widely across the NHS suggest that it would take 18-24 months, and perhaps longer, to reach an equivalent decision-making point for a new FBC or FBCs for NUHT and WCUHT. The baseline financial position of both Trusts is likely to further deteriorate over this time. This would further challenge the ability of both Trusts to maintain the quality of services and motivation of staff during the hiatus before alternative solutions could be found.

The drivers underlying the original decision making of NUHT and WCUHT are, if anything, expected to intensify. Any prospect of accessing the financial support necessary to address the historic and accumulating deficits of both organisations will continue to be contingent on organisational reconfiguration by merger, acquisition or third party franchising. Alternative options were considered at a high level within the OBC. No new evidence has emerged to strengthen the case for other configurations given that:

- increasing deficits will make both NUHT and WCUHT progressively less attractive as acquisition targets;\(^3\),\(^4\);
- there is no evidence of substantial, well-developed links and shared clinical pathways with other organisations to form the basis for a successful merger business case (apart from between BLT, NUHT and WCUHT);
- smaller two-way transactions, potentially involving out of sector partners, would be unlikely to realise the scales of merger benefit required without resorting to substantial service reconfiguration; and
- the precedent set by the recent award of a ten year franchise for Hinchingbrooke hospital to Circle suggests that this model would leave commissioners and/or the Department of Health liable for future operating losses.

A strong possibility exists that no alternative solution can be found that is capable of sustaining both NUHT and WCUHT with anything close to their current portfolio of services and facilities. Consequences of failure would very likely include significant forced reductions in services at each site to those designated as essential. Such a situation runs a substantial additional risk of reaching a tipping point where service quality, staff levels or clinical outcomes experience a sudden deterioration that would be very difficult to mitigate.

2.4 Risks of proceeding

Mergers are known to be associated with substantial risks, which impact both before and after day one. In some cases, issues relating to mergers remain many years after the transaction has taken place. Critical risks that have been identified and for which mitigation measures have been put in place include:

3 Acquirers would to be able to mitigate the high proportion of (low margin and loss making) non-elective activity taking place on the NUHT site and/or the legacy estates risks of the WCUHT site.

4 It is questionable whether an acquisition of either organisation by a Foundation Trust would be possible under Monitor’s Risk Evaluation of Investment Decision guidance.
• the need to secure transitional funding in advance of the transaction date – this remains outside of the immediate control of the parties, but is being mitigated through working closely with partners from the commissioning clusters and strategic health authority;

• leadership and management capacity – delivering the transaction and overseeing the successful integration of the three organisations post-merger, whilst continuing to deliver high quality day-to-day services, will be mitigated by providing dedicated additional resources for a transitional period;

• external stakeholder challenge – resulting in delays and/or potential requirement to abandon the merger at a later stage, is being mitigated through an active stakeholder engagement programme;

• inability to create a viable clinical and/or financial model without service reconfiguration – this would trigger the requirement for public consultation resulting in substantial delays, but has been mitigated by an early focus on maximising the opportunities for merger benefits arising from back office corporate and service changes;

• an adverse Co-operation and Competition Panel ruling – this is dealt with in more detail in section 5 below, but is being mitigated by committing the new Trust to operate in accordance with the Department of Health principles of cooperation;

• reaching agreement on the terms of the merger with NHS London and the Department of Health, this has been mitigated by reflecting these requirements within the FBC presented to the boards;

• commissioning of the PFI on the Royal London site – this creates an additional pressure on clinical leaders and senior management resources within BLT in the run-up to the merger and may result in unexpected disruptions to systems and processes, both of which will be mitigated through the allocation of clear accountabilities for service delivery post-move;

• loss of performance – the merger may distract from the delivery of operational targets, which is mitigated by appropriate resourcing of business as usual;

• transition of control arrangements to the new organisation – there is potential for controls to weaken during the transition period, which will be mitigated through the inclusion of gateway reviews in the transition process;

• loss of talent – merger is associated with uncertainty and change, risks are being mitigated through a coordinated talent management approach;

• loss of clinical support – resulting in a loss of momentum within the programme, this is being mitigated by the clinical advisory group structure that has been adopted, which involves clinicians and clinical leaders from across the three organisations;

• lack of focus on health outcomes – due to transaction and integration issues displacing other priorities, this is being mitigated through agreeing a plan-execute-review model and appropriate metrics in the requirements of the clinical academic groups;

• loss of GP support – good relations with GPs are critical to the development of patient pathways, this is being mitigated through the stakeholder engagement and communication strategy and plan; and

• delays to day one – extensions of the merger timescale impact adversely on the costs, momentum and reputation of the programme and are being mitigated by rigorous project management of delivery and the mitigation of programme risks.
3 Clinical due diligence

The addendum to the Department of Health Transaction Manual issued in October 2010\(^5\) includes a requirement for clinical due diligence (CDD) to be completed and submitted to the Trust boards considering the FBC. Independent consultants Serco were commissioned to carry out the CDD review of clinical risks at the three Trusts. The CDD did not identify any clinical risks that were sufficiently significant to threaten the merger proposal. The conclusions reached by the initial review were confirmed by Antony Sumara who was retained as an independent external advisor during the clinical due diligence exercise.

4 Due and careful enquiry

PricewaterhouseCoopers was commissioned to prepare an independent due and careful enquiry (DCE) report in line with the NHS London approach to transactions\(^6\). The report is designed to highlight risk and to provide an independent assessment of the financial model and proposed governance arrangements for the new organisation; and underpins the Trust boards' decisions on whether to sign off the FBC. The DCE concluded on 2 December 2011. Draft final DCE report provided to finance directors on 29 November 2011 does not identify any risks that are sufficiently significant to threaten the merger proposal.

5 Cooperation and competition panel update and response

The CCP provides independent advice to the Secretary of State on the application of the Department of Health’s Principles and Rules of Co-operation and Competition. This includes reviewing proposed mergers in relation to potential breaches of these principles and rules.

An initial request for a formal assessment of the merger was made to the CCP on 8 April 2011. Phase one of this process started on 1 June and concluded on 27 July, with the CCPs decision to progress to a phase two enquiry. The final response of the CCP is expected in the week commencing 16 January 2012. This follows on the decision to pause the transaction to allow the parties to make additional submissions.

Although it is clear that any merger reduces choice of organisations, the Trusts believe that the impact of this will be limited.

The CCP has indicated it is particularly interested in the costs and benefits to Newham’s residents. The merger has submitted that patients will still be within 30 minutes drive of between five and eight providers of elective care. The merger is expected to increase the accessibility of a range of specialist services, which will benefit residents of Waltham Forest and Newham especially.

The FBC contains an assurance that key non-elective services will be maintained on the Royal London, Newham and Whipp’s Cross sites. NUHT and WCUHT are unable to provide this undertaking as standalone Trusts. Just as importantly, the merger proposal enjoys the support of commissioners not least because of the importance of securing the future of non-elective services at all three sites.

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5.1 Timeline for the final CCP decision

The assessment process was paused until 30 November 2011 to allow further submissions, including the FBC, to be made. This evidence will be considered by the Panel on 5 December 2011. The outcome of this meeting is expected to be a consultation paper on findings and (probably) a paper on potential remedies, ie conditions, that the CCP will recommend are applied by the Secretary of State in his approval of the merger.

Following a brief period of consultation (during which the Trusts will make a response to the CCP), the Panel is due to make its final decision on 9 Jan 2012, to be published in the week beginning 16 January 2012, a week before the Department of Health Transaction Board meeting that will be reviewing the merger.

6 Heads of terms

The heads of terms set out an agreed basis for open and constructive cooperation between the three parties prior to the merger. Their format is based on a template commissioned by NHS London for use in merger transactions. Cluster commissioners are included as signatories to the heads of terms on the basis that commissioners are required to provide letters of support for the merger to be approved.

A draft version of the heads of terms was included in the outline business case approved previously. The intention is for the final version to be signed off in conjunction with the approval of the FBC.

Although the heads of terms are not legally binding, they are intended to create a moral obligation on the parties to abide by the terms contained in the agreement. The heads of terms may be terminated if any one or more of the Trusts agree that the merger should not proceed.

7 Timescales and next steps

The main components to the critical path of the merger:

- consideration and approval of the FBC by the commissioning clusters, Trusts and NHS London;
- consideration and approval of the merger FBC by the Department of Health Transaction Board;
- consideration and approval of the merger by the Secretary of State;
- laying of disestablishment and establishment orders before Parliament;
- authorisation of the new Trust on 1 April 2011; and
- board appointments for the new organisation.

<table>
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<tr>
<th>Date</th>
<th>Event</th>
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<tr>
<td>30 November</td>
<td>Integration Board to consider the FBC</td>
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<td>6 December</td>
<td>WCUHT Board to consider the FBC</td>
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<td>7 December</td>
<td>BLT and NUHT Boards to consider the FBC</td>
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<td>8 December</td>
<td>ELC and ONEL Cluster Boards to consider the FBC</td>
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<tr>
<td>w/c 12 December</td>
<td>CCP publishes draft findings for consultation</td>
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<tr>
<td>13 December</td>
<td>NHS London Board to consider the FBC</td>
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<tr>
<td>5/6 January 2012</td>
<td>Appointment of Chair and Non-executive director(s) designate</td>
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<tr>
<td>w/c 16 January</td>
<td>Publication of final decision by the CCP</td>
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8 Process and outcomes of communications and engagement

Early appointments with responsibility for communications and engagement were made to the merger team soon after the project’s launch in March 2011; building on lessons learned from other similar transactions. A detailed stakeholder engagement plan was put in place and key individuals and groups have been kept abreast of the merger project through a combination of written briefings, project representatives attending established meetings and at specifically convened meetings. These activities increased significantly in intensity following approval of the OBC in early August 2011.

8.1 Process for inviting feedback on the merger

A prospectus setting out details of the merger and inviting feedback was published in July 2011 and has been distributed to 26,000 individuals and organisations around east London, including GPs, local and national politicians, patient groups, local authorities etc. Feedback has also been solicited through the following:

- merger-related items on the agenda of Trust public board meetings;
- ongoing hosting of drop-in information stalls at the three Trusts;
- posters, postcards and banners displayed in common areas in the hospitals;
- a transitional website launched on 15 November; and
- leaders from the Trusts and merger team have attended over 100 meetings with stakeholders and have convened borough based meetings as well as four dedicated events for stakeholders across north east London.

GPs have been invited to attend specific events focusing on clinical, non-clinical and financial aspects of the merger. These have been in addition to borough-based GP events and the attendance of senior members of the merger team at Clinical Commissioning Groups and GP meetings. Membership of the BLT clinical reference group has also recently been extended to include NUHT, WCUHT and their associated GP commissioners.

All LINks have been approached for their views on the merger, including a specific request to support the development of best practice models for patient experience and involvement and to provide input on the website.

Local authorities have been regularly updated on the merger and forthcoming engagement activities, including attendance at all Overview and Scrutiny Committees. All MPs and relevant GLA members in east London have been offered personal meetings and have received information materials and invitations to comment. The Rt Hon Stephen Timms MP

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7 A vision of future healthcare for local people
http://www.bartsandthelondon.nhs.uk/assets/docs/Merger/110802-BELH-prospectus-final.pdf; a clinical benefits prospectus is due to be published at the end of November 2011
8 To date over 2,000 visits by staff, volunteers, visitors and patients have been recorded
(Labour, East Ham) has written an article for the Newham Recorder in which he expressed support for the merger.

A separate staff engagement strategy has been developed. Regular information has been supplemented by open-sessions and events targeting senior leaders who have then been asked to cascade information. All staff have been invited to drop-in sessions.

8.2 Comments and concerns

Over 220 responses on the merger have been received to date:

- 75 (34%) supported the merger;
- a further 54 (24%) support the merger but had concerns or required reassurance;
- 39 (18%) expressed concerns; and
- only 8 (4%) did not support the merger.

It was unclear whether the remaining 44 (20%) responses supported or opposed the merger.

Respondents identified the following improvements that needed to be addressed (irrespective of a merger): improving communication between hospitals, GPs and patients; reducing waiting lists; improving patient care; ensuring the quality and cleanliness of wards; and good administrative processes, with specific reference to patient and GP letters.

Some of the benefits of the merger identified by responses included the merged Trust's ability to safeguard services, to support NUHT and WCUHT, and to improve patient care through sharing expertise and making services more seamless. Specific concerns relating to the merger focused on maintaining a balance between the large merged organisation and the local community.

Those responses that did not support the merger focused on concerns that the size of the organisation would compromise the quality and safety of services. Also in relation to size, the new Trust was considered to present a threat to the viability of other north east London providers, in particular Homerton University Hospital NHS Foundation Trust.

8.3 Emerging themes from stakeholder feedback

This section presents the six thematic areas into which feedback has been consolidated. In each case, details are also provided on the ways in which the FBC and/or the activities of the merger project have been changed in response to the feedback received.

- respondents wanted a better understanding of the financial context of the merger, specifically including the impact of the PFI at BLT in relation to the merged Trust. In addition to the details contained in the FBC, further information has been disseminated at finance-focused and other events. Financial aspects of the merger also formed a central component of the independent due and careful enquiry commissioned from PricewaterhouseCoopers.

- respondents were concerned that the merger would limit choice by centralising services, specifically to the new Royal London site. Commissioners have been involved in validating the assumptions made by the financial model on which the FBC is based, to ensure that this is consistent with commissioning strategic plans. Plans

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9 A number of areas of concern, relating to cross-sector care pathways and existing service agreements for specialist services, were raised at a meeting between representatives of the merger project and Homerton University Hospital Foundation Trust. In response to these a letter has been issued setting out the commitment of the new trust to abide by the Department of Health principles and rules for cooperation and competition (Department of Health, Gateway reference 14611, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_18221).
for the realisation of the clinical benefits set out in the FBC do not require service reconfiguration. Should such changes be required in future to meet new challenges or circumstances they would be made only after the conclusion of the necessary public consultation.

- respondents sought reassurance on the ability of commissioners, providers and other parties to influence the merged Trust effectively, in particular on issues of local importance. The FBC addresses this by retaining senior local management on each site. Commissioners and patients are also being actively involved in shaping the priorities of the clinical academic groups, in line with a foundation Trust based partnership working model.

- respondents wanted to understand the measures that would be put in place to ensure that merger benefits would be realised. The FBC sets out the proposed performance management framework based on metrics that will also reflect external priorities of commissioners, patients etc.

- respondents identified the need for effective communication. Communications and engagement has been identified as a priority for work streams to address as part of their integration planning.

- respondents noted the importance of maintaining staff support, given ongoing anxiety about the scale and pace of change. A detailed and ongoing process of staff engagement has been in place for some time and a full consultation with staff on TUPE will take place in early 2012.

9 New Trust name

Agreement on the name of the merged Trust is an integral part of establishing the brand and visual identify for the new organisation. “Barts and East London Healthcare merger project” was adopted as an interim name by the supervisory board in March 2011. The name of the new organisation needs to be agreed as part of the approvals process for the merger and will be reflected in submissions to NHS London and the Department of Health.

Each Trust undertook an internal engagement exercise with executives and senior leaders asking for views on a shortlist of four options:

- Barts and East London Healthcare
- Barts and East London Health
- Barts Healthcare
- Barts Health

Feedback received from staff related primarily to the inclusion of “east London” and the length of the name. Similarly these points were raised by NHS partners (commissioners and other acute providers in north east London). However, their concern was that the use of ‘east London’ would not be appropriate as it could cause confusion.

A significant consideration was the length of the name, bearing in mind that it would in future need to include the “Foundation Trust” designation.

At the 30 November 2011 Integration Board the new name was agreed as Barts Health NHS Trust with the local hospital names to be retained.
10 Full business case

In August 2011 NHS London authorised the Trusts to proceed with the preparation of a FBC for merger. This followed the approval of the outline business case by Trust boards in July 2011. The FBC describes in detail how the merger of BLT, NUHT and WCUHT will create a strong and stable financial platform to transform health services in North East London, bringing new opportunities and contributing to the economic regeneration of this area.

The format and content of the FBC and supporting documents are consistent with the requirements of the NHS London Approach to Transactions and the associated assurance process, with discrete sections setting out the following in detail:

- the case for change (Section 3);
- the vision and strategy for the new organisation (Section 4);
- the structure and governance of the new organisation (Section 5);
- clinical and financial benefits of the merger (Section 6);
- overview of the long term financial model for the period 2012/13 to 2016/17 (Section 7);
- communications and engagement activity that has taken place to date (Section 8);
- how integration will be achieved (Section 9); and
- the timelines and approvals from merger to Foundation Trust authorisation (Section 10).

Separate appendices provide detailed supporting information including: analysis of the local population and health inequalities; outcomes of an equality and human rights impact assessment; design principles and key performance indicators informing the future state; policies required for day one; a detailed merger timeline and integration programme plan; approach to collective consultation; financial assumptions and underlying cost reduction opportunities.

10.1 Ambitions of the new Trust

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<th>Number</th>
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<tr>
<td>1.</td>
<td>Patients will be at the heart of everything the Trust does, informing decision-making to ensure that patients feel confident, safe, and cared for</td>
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<td>2.</td>
<td>The health care provided will be of consistently high clinical quality</td>
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<tr>
<td>3.</td>
<td>Standards of patient safety will be continuously improved</td>
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<td>4.</td>
<td>Excellence in research and development will be sustained and developed</td>
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<tr>
<td>5.</td>
<td>Excellence in education and training will be sustained and developed</td>
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<td>6.</td>
<td>Human rights and equalities will be promoted</td>
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<td>7.</td>
<td>The Merged Trust will work with Commissioners, GPs and primary care teams, as well as Health and Wellbeing Boards, to improve health and to reduce health inequalities, with an initial focus on older people, on those having babies and on those with cancer, diabetes, and tuberculosis</td>
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<td>8.</td>
<td>The Merged Trust will work with partners in Social Care to ensure that the care needed by those who are most vulnerable is not compromised by organisational boundaries</td>
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<td>9.</td>
<td>The Merged Trust will make best use of the public resources invested by commissioners</td>
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<td>10.</td>
<td>Finally, the Trust Board will be open and accountable to patients and the local population, and will listen to the views of patients and the public in making improvements in the services the Trust provides</td>
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Figure 1 The ten pledges for the Merged Trust set out in the FBC
The new organisation intends to achieve the following outcomes within five years:

- to achieve among the lowest rates of hospital mortality in the country;
- to achieve among the lowest rates of defects and hospital associated harm in the NHS;
- to be a quality leader among NHS Trusts - consistently among the highest ranking in national quality indicators and the top performers in national patient surveys;
- to be the employer of choice for staff, supporting their health and well-being and helping them to thrive in their work; and
- to be authorised as a NHS Foundation Trust.

A strong strategic case for change has already been set out in the OBC, which centred on the legacy of deprivation in east London: poor health outcomes and high health inequalities. These factors are expected to be amplified by the anticipated population growth if action is not taken now.

Each of the three Trusts faces different combinations of significant challenges relating to staffing, finance and estates. Coupled with this, their clinical services are anticipated to find it increasingly difficult to meet service standards and to recruit and retain staff. These problems are already acute at NUHT and WCUHT, both of which lack a viable model to secure their future as stand-alone entities. Were they to fail, east London would struggle to maintain comprehensive health services particularly in the areas of emergency and maternity.

The intention from the outset is for the design of the merged Trust to be foundation Trust ready, with an organisational structure based on strong clinical and academic leadership achieved through Clinical Academic Groups (CAGs) supported by a full range of business functions. The aim is to enable local clinical leadership and to allow decision-making close to the point of delivery of care, and to bring benefits including:

- higher quality services, with more extensive 24/7 cover;
- less fragmented care pathways for patients; and
- improved access to specialist services, particularly for the populations served currently by the NUHT and WCUHT sites.

The FBC describes a pragmatic approach to integration over a three-year period based on lessons from other mergers. Year one will focus on integration, year two on service improvement so that years three onwards can concentrate on transformation (including large-scale pathway redesign).

### 10.2 Size of the financial gap and benefits of the merger

As they stand the three Trusts need to achieve savings of £239m over the next 5 years (£169m of which is required by BLT), of which only £208m have been identified. There is little prospect of going beyond this without compromising services. The FBC sets out that £31.8m of immediate savings arise from the merger without any reconfiguration of services being required. These opportunities are uniquely related to the merger and that would not be available to the Trusts otherwise, and arise as a result of savings including:

- a 22% reduction in pay costs as management structures are streamlined across corporate functions (£13m);

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10 Eg finance; human resources; governance; procurement; information, communication and technology; estates and facilities; communications; and education, research and development
• corporate non-pay items including the consolidation of IT systems and fee savings (£4.1m);
• decreased management costs within clinical academic groups (allowing for an increased investment in clinical leadership capacity) (£2m); and
• standardising clinical performance to the best practice and performance found within the Trusts currently (£12.7m).

A further £26.4m of new cross-Trust savings schemes have been identified in 2013/14 (year two post-merger), over and above Trust-based cost improvement schemes developed within the individual organisations.

Importantly the profile of savings required by the merged Trusts has less year-on-year variability and has lower ‘peak’ savings than those for individual Trusts.

Equally importantly, WCUHT has no capability to make the capital investment in its infrastructure that it requires on a stand-alone basis. The merged Trust can and will do so. Finally, NUHT and WCUHT have extremely poor liquidity positions that require cash funding.

10.3 **Summary of the long term financial model**

A number of changes to the background context have occurred since the OBC. Importantly:

• year end forecasts for NUHT and WCUHT have deteriorated significantly;
• assumptions concerning the levels of cost reduction that each Trust can achieve safely have been amended (and in the cases of NUHT and WCUHT, reduced);\(^{\text{11}}\)
• new clinical standards have come into effect in emergency care (with associated cost implications);
• inflation has outstripped the 2.5% rate assumed previously; and
• the Independent Reconfiguration Panel has ruled that changes to the King George Hospital site proposed under the Health for North East London consultation can go ahead (which will place additional demand on services at WCUHT and NUHT).

On this basis, the combined deficit of NUHT and WCUHT is forecast to reach £38m by the end of 2016/17. Although BLT is forecast to deliver a surplus over the same period, as a foundation Trust it would require significantly more aggressive cost reduction programmes than similar peers. This arises from the large PFI charge the organisation will have to service.

Although the model forecasts the merged Trust making recurrent surpluses from 2015 onwards transitional support will be required during its early years to fund:

• £86.5m of I&E support to address merger costs (of which £10.1m has already been agreed for 2011/12), comprising:
  o redundancy costs;
  o project and other integration costs;
  o increased CNST contributions;
  o impact on business as usual during 2012/13 in the immediate aftermath of the merger; and
  o increased public dividend capital costs.
• £64.7m of cash funding to cover:

\(^{\text{11}}\) Based on the outcomes of the NHS London scenario modelling analysis
- capital investment requirements at WCUHT;
- historic loans at WCUHT; and
- working capital support at WCUHT and NUHT.12

On this basis, the merged Trust is forecast to become profitable by 2015. Furthermore, based on a 3.5% cost of capital this investment would produce a £48m return on this investment by the end 2016/17. This is in stark contrast to the large and growing deficits that will result in two of the three Trusts if they do not merge.

The FBC considers a downside scenario based on a combination of financial risks that might arise from: delays in implementing a programme to improve the quality of clinical coding (affecting income); not achieving recurrent cost saving targets; higher rates of PFI cost-inflation; flat or declining patient activity; higher rates of pay inflation; unplanned capital costs and/or lower than expected proceeds from land sales. This approach provided an early opportunity to consider potential mitigating actions.

Under this set of downside assumptions, further work would be required to identify internal mitigations to maintain financial stability. Should sufficient internal opportunities to secure additional efficiencies and reduction in expenditure at an individual department and service line level not be found, it is possible that service reconfiguration would be required. However, it is important to note that there are no current plans to make any service reconfigurations as part of the merger. Any service reconfiguration that proved to be necessary at a later date, would be subject to statutory consultation on this topic.

11 Conditions of approval

In their unanimous approval of the OBC in August 2011, the three Trust boards noted a number of specific issues that would require resolution prior to the merger.

The financial model in the FBC described in section 10.3 is based on the total funding requirement of £171.2m for transitional support over years 2011/12 to 2016/17. The current expectation is that this will be funded through:

i) agreement to release the outstanding £20 million of NHS Bank non-recurrent financial support for Barts and The London’s PFI transition costs;

ii) the existing agreement by NHS East London and the City, NHS Outer North East London, BLT, NUHT and WCUHT, and NHS London to collectively fund the £10.1m of integration project costs in 2011/12;

iii) NHS East London and the City and NHS Outer North East London funding £15.1m of integration project costs in 2012/13 (year one post-merger) and £10.6m of integration project costs in 2013/14 (year two post-merger);

iv) NHS London and Department of Health agreement to provide £50.7m I&E funding over the period 2012/13 to 2016/17 (years one to five post-merger);

v) NHS London and Department of Health agreement to provide £14m to WCUHT on approval of the business case for the associated capital programme;

vi) agreement by the NHS London Challenged Trust Board to release the £26.3m funding allocated to WCUHT and NUHT; and

vii) NHS London and Department of Health agreement to provide £24.4m balance to meet the full cash funding requirement of the merger.

12 Notably, the cash funding element is required irrespective of whether the merger takes place.
Board approval of the FBC for a merger on 1 April 2012 is therefore being sought on the basis that the following conditions are met, specifically:

- confirmation of the agreements to provide: £20m of outstanding NHS Bank support; transitional support comprising £10.1m of I&E support in 2011/12 and £76.4m of I&E funding in years 2012/13 to 2016/17; and £64.7m of cash funding; as set out in points (i) to (vii) above; prior to submission of the merger case to the Department of Health Transaction Board in the week commencing 23 January 2012;
- the transitional support from NHS East London and the City and NHS Outer North East London in years 2012/13 and 2013/14 referred to in point (iii) above forms a part of a wider agreement concerning the management and mitigation of risks within the service contracts; and
- approval of the FBC by the three Trust boards and two cluster boards.

Boards should note that the approval of the FBC is being made in the absence of a final decision on the merger by the CCP, which could recommend to the Secretary of State that approval of the merger should be subject to remedies that would have a material impact on the FBC and long term financial model. A resulting decision to make significant changes to the FBC may require separate board approval.

Boards should also note the approval of the FBC and accompanying documentation will not restrict the ultimate decision-making authority of the board of the merged Trust concerning the content and implementation of the post-merger plans they contain.

Finally, approval of the FBC is made on the assumption that there is no significant failure in clinical governance at any one or more of the Trusts between the date on which the FBC is approved and the date on which the Department of Health Transaction Board approves the merger.

12 Recommendations

The boards are requested to make the following decisions on the basis of the evidence presented and taking due regard to their responsibilities:

TO NOTE the contents of the navigator paper

TO NOTE the timescales and next steps for the merger including the CCP, NHSL and DH transaction board processes

TO NOTE the communications and engagement process that has been undertaken, the feedback received and the response to this

TO NOTE the informal engagement process on the new Trust name and TO ENDORSE the agreed name of Barts Health NHS Trust

TO APPROVE the full business case for the merger of BLT, NUHT and WCUHT on the basis of the following conditions being met:

(i) agreement of transitional support and the associated risk share arrangements in advance of the Department of Health Transaction Board; and

(ii) approval of the FBC by the three Trust boards and two cluster boards.

TO NOTE that the final CCP decision may include remedies that require changes to the FBC and long term financial model

TO NOTE that the approval of the FBC will not restrict the decision-making authority of the merged Trust
Full business case

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1. Executive summary

1.1 Purpose of this document

This Full Business Case (FBC) makes the case for a merger between Barts and The London NHS Trust (BLT), Newham University Hospital NHS Trust (NUHT) and Whipps Cross University Hospital NHS Trust (WCUHT). The proposed new organisation will be referred to hereafter as the ‘Merged Trust’. This document builds on an earlier Outline Business Case (OBC) approved by the three Trust Boards in July 2011 and by NHS London in August 2011.

East London has a rapidly growing and diverse community with some of the worst health measures in the country. In common with the rest of the UK, life expectancy has increased over recent decades, but so too have the inequalities in health. The East End of London has long been a major point of entry for people wishing to settle in London and the UK. Many of these people have limited or no ability to speak English, nor do they have an understanding of how to access the health services that are available to them.

At the heart of the Merged Trust’s vision is an ambition to transform the health of east Londoners by providing leading, world class, patient-centred healthcare. Many of the existing Trusts’ services attract patients and funding from all over the country, but the Merged Trust’s central mission will be to deliver the highest quality healthcare and to tackle decisively the persistent health inequalities within the populations served. The combined service portfolio of the Merged Trust and the strong partnerships with primary and social care will offer pathways of care which encompass community, general acute and specialist services. Through excellent relationships with outstanding academic institutions, and as a member of UCL Partners, a leading Academic Health Sciences System, the Merged Trust will discover and spread leading practice and service innovation across all sites and to the wider health service beyond. Education offerings will be first class and research will rank with the best in the country. All of the Merged Trust’s hospitals will contribute to maximising the impact of high quality research and education, translating this into improved clinical outcomes.

The aim of the merger of BLT, NUHT and WCUHT is to transform health services in north east London, ensuring that everyone, whatever their need or background, will benefit as a result.

A strong and stable financial platform is a pre-requisite if these challenging objectives are to be achieved. The Merged Trust will have the scale and management capability to delivery such a platform.

The creation of a Trust of this scale brings new opportunities, not least as the largest local employer and as a significant procurer of goods and services. The Merged Trust’s campaign to improve health will begin with its own 15,000 employees, the majority of whom are part of the populations served. Furthermore, its contribution to economic regeneration will start with the Merged Trust’s capacity to employ local people and raise their aspirations.

In striving to fulfil these ambitions, the Merged Trust is committed to working in accordance with the following ten pledges:
Executive summary

1. Patients will be at the heart of everything the Trust does, informing decision-making to ensure that patients feel confident, safe, and cared for

2. The health care provided will be of consistently high clinical quality

3. Standards of patient safety will be continuously improved

4. Excellence in research and development will be sustained and developed

5. Excellence in education and training will be sustained and developed

6. Human rights and equalities will be promoted

7. The Merged Trust will work with Commissioners, GPs and primary care teams, as well as Health and Wellbeing Boards, to improve health and to reduce health inequalities, with an initial focus on older people, on those having babies and on those with cancer, diabetes, and tuberculosis.

8. The Merged Trust will work with partners in Social Care to ensure that the care needed by those who are most vulnerable is not compromised by organisational boundaries

9. The Merged Trust will make best use of the public resources invested by commissioners

10. The Trust Board will be open and accountable to patients and the local population, and will listen to the views of patients and the public in making improvements in the services the Trust provides.

The new organisation intends to achieve the following outcomes within five years:

- **Achieving among the lowest rates of hospital mortality**
- **Achieving among the lowest rates of defects and hospital associated harm in the NHS**
- **Being a quality leader among NHS Trusts - consistently among the highest ranking in national quality indicators and the top performers in national patient surveys.**
- **Being the employer of choice for staff, supporting their health and wellbeing and helping them to thrive in their work**
- **Achieving authorisation as a NHS Foundation Trust.**

It is recognised that the bold ambitions of the new organisation represent a significant step from where the existing Trusts are both operationally and culturally. Therefore a comprehensive programme of organisational development is being created and implemented to make the necessary changes to working practices and, importantly the hearts and minds of the staff.

The Merged Trust will be one of the largest in the NHS in England, serving a population of around a million people. In delivering the largest hospital redevelopment programme in the NHS, the new organisation will be able to offer care in outstanding facilities using state-of-the-art equipment. As a leading trust with cutting-edge facilities, the new organisation will attract staff of the highest calibre across all clinical and non-clinical professions.

Without this merger it is unlikely that such a transformation would be achievable at pace, given the organisational and financial challenges in the current system.
Executive summary

1.2 The strategic case for change

East London has a legacy of deprivation and displays some of the worst health outcomes and health inequalities in the country. In addition, population growth of 16.5% over the next 10 years is anticipated, putting significant pressure on already stretched services.

Additional activity increases are expected in emergency and maternity services at NUHT and WCUHT resulting from the Health for north east London programme. At the same time, commissioner intentions include a significant shift in activity away from the hospital setting. Unless the Trusts are able to flex and scale their services it will be very challenging to respond to these conflicting agendas.

Across the three Trusts there are pockets of excellent performance but no one trust displays excellence and the highest level of outcomes across all areas of operational performance, productivity, quality, and patient experience.

Workforce pressures affect all three organisations and, in particular, NUHT and WCUHT. Challenges include recruiting and retaining staff, high usage of temporary and agency staff, and problems in sustaining 24/7.

The financial challenges are also significant. Only BLT is financially viable as an independent entity in the long-term. The financial challenges facing NUHT and WCUHT are of a scale that is likely to result in one or both of them being placed in the NHS failure regime. All three Trusts face infrastructure challenges, particularly in relation to information systems and estates.

The challenges facing the three Trusts are of a significance that, without change, it will not be possible to maintain comprehensive and viable health services across north east London.

This merger offers a once in a unique lifetime opportunity to change the face of healthcare in north east London and the lives of residents, including; a viable financial future for NUHT and WCUHT; early investment in badly-needed new facilities; more specialist services available locally for patients; improvements to the health of East Londoners; the ability to attract the highest calibre of staff, and first class research and education.

1.3 Vision and strategy for the Merged Trust

The vision of the Merged Trust is to provide a full portfolio of services to meet the needs of the local population, and to be recognised locally, nationally and internationally for outstanding clinical services, research and education.

The care provided by the Merged Trust will range from community services in Tower Hamlets, local acute care to inner and outer north east London boroughs, and specialist services at a pan London and national level. The scale of the Merged Trust's activities will be notable, with approximately 1.3m outpatient attendances, 100,000 elective and 140,000 non elective finished consultant episodes per year, and 15,000 births.

Four strategic outcomes are identified to meet the challenges facing healthcare services locally and to achieve the Merged Trust's vision. These are;

- A significant contribution to programmes which improve health and reduce health inequalities achieved through joint working with local partners via the Health and Wellbeing Boards
- Secure local acute services, with improved access across north east London to the full range of specialist services supported by enhanced research and education capabilities
- Better quality as well as reduced variability of clinical outcomes, patient experience and operational performance
- Financial resilience and a sustainable platform for acute services in north east London.
In striving for excellence across this portfolio of clinical services, and across research and education, the Merged Trust will measure its success in meeting its vision and strategy through achieving the five key outcomes set out in 1.1 within five years.

1.4 Structure and governance of the Merged Trust

The organisational and governance structures of the Merged Trust have been designed using a suite of agreed design principles, which will establish the new organisation like a Foundation Trust from its inception.

Executive and non executive portfolios have been clearly delineated, as has the distinction between executive decision making groups and committees, and those committees which provide a fundamental assurance role to the Board. Accountability from the Board through to the ward or point of front line service delivery via has been clearly set out.

In particular, the organisational structure has been designed with strong clinical and academic leadership at its heart from the very outset. This will be achieved through the establishment of eight Clinical Academic Groups (CAGs). The CAGs will act as the engine room of the Merged Trust in delivering its vision. They will be supported by a full range of business functions, including finance; human resources (HR); governance; procurement; information, communication and technology (ICT); estates and facilities; communications; and education, research and development. The CAG structure will enable local clinical leadership of services and allow decision making close to the point of delivery of care. They will drive the highest levels of quality across clinical services, research and education and will ensure a uniformly high standard of care to all populations served.

The Merged Trust will have a clear and coherent performance management framework that ensures an integrated approach to managing performance across quality, workforce, finance and activity. Responsibility for operational performance will be devolved to the lowest possible level in the organisation, namely the ward or department providing the direct care to patients.

1.5 Clinical benefits

Without a merger, all three trusts will be challenged to achieve the service standards outlined in NHS London’s recently published acute medicine and emergency general surgery specification; and the current severe pressure on recruiting and retaining staff will become even more acute. This challenge is greatest at NUHT and WCUHT.

Put simply, the quality of care for patients is at risk. With merger, the trusts will pool their resources and so provide higher quality services, 24/7 for residents across the whole of north east London.

The merger will enable clinical pathways offered by the three existing Trusts to be developed and improved across what is currently a fragmented system, and will enable clinical leaders more rapidly to identify and execute best practice clinical treatment pathways across the new organisation.

The merger will provide direct clinical and health benefits for patients and for the local population. Examples include; extending access to non-complex chemotherapy services closer to home to improve the experiences of and clinical outcomes for people with cancer; and helping people with diabetes to manage their own disease thereby improving their quality of life and limiting the impact of diabetes on the community, both in terms of use of health resources and in terms of the wider impacts on incapacity and unemployment.

These are just two examples of the clinical improvements that merger will bring; the aspiration is to transform all services across health services in north east London. These aspirations have widespread support from our service and academic partners, commissioners and stakeholders. The merger of the three Trusts is widely believed to offer the best opportunity to secure and sustain these benefits across the local populations served.
1.6 Financial benefits

Financial plans for the three Trusts demonstrate that savings of some £238.8 million over the next five years are required. Individually the Trusts have only been able to identify around £208.1 million of savings. Any further savings made as individual trusts could threaten both the viability and quality of services.

The merger gives the Trusts the immediate opportunity to achieve a further £31.8m as a result of cost reductions opportunities made possible by merger synergies. These cost savings would not be available to the three trusts individually. After the merger, further opportunities will be identified as a single Trust.

For WCUHT and NUHT, this merger is the only means by which the required level of CIP savings can be achieved without service reconfiguration.

Equally, because of complex financial rules, WCUHT in particular is unable to secure the necessary investment in new buildings that could provide a better, safer, more economical environment. Key investment projects required over the coming years include improvements to maternity and A&E services, and are critical to support the reconfiguration approved in the Health for north east London programme. These investments will be secured in the context of the merger.

1.7 The long term financial future

As noted above, the financial benefits afforded by the Merged Trust are critical to the future of the three trusts and, in particular, to NUHT and WCUHT, which are not financially viable on their own and face the significant risk of entering the NHS failure regime.

WCUHT and NUHT require cash funding in order to resolve current financial difficulties. BLT needs to find £144 million of savings over the next five years to be viable. If the Trusts do not merge, WCUHT and NUHT will need to make significant savings in patient services and care, and are projected to have a combined deficit of £38 million by 2017 (even if funding can be found to resolve the current cash requirement).

This solution to the long term financial viability of services across all three Trusts is necessary and urgently needed to put the local health system on a secure footing, safeguarding high quality, locally accessible health care for the people of north east London.

Under a set of downside assumptions, further work would be required to identify internal mitigations to maintain financial stability. Should sufficient internal opportunities to secure additional efficiencies and reduction in expenditure at an individual department and service line level not be found, it is possible that service reconfiguration would be required. However, it is important to note that there are no current plans to make any service reconfigurations as part of the merger. Any service reconfiguration that proved to be necessary at a later date, would be subject to statutory consultation on this topic.

1.8 The integration roadmap

In light of the learning from other mergers, careful consideration has been given to designing the proposed integration journey. In addition to ensuring the engagement of the clinical leadership from the outset, a pragmatic approach has been adopted to ensure integration is achieved early and quickly whilst minimising any disruption. Three distinct phases have been identified and planned for

- Year 1 will focus on integration and the move from three leadership and management structures to one integrated team in order to maintain clinical, operational and financial control and deliver early merger benefits
Executive summary

- By Year 2 the functional integration programmes will be completed and the focus will turn to service improvement, and delivery of the clinical and patient experience improvements and financial benefits of the merger.
- From Year 3 onwards, the new organisation will enter a period of transformation including larger scale pathway redesign informed by the finalised clinical strategy.

This phased approach of integration, improvement and transformation takes into account that the new organisation will face a number of significant challenges alongside merger. In addition to maintaining business as usual, the three existing Trusts are currently managing a number of major developments, including the completion and opening of new PFI facilities.

A significant amount of work to prepare for integration has already been achieved. The programme team acknowledges, however, that there is still more to do. Funding support for additional of additional resources has been identified to support the step up in pace required to plan and manage the integration, whilst retaining sufficient capacity to maintain a clear focus on continuing to deliver safe, high quality patient care.

1.9 Securing support and approval

It is vitally important that the merger is developed with local partners and the diverse communities of north east London if the Merged Trust is to deliver a step change in the health of local people within a generation. Throughout the preparation for merger, the future organisational design and transition plans have been developed as part of an ongoing engagement process with a range of stakeholders.

This has included clinical workshops with hundreds of clinicians from across the three Trusts, more than 100 meetings with MPs, local authority officers, councillors, commissioners, other NHS Trusts, the voluntary sector and the public; and a series of road shows for staff, patients and the public which have taken place between August and November 2011.

More than 200 responses were received via meetings and events, road-shows and in letters and other communications, and the feedback has informed the development of the FBC and the integration plans for the Merged Trust.

Prior to approval, this FBC will be formally reviewed by NHS London, commissioning partners, wider stakeholders and the Competition and Co-operation Panel to ensure that it is robust and fits with the wider market intentions across London. The key dates for approval are set out in the table below:

<table>
<thead>
<tr>
<th>Table 1: FBC approval timetable</th>
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</thead>
<tbody>
<tr>
<td>Approval required</td>
</tr>
<tr>
<td>Integration Board sign off</td>
</tr>
<tr>
<td>NUHT Board decision making</td>
</tr>
<tr>
<td>WCUHT Board decision making</td>
</tr>
<tr>
<td>BLT Board sign decision making</td>
</tr>
<tr>
<td>NHS ONEL board formal consideration</td>
</tr>
<tr>
<td>NHS ELC board formal consideration</td>
</tr>
<tr>
<td>CMG approval</td>
</tr>
<tr>
<td>NHS London Board decision making</td>
</tr>
<tr>
<td>Department of Health Transaction Board and subsequent consideration by the Secretary of State</td>
</tr>
</tbody>
</table>

The merger programme team and ultimately the Merged Trust will continue to listen to and engage with stakeholders prior to Day 1 and beyond.
1.10 Conclusion

This FBC presents a strong case for the merger between BLT, NUHT and WCUHT. The clinical benefits described will reduce health inequalities, improve the health of the population and improve the quality of services provided to the local population.

The merger will mitigate against the risk that WCUHT and NUHT will fail financially and will provide a solution to the long term financial viability of services across all three Trusts. This will ensure the local health system is secure and resilient, and will safeguard high quality, locally accessible health services for the population of north east London.

This merger offers a once in a lifetime opportunity to change the face of healthcare in north east London, to improve the health of East Londoners and to provide world class, patient-centred healthcare.
2. Introduction

**Synopsis**
This Chapter provides an overview of the purpose and structure of the FBC document.
- Section 2.1 sets out the purpose of the document
- Section 2.2 provides an overview of the information included within the FBC, further information that is provided in supporting documentation, and detail of the plans and strategies that will follow at a later date
- Section 2.3 sets out the structure of the document.

2.1 Purpose of this document
This document is a Full Business Case (FBC) for the statutory merger of Barts and The London NHS Trust (BLT), Newham University Hospital NHS Trust (NUHT) and Whipps Cross University Hospital NHS Trust (WCUHT).

This document builds upon the proposals set out in the OBC (approved by NHS London on 4 August 2011), providing further details on the case for change, the vision and strategy for the new organisation, its organisational structure and governance arrangements. It also details how the transition will be undertaken and how the new organisation will operate at key points during the transition programme.

This FBC demonstrates that a merged organisation will be better placed than the three existing entities to respond to health needs and demographic growth, commissioner intentions, quality improvement priorities, and financial constraint.

2.2 The FBC and supporting documentation
In comparison to the OBC, which set out the initial case for change, this FBC describes in greater detail how this merger will be delivered in an effective and sustainable way. It describes how the Merged Trust will be structured from the Board to the ward including how the executive directors and their directorates will operate to support the work of the CAGs, collectively helping to drive innovation and improvement.

Using a long-term financial model, this FBC demonstrates how the Merged Trust will achieve and sustain financial viability in the context of the challenging financial climate and the ongoing need for investment in infrastructure.

It also demonstrates how a timely integration of BLT, NUHT and WCUHT will be achieved whilst at the same time safeguarding patient safety and high quality care throughout. This is set out in the clinical and corporate workstream plans; the organisational development plan; the performance management framework, and risk management and programme management arrangements.

Underpinning this FBC is a suite of strategies and working papers which has been developed by the clinical and corporate workstreams during the integration planning phase. These documents are set out in the table below and provide further detail to the FBC. For example, detailed organisational development plans set out in the OD and HR Strategy are not replicated in the FBC but are referenced.
### Table 2: FBC supporting documentation

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draft Organisational Development and HR Strategy</td>
<td>Sets out the planned interventions to facilitate organisational change and ensure organisational effectiveness.</td>
</tr>
<tr>
<td>Draft Communications and Engagement Strategy</td>
<td>Sets out the approach to internal and external stakeholder communication and engagement.</td>
</tr>
<tr>
<td>Initial Equality Impact Screening of the Outline Business Case</td>
<td>An equality impact analysis of the merger proposals at the outline business case stage.</td>
</tr>
<tr>
<td>Equality and Diversity Guidance for CAG and Corporate Services</td>
<td>This paper provides CAGs and corporate workstreams with specific guidance and recommendations for their equality and diversity obligations linked to the findings and recommendations within the Equality Impact Assessment of the Outline Business Case.</td>
</tr>
<tr>
<td>Clinical Academic Group (CAG) Improving patient experience guidance</td>
<td>Early discussions have confirmed a commitment to put improving patient experience at the heart of the Trust’s priorities. This document begins to set out what this will mean for each CAG, and how the Trust as a whole will support this agenda through the development and delivery of a Patient Promise.</td>
</tr>
<tr>
<td>Draft Patient Experience Strategy</td>
<td>Sets out the strategy and improvement plan for ensuring that patients’ and carer’s experience exceeds their expectations.</td>
</tr>
<tr>
<td>Long Term Financial Model</td>
<td>Sets out the financial viability of the Trust over a five year period.</td>
</tr>
<tr>
<td>Clinical Academic Group strategy and integration plan documents</td>
<td>A pack for each of the eight CAGs which incorporates for each CAG, the planned strategic objectives, clinical benefits, critical success factors, and standardisation opportunities.</td>
</tr>
<tr>
<td>Transition Project Plans</td>
<td>A suite of detailed plans showing the steps and milestones within each corporate and clinical workstream which will need to be delivered for day one and for the first year of operation.</td>
</tr>
<tr>
<td>Draft Board and Sub Committee Terms of Reference</td>
<td>Sets out the objectives, scope, membership, responsibilities and working practices of the Board and its Sub Committees.</td>
</tr>
<tr>
<td>Heads of Terms for the Merger</td>
<td>Sets out how ‘headline issues’ will be managed.</td>
</tr>
<tr>
<td>Outline Business Case (OBC) summary prospectus; “A vision of future healthcare for local people”</td>
<td>The prospectus gives details of the proposed merger and invites comment from the 26,000 recipients across all areas of the community.</td>
</tr>
<tr>
<td>Health and healthcare benefits prospectus</td>
<td>Examples to show the broad range of improvements that could be made if the trusts were to merge</td>
</tr>
<tr>
<td>Draft staff engagement strategy</td>
<td>This document outlines the extensive staff engagement programme which is a key component of the Organisational Design Strategy.</td>
</tr>
<tr>
<td>Roadshow Reports</td>
<td>A brief paper outlining the number of roadshows undertaken as one aspect of the communications and engagement programme. The paper includes information on the stakeholder groups and the numbers engaged.</td>
</tr>
<tr>
<td>Event Reports</td>
<td>Event reports have been produced for each of the large stakeholder sessions undertaken. The reports include the format of the day, feedback received from attendees such as GPs, councillors, LINk members, patient representatives and members of parliament. The materials and presentations used are also included as are delegate lists.</td>
</tr>
<tr>
<td>Formal views on the proposed merger from each of the commissioning clusters in north east London</td>
<td>NHS East London and the City and NHS Outer north east London will each take a formal view of the Full Business Case following an assurance process undertaken in conjunction with NHS London. Formal views from each commissioning cluster will be available following their extraordinary meetings on 8 December 2011.</td>
</tr>
<tr>
<td>Formal views of key stakeholders</td>
<td>All feedback received on the proposal to merge has been included in the communications and engagement section within the FBC but is non-attributable to individuals or organisations. This paper outlines the approach undertaken to gather views, the key themes resulting from this engagement and how the three trusts have responded. All formal responses to the proposal to merge have been documented within this report.</td>
</tr>
</tbody>
</table>
It should be noted that a number of plans are yet to be developed and are therefore not referenced as part of the FBC or set out within the supporting documentation. These include:

1. **A five year Clinical Strategy** – Each CAG has developed a clinical vision and strategic objectives which underpin the Merged Trust’s proposed vision and strategic outcomes. These, along with detailed integration plans, will inform the CAG business plans for Year 1 and will be developed further to form a five year Clinical Strategy for the merged organisation. The Clinical Strategy will be agreed early in Year 2 in line with the Trust’s plans for Foundation Trust preparation.

2. **A five year Estates Strategy** – the Merged Trust’s Estates Strategy must be informed by the requirements of the Clinical Strategy which will be finalised in Year 2. However, an initial review of the existing Trust’s Estates Strategies has already taken place to guide the Estates and Facilities Management operations during Year 1 and Year 2. The Merged Trust’s Estates Strategy will be finalised six months after the Clinical Strategy, but the detailed planning for estates utilisation, investments and disinvestments will take place in parallel with the development of the Clinical Strategy. Throughout Year 1 and Year 2 the capital programmes established under the existing Trusts will be maintained. The Merger will enable these plans to be delivered in a way potentially not achievable by the individual Trusts e.g. the capital development plans for the WCUHT estate in line with Health for north east London. It is unlikely that any new capital investment will be undertaken or any new contracts let in anticipation of changing estates and facilities management requirements brought about by the Clinical Strategy. Variance to this protocol will only be undertaken when all three Trusts are in prior agreement and there is a validated long term clinical need driving the requirement.

3. **A five year Informatics Strategy** – the pan-London contract with BT for the provision of the Cerner Millennium electronic patient record system (EPR) is due to expire in 2015. The choice of EPR is integral to the development of an Informatics Strategy for the Merged Trust as it will inform the required changes to all downstream systems. Coordinated work on EPR procurement options for Trusts across London has recently begun but it is anticipated that the general direction of travel will be known in January 2012. In preparation for the development of the Informatics Strategy a number of clinical engagement workshops will take place from November 2011 to ensure the clinical informatics needs of the organisation are fully understood. These requirements will be reviewed by the Informatics Steering Group at the end of December 2011 and integrated into the draft Informatics Strategy which will cover key aspects such as a single EPR system, consolidation and rationalisation of other systems and capital investment requirements. An overview of the draft strategy will be submitted to the transition executive in February 2012 and a full draft will be developed for consultation by the end of March 2012. A final Informatics Strategy will be signed off in June 2012.

4. **A Service Line Management (SLM) Plan** – there is a firm commitment to implementing service line management in the new organisation. SLM is a pre-requisite for achieving Foundation Trust status and enables organisations to understand the performance of individual specialist areas and manage them as distinct operational units. This approach enables services to be organised in a way that best supports clinical delivery for patients whilst also delivering efficiencies for the Trust. Development of service line reporting, which underpins service line management, will not be complete for Day 1 but is anticipated to be in place by the end of the Merged Trust’s first year of operation.
2.3 **Structure of this document**

The FBC is structured as follows:

- **Section 3** sets out the case for change, provides background information about the challenges facing the three Trusts and the health market in north east London
- **Section 4** describes the vision and strategy for the new organisation. It sets out how things will be different in the new organisation and provides a high level view of the stages of transition
- **Section 5** sets out the structure and governance of the new organisation and how the organisational vision and objectives will be delivered
- **Section 6** describes the clinical and financial benefits of the merger
- **Section 7** provides an overview of the financial viability of the new organisation for the period 2012/13 to 2016/17, through the long term financial model
- **Section 8** describes the communications and engagement activity that has taken place to date, the feedback received, and the actions taken in response
- **Section 9** describes how integration will be achieved, explaining the phases of transition, key activities and milestones, and how the merger process will be managed
- **Section 10** focuses on the timelines and approvals required for the merger, the key legal and regulatory aspects relating to the merger and the Foundation Trust authorisation process.
3. Background and the case for change

**Synopsis**

This chapter sets out the case for change for the merger between BLT, WCUHT and NUHT, and explains why a change is needed in North East London.

East London has a legacy of historical deprivation and displays some of the worst health outcomes and health inequalities in the country. At the same time population growth of 16.5% over the next 10 years is anticipated, putting significant pressure on already stretched services.

Additional activity increases are expected in emergency and maternity services at NUHT and WCUHT resulting from the Health for North East London programme. At the same time, commissioner intentions include a significant shift in activity out of hospitals to community settings.

Unless the Trusts are able to flex and scale their services it will be very challenging to respond to these agendas.

Across the three Trusts there are pockets of excellent performance but no one trust displays excellence and the highest level of outcomes across all areas of operational performance, productivity, quality, and patient experience.

Workforce pressures affect all three organisations and in particular NUHT and WCUHT. Challenges include recruiting and retaining staff, dependence upon temporary and high cost agency staff, and therefore problems in staffing and sustaining high quality services 24 hours a day, 7 days a week.

The financial challenges are also significant. Only BLT is financially viable as an independent entity in the long-term. The financial challenges facing NUHT and WCUHT are of a scale that is likely to result in one or both of them being placed in the NHS failure regime. All three Trusts face infrastructure challenges, particularly in relation to information systems, aging technology and estates.

It is in no-one’s interest if both WCUHT and NUHT enter the failure regime. BLT too, as a major tertiary services provider has a strong interest in ensuring that its partner District hospital services are financially sound, organisationally stable, and provide high quality clinical services.

This merger offers a once in a generation opportunity to change the face of healthcare in East London and the lives of residents, including; a viable financial future for NUHT and WCUHT; early investment in badly needed new facilities; more specialist services available locally for patients, improvements to the health of East Londoners, the ability to attract the highest calibre of staff, as well as first class research and education.

- Section 3.1 describes the health needs of the local population and the health inequalities
- Section 3.2 explains how commissioner intentions will provide a challenge to the Trusts’ activity levels in the short term
- Section 3.3 describes the variability of the existing Trusts’ performance against key measures of operational delivery, quality, productivity and patient experience
- Section 3.4 describes the key workforce challenges facing the Trusts
- Section 3.5 sets out the historical financial challenges experienced by the Trusts and the future pressures from essential investments to maintain and upgrade infrastructure
- Section 3.6 provides an overview of why the merger offers the best response to the above challenges. The detail of how the new organisation will respond is covered further in subsequent chapters
- Section 3.7 explains how the proposed merger will not adversely affect choice and competition in the healthcare market or patient choice.
The OBC for this merger considered the options available to address the health needs of the population in north east London in an effective and sustainable way. It concluded that the preferred option was a three way merger between BLT, NUHT and WCUHT.

This section of the FBC revisits the reasons why a change is needed in north east London. It acts as a frame of reference for the rest of the document and sets out why the merger offers the right solution. It summarises the challenges that are facing the three trusts, in particular: the changing healthcare needs of the population; variations in the standards of care; and the need to deliver services within much tighter financial constraints.

There are many examples of excellence across each of the three Trusts. For example, NUHT is nationally recognised as a leader in diabetes services; WCHUT delivers one of the most successful colorectal services in the country; the Royal London Hospital is an international leader in trauma care and provides one of the largest renal services in Europe, including transplantation; the cardiology service across Barts and the London Chest Hospital at BLT is a leader in the field of cardiology care and is an accredited Biomedical Research Unit, and Barts is a leader in cancer treatments and research.

All three Trusts face significant challenges to sustain and develop excellence in healthcare, and the case for change has been considered across the themes of:

- Health needs of the local population
- Commissioner intentions and activity
- Operational performance and quality
- Workforce
- Finance and infrastructure

These drivers of change set the context for the merger case and why the Merged Trust has been proposed as a solution to the current challenges.

The remainder of the FBC document seeks to demonstrate how the merger can meet the challenges and exploit the strengths of the three individual trusts.

### 3.1 Health needs and health inequalities

North east London has a uniquely diverse and culturally-rich community. However, it is steeped in a legacy of historical deprivation and consequently it displays some of the worst health outcomes and health inequalities in the country. The following section demonstrates how particular social, economic and demographic factors manifest themselves in high levels of health needs and how this poses unique challenges to local acute healthcare providers.

#### 3.1.1 Health inequalities, poverty and deprivation

The people who live in north east London have poorer health, and a shorter lifespan than those living in other parts of London and in many other parts of England, as illustrated by Table 1. For example, in comparison to the England averages:

- Life expectancy for men and women in Newham, Tower Hamlets and Waltham Forest is significantly below average, with above average rates of premature deaths from cardiovascular disease. Tower Hamlets has significantly worse survival rates for cancer, one year after diagnosis. This is most probably due to relatively late presentation and diagnosis
- The rate of infant mortality in Newham is above the average
- Rates of smoking related deaths in Newham and Tower Hamlets are significantly above average
• Rates of diabetes are significantly above average across Waltham Forest, Tower Hamlets and Newham.

• Rates of new cases of tuberculosis are significantly above average, especially in Newham.

### Table 3: Selected measures of health for north east London population

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Notes</th>
<th>Newham</th>
<th>Tower Hamlets</th>
<th>Waltham Forest</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy (males)</td>
<td>1</td>
<td>76.2</td>
<td>76.0</td>
<td>77.1</td>
<td>78.3</td>
</tr>
<tr>
<td>Life expectancy (females)</td>
<td>1</td>
<td>80.5</td>
<td>80.9</td>
<td>81.6</td>
<td>82.3</td>
</tr>
<tr>
<td>Infant deaths</td>
<td>2</td>
<td>5.3</td>
<td>4.4</td>
<td>4.7</td>
<td>4.71</td>
</tr>
<tr>
<td>Deaths from smoking</td>
<td>3</td>
<td>251.0</td>
<td>306.5</td>
<td>229.6</td>
<td>216</td>
</tr>
<tr>
<td>Early deaths: heart disease and stroke</td>
<td>3</td>
<td>116.9</td>
<td>113.6</td>
<td>90.3</td>
<td>70.5</td>
</tr>
<tr>
<td>Early deaths: cancer</td>
<td>3</td>
<td>118.1</td>
<td>141.4</td>
<td>113.2</td>
<td>112.1</td>
</tr>
<tr>
<td>People diagnosed with diabetes</td>
<td>4</td>
<td>7.0</td>
<td>6.1</td>
<td>5.5</td>
<td>5.4</td>
</tr>
<tr>
<td>New cases of TB</td>
<td>5</td>
<td>120</td>
<td>63</td>
<td>47</td>
<td>15</td>
</tr>
</tbody>
</table>

**Key:**
- Significantly worse than the England average
- Not significantly worse than the England average
- Significantly better than the England average

**Notes**
1. At birth 2007 - 2009
2. Rate per 1000 live births 2007 - 2009
3. Per 100,000 population aged 35 +, directly age standardised rate 2007-2009
4. % of people on GP registers with a recorded diagnosis of diabetes 2009/10
5. Crude rate per 100,000 population 2007-2009

*Source: Association of Public Health Observatories, Health Profiles, July 2011*

Levels of deprivation across all three boroughs are significantly above average, as are measures for children in poverty, violent crime and long term unemployment, as shown in Table 2.

### Table 4: Indicators of deprivation within the catchment of the Merged Trust

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Notes</th>
<th>Newham</th>
<th>Tower Hamlets</th>
<th>Waltham Forest</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation</td>
<td>1</td>
<td>86.1</td>
<td>78.5</td>
<td>53.9</td>
<td>19.9</td>
</tr>
<tr>
<td>Children in poverty</td>
<td>2</td>
<td>42.6</td>
<td>57</td>
<td>34.3</td>
<td>20.9</td>
</tr>
<tr>
<td>Statutory homelessness</td>
<td>3</td>
<td>1.02</td>
<td>7.94</td>
<td>3.11</td>
<td>1.86</td>
</tr>
<tr>
<td>Violent Crime</td>
<td>4</td>
<td>90.7</td>
<td>27.3</td>
<td>26.4</td>
<td>15.8</td>
</tr>
<tr>
<td>Long term unemployment</td>
<td>5</td>
<td>11.8</td>
<td>13.6</td>
<td>8.7</td>
<td>6.2</td>
</tr>
</tbody>
</table>

**Key:**
- Significantly worse than the England average
- Not significantly worse than the England average
- Significantly better than the England average

**Notes**
1. % of people in this area living in 20% most deprived areas in England 2007
2. % children in families receiving means-tested benefits & low income 2008
3. Crude rate per 1,000 households 2009/10
4. Recorded violence against the person crimes crude rate per 1,000 population 2009/10
5. Crude rate per 1,000 population aged 16-64, 2010

*Source: Association of Public Health Observatories, Health Profiles, July 2011*

Levels of housing need are also significant with above average homelessness in Tower Hamlets and Waltham Forest. The acute housing shortage is evidenced by the overcrowding rates set out in Table 5. Across Tower Hamlets, Newham and Waltham Forest, 24% of households are rated as overcrowded, meaning there is at least one room too few for the number of people residing in the dwelling. This compares adversely to the London average of 17% and the England average of 7%. Overcrowding is one of the key factors behind the above average rates of TB illustrated previously in Table 1.
Background and the case for change

Table 5: Rates of housing overcrowding within the catchment of the Merged Trust

<table>
<thead>
<tr>
<th>Area Name</th>
<th>All households</th>
<th>Average household size</th>
<th>Average number of rooms per household</th>
<th>Households - with an occupancy rating of -1 or less</th>
<th>Percentage of households rated as overcrowded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Hamlets</td>
<td>78,530</td>
<td>2</td>
<td>4</td>
<td>22,984</td>
<td>29%</td>
</tr>
<tr>
<td>Newham</td>
<td>91,821</td>
<td>3</td>
<td>4</td>
<td>24,151</td>
<td>26%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>89,788</td>
<td>2</td>
<td>5</td>
<td>14,408</td>
<td>16%</td>
</tr>
<tr>
<td>Total</td>
<td>260,139</td>
<td>2</td>
<td>4</td>
<td>61,543</td>
<td>24%</td>
</tr>
<tr>
<td>London</td>
<td>3,015,997</td>
<td>2</td>
<td>5</td>
<td>522,471</td>
<td>17%</td>
</tr>
<tr>
<td>England</td>
<td>20,451,427</td>
<td>2</td>
<td>5</td>
<td>1,457,512</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: GLA census key statistics, 2001

A further indicator of deprivation is the proportion of children eligible for free school meals, as shown in Table 6. Across the catchment, 41% of children are eligible for free school meals, compared to 23% pan London, and 13% across England as a whole.

Table 6: Secondary school children eligible for and taking free school meals 2009

<table>
<thead>
<tr>
<th>Area Name</th>
<th>Number on roll</th>
<th>Number of pupils taking free school meals</th>
<th>Percentage taking free school meals</th>
<th>Number of pupils known to be eligible for free school meals</th>
<th>Percentage known to be eligible for free school meals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newham</td>
<td>18,610</td>
<td>5,548</td>
<td>30%</td>
<td>7,479</td>
<td>40%</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>14,500</td>
<td>6,315</td>
<td>44%</td>
<td>8,077</td>
<td>56%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>13,890</td>
<td>2,747</td>
<td>20%</td>
<td>3,526</td>
<td>25%</td>
</tr>
<tr>
<td>Total</td>
<td>47,000</td>
<td>14,610</td>
<td>31%</td>
<td>19,082</td>
<td>41%</td>
</tr>
<tr>
<td>LONDON</td>
<td>447,630</td>
<td>80,940</td>
<td>18%</td>
<td>101,040</td>
<td>23%</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>3,278,130</td>
<td>338,320</td>
<td>10%</td>
<td>438,860</td>
<td>13%</td>
</tr>
</tbody>
</table>

Source: Department for Children, schools and Families, 2011

Poverty and deprivation, lower educational status, poor housing, and worklessness are all associated, individually and in combination, with poor health status. All are endemic in north east London, where local people experience, on average, relatively poor health and life chances.

In recent years, local Primary Care Trusts have strived to deliver health improvement programmes to the population through interventions such as smoking cessation and disease specific screening. However, such interventions have been only partially successful with below average take up rates. At the same time relatively high emergency admission rates for people with long term health conditions (e.g. heart disease, diabetes, and respiratory disease) indicate that local services need to work more effectively in partnership to provide the packages of health care which will improve health as well as reduce preventable hospital admissions.

3.1.2 New entrants, population churn and population growth

In addition to the endemic underlying causes of potentially preventable ill health and premature mortality, north east London has traditionally been the home of many new entrants to the UK, who often arrive with limited resources and a range of health and social challenges. There is also a pattern of movement to the suburbs or out of London for those who become more affluent, with their places then taken by further new entrants. Thus, whilst local services and public health programmes may be successful in improving health, this will not always follow through in terms of measurable reductions in local health inequalities.

The scale of local population movement also places limits on the continuity of care which is especially important for the effectiveness of health improvement programmes, and for the
Background and the case for change

care of people with long term conditions. In 2010/11, GP registers recorded a total population turnover rate of 31.2% across inner north east London as shown in Table 7.

Table 7: Population churn and net population growth 2010/11

<table>
<thead>
<tr>
<th>PCT</th>
<th>Additions</th>
<th>Removals</th>
<th>List Size</th>
<th>Net Change</th>
<th>% Net Change</th>
<th>Turnover</th>
<th>Turnover Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Hamlets</td>
<td>49,462</td>
<td>39,208</td>
<td>258,790</td>
<td>10,254</td>
<td>4.0%</td>
<td>88,670</td>
<td>34.3%</td>
</tr>
<tr>
<td>City &amp; Hackney</td>
<td>37,546</td>
<td>34,352</td>
<td>261,469</td>
<td>3,194</td>
<td>1.2%</td>
<td>71,898</td>
<td>27.5%</td>
</tr>
<tr>
<td>Newham</td>
<td>60,197</td>
<td>49,721</td>
<td>347,211</td>
<td>10,476</td>
<td>3.0%</td>
<td>109,918</td>
<td>31.7%</td>
</tr>
<tr>
<td>Total</td>
<td>147,205</td>
<td>123,281</td>
<td>867,470</td>
<td>23,924</td>
<td>2.8%</td>
<td>270,486</td>
<td>31.2%</td>
</tr>
</tbody>
</table>

Source: Newham, City and Hackney and Tower Hamlets GP registers 2010/11

An added pressure for local acute healthcare providers is the forecast 16.5% growth in the catchment population by 2021, as shown in Table 8. This growth will be driven by a combination of factors including the number of births exceeding deaths, and continuing new arrivals into the area, driven in part by the housing development within the Thames Gateway. Additionally, individuals and families will continue to move to north east London due to the fact that it is relatively cheaper than other parts of Greater London.

Table 8: Greater London Authority Population Growth Forecasts 2011 to 2021

<table>
<thead>
<tr>
<th></th>
<th>Newham</th>
<th>Tower Hamlets</th>
<th>Waltham Forest</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>268,854</td>
<td>254,246</td>
<td>232,726</td>
<td>755,826</td>
</tr>
<tr>
<td>2021</td>
<td>318,242</td>
<td>312,396</td>
<td>249,875</td>
<td>880,513</td>
</tr>
<tr>
<td>% Change</td>
<td>18.4%</td>
<td>22.9%</td>
<td>7.4%</td>
<td>16.5%</td>
</tr>
</tbody>
</table>


Linked to the population growth rates, the catchment population is younger than in other parts of London, with a relatively higher birth rate, as illustrated by Figure 1. This profile places a high demand on children's and maternity services. For example in Newham 10.2% of the population are under 5 years of age.

Figure 1: Age profile of Tower Hamlets, Newham and Waltham Forest boroughs

Source: GLA Data 2011

Forecasts suggest that the younger age profile of the catchment will continue into the future, although in certain areas such as Waltham Forest, forecasts are anticipating an increase in number of residents over the age of 65. This will have implications for local acute services as
older people are generally higher users of healthcare who tend to have multiple and complex needs.

3.1.3 Diversity within north east London

The population of north east London is one of the most diverse in the country. Of the three boroughs, Newham is the most ethnically diverse with 70.2% of the population coming from a black and minority ethnic (BAME) background against a Greater London average of 34.3%.

Table 9: Ethnic Diversity of the Merged Trust’s catchment population

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Chinese and Other Asian</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Tower Hamlets 53.3% 6.3% 32.4% 5.1% 2.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waltham Forest 57.5% 20.0% 13.7% 5.0% 3.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Newham 29.8% 25.6% 32.9% 6.4% 5.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Greater London 65.7% 13.9% 11.5% 4.8% 4.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021 (including increase / decrease from 2011)</td>
<td>Tower Hamlets 53.9% (0.6%) 5.9% (-0.4%) 30.8% (-1.6%) 6.0% (0.9%) 3.5% (0.5%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waltham Forest 54.4% (-3.1%) 21.0% (1.0%) 14.4% (0.7%) 5.7% (0.7%) 4.5% (0.8%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Newham 27.2% (-2.6%) 25.9% (0.2%) 33.7% (0.9%) 7.0% (0.6%) 6.1% (0.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Greater London 63.0% (-2.7%) 14.7% (0.8%) 12.2% (0.7%) 5.3% (0.5%) 4.8% (0.8%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: GLA Data 2011

The proportion of state school pupils who speak English at home varies markedly between the outer north east London borough of Waltham Forest where 56.8% speak English at home and the inner north east London boroughs of Tower Hamlets and Newham where the rate is just 24.1% and 30.2% respectively, as shown by Table 10. With more than 150 languages spoken within the catchment, and with a substantial proportion of the population not speaking any English, providing accessible healthcare tailored to the particular needs of diverse communities can be both challenging and complex.

Table 10: Proportion of state school children who speak English at home

<table>
<thead>
<tr>
<th>Languages spoken at home by state school pupils</th>
<th>Greater London</th>
<th>Newham</th>
<th>Tower Hamlets</th>
<th>Waltham Forest</th>
</tr>
</thead>
<tbody>
<tr>
<td>English/Believed to be English</td>
<td>60.5</td>
<td>30.2</td>
<td>24.1</td>
<td>56.8</td>
</tr>
<tr>
<td>Other</td>
<td>39.5</td>
<td>69.8</td>
<td>75.9</td>
<td>43.2</td>
</tr>
</tbody>
</table>

Source: ONS Data 2010

Another perspective on the ethnic diversity of the catchment is the proportion of mothers who give birth who were themselves born outside the UK. Table 11 illustrates that the catchment has a far higher proportion of mothers born outside the UK than the London and England average (69%).
Diversity poses significant challenges for healthcare providers. BAME communities may have problems in accessing healthcare with factors such as language, culture and the attitudes of healthcare professionals compromising their likelihood of receiving the care they need.

In turn, barriers to accessing healthcare can mean that when patients present to health services, they are sicker than they might otherwise have been.

In addition, BAME communities often report relatively poor health. The 2001 census showed that minority groups are more likely to report their health as “not good”. This has been shown to correlate with use of health services and may explain the apparently high demand for acute services. Additionally, certain ethnic groups are known to be more pre-disposed to certain illnesses. For example death rates for coronary heart disease for those born in the Indian sub-continent and living in England are 38% higher for men and 43% higher for women than rates for the country as a whole. This is in addition to a pre-disposition to specific long term health conditions such as sickle cell anaemia and thalassaemia.

Ethnic diversity across the three boroughs is projected to increase markedly between 2011 and 2021. The increase will be particularly seen in Waltham Forest where the white population is set to decrease by 3.1% compared to a Greater London average decrease of 2.7%. This diversity will require healthcare providers to be aware of, and responsive to, the differing needs of ethnic groups.

In view of the challenges posed by diversity, levels of deprivation and demographic change, plus the impact these factors have on health inequalities, the NHS needs to change to provide new models of service delivery in north east London, with clinical pathways and services that take full account of the unique needs of local patients. If progress is to be made in reducing health inequalities and improving the health of the population as a whole, due regard must be given to promoting equalities, diversity and human rights.

Although it is recognised that addressing health inequalities will continue to be an intrinsically difficult process, it is one which will be most effectively approached in partnership with local health, social care, local government and community partners. The Merged Trust is determined to seize these opportunities and Chapter 4 provides further information concerning how this will be taken forward.

### Table 11: Mothers within the Merged Trust’s catchment born outside the UK, 2010

<table>
<thead>
<tr>
<th>Area of usual residence of mother</th>
<th>Mothers born within the UK</th>
<th>Mothers born outside the UK</th>
<th>EU</th>
<th>Rest of Europe (non EU)</th>
<th>Middle East and Asia</th>
<th>Africa</th>
<th>Rest of World</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newham</td>
<td>24%</td>
<td>76%</td>
<td>20%</td>
<td>2%</td>
<td>49%</td>
<td>25%</td>
<td>4%</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>34%</td>
<td>66%</td>
<td>11%</td>
<td>3%</td>
<td>67%</td>
<td>13%</td>
<td>6%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>37%</td>
<td>63%</td>
<td>32%</td>
<td>7%</td>
<td>29%</td>
<td>25%</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>31%</td>
<td>69%</td>
<td>21%</td>
<td>4%</td>
<td>48%</td>
<td>22%</td>
<td>5%</td>
</tr>
<tr>
<td>LONDON</td>
<td>44%</td>
<td>56%</td>
<td>24%</td>
<td>6%</td>
<td>32%</td>
<td>28%</td>
<td>10%</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>74%</td>
<td>26%</td>
<td>29%</td>
<td>4%</td>
<td>36%</td>
<td>22%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Source: ONS data, 2010

### 3.2 Policy context and commissioner intentions

At a national level, the Government White Paper ‘Equity and Excellence: Liberating the NHS’ (July 2010) set an agenda for the NHS to deliver efficiency savings of £20bn by 2014 to meet the current financial challenge and the future costs of demographic and technological change. In addition to this financial challenge, the NHS will continue to be held to account against quality, safety and patient experience indicators.
At a pan London level, a number of developments have been implemented that centralise provision of the most specialist care. For example, eight hyper acute stroke centres have been established across London to provide specialist care to patients following a stroke. These are networked to 24 local stroke units to which patients are transferred following the acute phase of care to continue their recovery. Additionally, four major acute trauma centers have been established in the capital with one situated at the Royal London Hospital. The concentration of certain acute specialties in specialist centres such as these achieves a critical mass of patients, expertise and resources and enables improved access to high quality care in the most appropriate setting. The stroke and trauma changes have already demonstrated improvements in patient outcomes.

Commissioner organisations in London, as elsewhere, are in a state of transition with the move to clinical commissioning groups being planned. However, a firm objective of local commissioners, as set out in their Commissioning Strategic Plans (CSPs), is to achieve significant changes in the way care is delivered to patients, with more patients seen in outpatient and community based settings. Plans include:

- Improving access to primary care as well as access to specialist assessments and screenings in a primary care setting
- Reducing attendances in Accident & Emergency departments and unscheduled admissions, through extending primary care access (such as through out-of-hours services), creating alternative care pathways and integrating case management of patients with long-term conditions
- Better management of delayed discharges from hospital including the use of hospital care at home programmes; community rehabilitation services; and intermediate care teams
- Reducing follow-up activity in secondary care where clinically indicated, providing it closer to home through primary or community care
- De-commissioning procedures with limited or questionable indication of clinical value.

For the three Trusts involved in this merger, this means significant and imminent reductions in activity (and the implications on workforce, estates and economies of scale) and the need to re-design care pathways to achieve more high quality, patient focussed and efficient care.

At the same time however, whilst a reduction in activity for the three Trusts is planned in some areas, in other areas, significant growth is anticipated, for example in maternity and A&E services. This growth is linked both to the planned reconfiguration of services as part of the Health for north east London programme, recently approved by the Secretary of State, and to the need in the longer term, for acute services in north east London to meet the health needs of a diverse and deprived population which is forecast to grow significantly in number. This will require resilient and viable local services.

In order to respond to the policy context and local commissioning intentions, trusts must be flexible and able to scale their organisations appropriately. The Merged Trust will form one of the largest trusts in Europe which will be equipped with cutting edge facilities fit for delivering the highest quality healthcare in the 21 Century. Its combined service portfolio and strong partnerships with primary and social care will offer end to end pathways of care across community, general acute, and specialist services. Its size and scale, will enable greater flexibility to respond to current commissioning plans, as well as to meet and adapt to future changes and priorities as these arise.

### 3.3 Operational performance and quality

Amongst the three Trusts there are some excellent examples of leading practice and quality. For example, NUHT is amongst the top 20% nationally for some aspects of patient experience measured by the national patient survey and BLT provides area-wide services.
such as the Hyper Acute Stroke Unit (HASU) and a major trauma centre. The diabetes service at NUHT and the colorectal service at WCUHT are amongst the best in the country.

However, whilst each Trust can demonstrate good performance in discrete areas, none has shown consistent performance to the highest standards across all departments.

There are a number of fundamental structural, resource and service challenges that are affecting the quality of services across the three Trusts.

3.3.1 Operational delivery

Table 12 below illustrates the variability of operational performance amongst the three Trusts and in comparison to the national average. Against key metrics such as elective inpatient waiting times, cancer and A&E waits, the Trusts individually demonstrate both above average and below average performance.

### Table 12: Key operational metrics across the three trusts

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Metric</th>
<th>Period</th>
<th>BLT Value</th>
<th>NUHT Value</th>
<th>WCUHT Value</th>
<th>National Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE01</td>
<td>Median wait for elective inpatient treatment (weeks)</td>
<td>Apr-11</td>
<td>6.9</td>
<td>4.2</td>
<td>8.4</td>
<td>8.2</td>
</tr>
<tr>
<td>PE02</td>
<td>Diagnostic waits - % of patients waiting over 5 weeks</td>
<td>Q4 1011</td>
<td>2.5%</td>
<td>4.0%</td>
<td>1.2%</td>
<td>5.3%</td>
</tr>
<tr>
<td>PE03</td>
<td>Cancer waits - % seen within 14 days of GP referral to first outpatient appointment</td>
<td>Q4 1011</td>
<td>100.0%</td>
<td>97.6%</td>
<td>97.4%</td>
<td>96.0%</td>
</tr>
<tr>
<td>PE04</td>
<td>Cancer waits - % waiting less than 31 days from decision to treat to first treatment</td>
<td>Q4 1011</td>
<td>99.3%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.2%</td>
</tr>
<tr>
<td>PE05</td>
<td>Cancer waits - % waiting less than 62 days from GP referral to first treatment</td>
<td>Q4 1011</td>
<td>97.5%</td>
<td>91.7%</td>
<td>91.3%</td>
<td>86.5%</td>
</tr>
<tr>
<td>PE15</td>
<td>Mixed sex accommodation breach rate per 1000 FCEs</td>
<td>May-11</td>
<td>25.67</td>
<td>0.0</td>
<td>0.72</td>
<td>1.41</td>
</tr>
<tr>
<td>PE16</td>
<td>Cancellation of elective surgery per 1000 procedures for non clinical reasons</td>
<td>Q3 1011</td>
<td>13.6</td>
<td>3.5</td>
<td>6.4</td>
<td>10.6</td>
</tr>
</tbody>
</table>

Source: Acute Trust Quality Dashboard, summer 2011

All three Trusts demonstrate better than average performance with regards to the proportion of patients waiting more than 5 weeks for diagnostic appointments. This is also the case with regards to cancer 14-day, 31-day and 62-day waiting times and first treatment metrics.

However, whilst BLT and NUHT demonstrate better than average performance in relation to median waiting times, patients at WCUHT wait marginally longer than average for elective inpatient treatment.

In terms of mixed sex accommodation breach rates, both NUHT and WCUHT perform better than average, but the breach rate at BLT is far higher than average.

Cancellations of elective surgery also vary, with an above average rate of procedures cancelled at BLT than at NUHT and WCUHT, which both demonstrate better than average performance.

In respect of A&E operational performance, a sample month of September 2011 was examined, and Table 13 below also shows mixed performance. All Trusts fail to achieve the target for 95% of patients waiting 15 minutes or less for an initial assessment.

However, BLT performs favourably in respect of waiting times to treatment, with a median waiting time to treatment of 29 minutes. BLT’s performance against this measure falls well within the national performance threshold of 60 minutes but patients attending NUHT and WCUHT wait longer than this threshold.

With regards to the proportion of patients who leave A&E without being seen, both BLT and WCUHT demonstrate performance which is well within the national performance threshold of 5%. However, NUHT does not perform favourably against this measure, with 10% of patients leaving A&E without being seen.

Overall, all three Trusts during the month of September performed within the 4 hour performance threshold for the total time spent in A&E. It is recognised however that the three trusts have each struggled to achieve this target at specific times of significant pressure.
3.3.2  Productivity

Key measures of productivity also indicate variation across the three existing Trusts as shown in the table below.

Table 14: Key productivity metrics from across the three Trusts

<table>
<thead>
<tr>
<th>Measure of productivity</th>
<th>BLT</th>
<th>NUHT</th>
<th>WCHUT</th>
<th>London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Case Rate (1)</td>
<td>28%</td>
<td>16%</td>
<td>34%</td>
<td>32%</td>
<td>33%</td>
</tr>
<tr>
<td>Outpatient First-to-Follow-Up Ratio (2)</td>
<td>2.67</td>
<td>2.70</td>
<td>2.01</td>
<td>2.42</td>
<td>2.22</td>
</tr>
<tr>
<td>Outpatient DNA Rate (2)</td>
<td>14%</td>
<td>13%</td>
<td>14%</td>
<td>12%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Source: (1) HES Data 2010/11 (2) HES Data 2009/10

The day case rate at WCUHT is marginally better than the London and England averages. The day case rates at BLT and NUHT are below average.

Similarly, WCUHT demonstrates a better than average first to follow-up ratio for outpatient attendances in comparison to the London and England averages. The first to follow-up ratios for BLT and NUHT compare less favourably to the London and England averages.

The rate at which patients do not attend (DNA) outpatient appointments is higher than the London and England average at all three Trusts.

In addition, length of stay rates vary across the three Trusts; NUHT is in the top quartile nationally for length of stay performance. BLT and WCUHT perform in the third quartile nationally (see Appendix B for more information).

Table 15 below provides an illustration of productivity from the perspective of workforce sickness rates. The performance of the three Trusts against this metric is mixed. Midwifery sickness absence rates compare favourably against the national average, as do rates for ‘other’ staff groups which includes administrative staff. However, rates of sickness absence of nurses at NUHT compare unfavourably against the national average, in the same way as rates for medical staff at WCUHT.

Table 15: Sickness absence rates by staff group across the three Trusts

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Metric</th>
<th>Period</th>
<th>BLT Value</th>
<th>NUHT Value</th>
<th>WCHUT Value</th>
<th>National Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>OQ10</td>
<td>Workforce - sickness % - Medical</td>
<td>Mar-11</td>
<td>0.4%</td>
<td>0.9%</td>
<td>1.4%</td>
<td>1.1%</td>
</tr>
<tr>
<td>OQ11</td>
<td>Workforce - sickness % - Nurse</td>
<td>Mar-11</td>
<td>2.7%</td>
<td>5.7%</td>
<td>3.4%</td>
<td>4.1%</td>
</tr>
<tr>
<td>OQ12</td>
<td>Workforce - sickness % - Midwife</td>
<td>Mar-11</td>
<td>1.9%</td>
<td>4.3%</td>
<td>4.2%</td>
<td>4.4%</td>
</tr>
<tr>
<td>OQ13</td>
<td>Workforce - sickness % - Other</td>
<td>Mar-11</td>
<td>3.6%</td>
<td>3.3%</td>
<td>3.5%</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

Source: Acute Trust Quality Dashboard, summer 2011

3.3.3  Quality

There is also variable performance against key quality and safety metrics.

Patient safety

Table 16 sets out a number of patient safety metrics:

- NUHT and WCUHT achieve lower than average infection rates for MRSA and clostridium difficile, whereas BLT demonstrates infection rates which are higher than the national average
• The rate of patient safety incidents reported by WCUHT is lower than the national average, whereas the rate of incidents reported by BLT and NUHT are higher than other Trusts nationally

• The rate of written complaints made at NUHT and WCUHT is lower than the national average, whereas the rate of complaints at BLT is higher than the average figures nationally

• The rate of NHS Litigation Authority claims made at WCUHT and BLT is lower than and equal to the national average, whereas the rate of claims made at NUHT is higher than the national average.

Table 16: Key patient safety metrics across the three trust

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Metric</th>
<th>Period</th>
<th>BLT Value</th>
<th>NUHT Value</th>
<th>WCUHT Value</th>
<th>National Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>SG01</td>
<td>Rate of patient safety incidents reported in trusts per 100 admissions</td>
<td>Apr10 - Sept10</td>
<td>6.2</td>
<td>6.5</td>
<td>4.0</td>
<td>5.6</td>
</tr>
<tr>
<td>SG02</td>
<td>Rate of 'serious harm' patient safety incidents reported in trusts per 100 admissions</td>
<td>Apr10 - Sept10</td>
<td>0.8</td>
<td>0.1</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>SG05</td>
<td>HCAI - MRSA bacteraemia per 1,000,000 occupied bed days</td>
<td>Q3 2011</td>
<td>38.8</td>
<td>0.0</td>
<td>0.0</td>
<td>17.2</td>
</tr>
<tr>
<td>SG06</td>
<td>HCAI - c. diff bacteria rate per 100,000 occupied bed days</td>
<td>Q3 2011</td>
<td>12.7</td>
<td>1.1</td>
<td>8.9</td>
<td>8.4</td>
</tr>
<tr>
<td>OQ07</td>
<td>Rate of written complaints per 1,000 episodes</td>
<td>0910</td>
<td>8.6</td>
<td>4.3</td>
<td>4.3</td>
<td>4.7</td>
</tr>
<tr>
<td>OQ08</td>
<td>NHSLA claims per 10,000 bed days</td>
<td>0910</td>
<td>1.5</td>
<td>1.5</td>
<td>1.4</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Source: Acute Trust Quality Dashboard, summer 2011

Clinical effectiveness

Rates of hospital mortality are key measures of clinical effectiveness. In the recent publication of summary hospital-level mortality indicators (SHMIs) from the NHS Information Centre, both BLT and NUHT were in the top 14 of trusts given the highest banding score of three, awarded for the lowest ratio of deaths to expected deaths, with BLT showing the second lowest rate of all trusts nationally.

The Acute Trust Quality Dashboard produced for all Trusts echoes this strong performance, with below average mortality in relation to low risk procedures demonstrated by all three Trusts (as shown in Table 17).

Within the disease or treatment specific mortality rates (also shown in Table 17), there are however specific areas where mortality rates are higher than the national mean; myocardial infarction (MI) at all three Trusts; fractured neck of femur (NOF) at NUHT and WCUHT; diabetic emergencies at BLT and NUHT; and prenatual mortality at BLT and NUHT.

Table 17: Mortality ratios across the three Trusts

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Metric</th>
<th>Period</th>
<th>BLT Value</th>
<th>NUHT Value</th>
<th>WCUHT Value</th>
<th>National Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD03</td>
<td>Rate of hospital mortality per 1,000 episodes in low risk HRGs</td>
<td>RY Q3 1011</td>
<td>15.1</td>
<td>11.1</td>
<td>11.1</td>
<td>11.1</td>
</tr>
<tr>
<td>PD04</td>
<td>Rate of hospital mortality per 1,000 births (including still births)</td>
<td>RY Q3 1011</td>
<td>8.6</td>
<td>7.5</td>
<td>6.1</td>
<td>6.5</td>
</tr>
<tr>
<td>PD06</td>
<td>Emergency and elective age/sex standardised mortality ratio (SMR)</td>
<td>RY Q3 1011</td>
<td>95.0</td>
<td>91.2</td>
<td>75.9</td>
<td>100.0</td>
</tr>
<tr>
<td>PD09</td>
<td>Emergency age/sex standardised mortality ratio (SMR) - stroke</td>
<td>RY Q3 1011</td>
<td>61.4</td>
<td>90.6</td>
<td>64.8</td>
<td>100.0</td>
</tr>
<tr>
<td>PD10</td>
<td>Emergency age/sex standardised mortality ratio (SMR) - COPD</td>
<td>RY Q3 1011</td>
<td>68.2</td>
<td>62.4</td>
<td>90.5</td>
<td>100.0</td>
</tr>
<tr>
<td>PD11</td>
<td>Emergency age/sex standardised mortality ratio (SMR) - MI</td>
<td>RY Q3 1011</td>
<td>101.1</td>
<td>119.7</td>
<td>189.5</td>
<td>100.0</td>
</tr>
<tr>
<td>PD12</td>
<td>Emergency age/sex standardised mortality ratio (SMR) - NOF</td>
<td>RY Q3 1011</td>
<td>75.3</td>
<td>111.0</td>
<td>135.4</td>
<td>100.0</td>
</tr>
<tr>
<td>PD16</td>
<td>Emergency age/sex standardised mortality ratio (SMR) - Diabetic Emergencies</td>
<td>RY Q3 1011</td>
<td>174.5</td>
<td>269.3</td>
<td>63.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Acute Trust Quality Dashboard, summer 2011

Another key measure of clinical effectiveness is the proportion of patients who re-present at hospital following admission or treatment as shown in Table 18:

• The proportion of babies admitted to hospital 30 days following birth is below the national average at all three Trusts

• A&E re-attendances within 7 days of discharge compare unfavourably to the national average at all three Trusts

• Stroke re-admissions within 30 days compare unfavourably to the national average at all three Trusts
- COPD re-admissions within 30 days compare unfavourably to the national average at BLT and WCUHT
- Diabetic emergency re-admissions within 30 days compare unfavourably to the national average at BLT and WCUHT
- Unplanned A&E re-attendances within 7 days of discharge at all three trusts compare favourably to the national performance threshold of 5% during this sample month of September 2011.

### Table 18: Emergency re-attendances and re-admissions across the three Trusts

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Metric</th>
<th>Period</th>
<th>BLT Value</th>
<th>NUHT Value</th>
<th>WCUHT Value</th>
<th>National Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE08</td>
<td>A&amp;E reattendances - % within 7 days</td>
<td>Q3 1011</td>
<td>7.4%</td>
<td>8.2%</td>
<td>6.0%</td>
<td>6.8%</td>
</tr>
<tr>
<td>PE09</td>
<td>% of all A&amp;E attendances that are reattendances</td>
<td>Q3 1011</td>
<td>15.9%</td>
<td>16.4%</td>
<td>16.3%</td>
<td>16.1%</td>
</tr>
<tr>
<td>H02</td>
<td>Emergency readmission - % within 30 days following elective admission</td>
<td>Q3 1011</td>
<td>13.1%</td>
<td>8.2%</td>
<td>12.2%</td>
<td>12.6%</td>
</tr>
<tr>
<td>H04</td>
<td>Emergency readmission - % within 30 days following discharge - stroke</td>
<td>Q3 1011</td>
<td>4.4%</td>
<td>9.4%</td>
<td>6.3%</td>
<td>6.3%</td>
</tr>
<tr>
<td>H05</td>
<td>Emergency readmission - % within 30 days following discharge - COPD</td>
<td>Q3 1011</td>
<td>21.5%</td>
<td>21.4%</td>
<td>26.5%</td>
<td>23.3%</td>
</tr>
<tr>
<td>H06</td>
<td>Emergency readmission - % within 30 days following discharge - MI</td>
<td>Q3 1011</td>
<td>11.9%</td>
<td>19.6%</td>
<td>10.3%</td>
<td>14.5%</td>
</tr>
<tr>
<td>H07</td>
<td>Emergency readmission - % within 30 days following discharge - Diabetic Emergencies</td>
<td>Q3 1011</td>
<td>12.1%</td>
<td>7.7%</td>
<td>8.7%</td>
<td>11.7%</td>
</tr>
<tr>
<td>SC12</td>
<td>Emergency readmission - % of babies within 30 days following delivery</td>
<td>Q3 1011</td>
<td>5.4%</td>
<td>2.3%</td>
<td>19.2%</td>
<td>17.3%</td>
</tr>
</tbody>
</table>

Source: Acute Trust Quality Dashboard, summer 2011 (*A&E unplanned attendance data is taken from the Trust’s A&E clinical quality indicators, September 2011, published on Trust websites. The national performance threshold against which Trusts are measured is 5%*).

### 3.3.4 Patient experience

The most comparable data available about services at the three Trusts is found within the results of the 2010/11 inpatient survey. The survey gathers the views of patients across five domains – access and waiting times; quality of care; information and choice; relationships with medical and nursing staff; and cleanliness, quality and comfort of the care environment. Each domain comprises of a selection of specific questions to create a holistic picture of the patient experience. The results of the 2010/11 inpatient survey are set out in the table below.

### Table 19: Patient experience indicators across the three Trusts

<table>
<thead>
<tr>
<th>Average Domain Scores</th>
<th>60th Percentile Score (%)</th>
<th>BLT (%</th>
<th>NUHT (%)</th>
<th>WCUHT (%)</th>
<th>Merged Trust Average (%)</th>
<th>England Average (%)</th>
<th>London SHA Average (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and Waiting</td>
<td>87</td>
<td>82</td>
<td>75</td>
<td>79</td>
<td>79</td>
<td>84</td>
<td>81</td>
</tr>
<tr>
<td>Safe, high quality, co-ordinated care</td>
<td>67</td>
<td>59</td>
<td>65</td>
<td>60</td>
<td>60</td>
<td>65</td>
<td>62</td>
</tr>
<tr>
<td>Better information, more choice</td>
<td>71</td>
<td>63</td>
<td>71</td>
<td>66</td>
<td>66</td>
<td>67</td>
<td>66</td>
</tr>
<tr>
<td>Building relationships</td>
<td>85</td>
<td>77</td>
<td>77</td>
<td>77</td>
<td>77</td>
<td>83</td>
<td>80</td>
</tr>
<tr>
<td>Clean, comfortable, friendly place to be</td>
<td>81</td>
<td>75</td>
<td>78</td>
<td>77</td>
<td>77</td>
<td>79</td>
<td>78</td>
</tr>
<tr>
<td>Overall</td>
<td>78</td>
<td>71</td>
<td>73</td>
<td>70</td>
<td>71</td>
<td>71</td>
<td>73</td>
</tr>
</tbody>
</table>

Source: Acute inpatient survey 2010/11

Across the five domains, all three existing Trusts fail to match the top 20% of scores at a national level, except for NUHT which achieves the 80th percentile score in one area - information and choice. Additionally, the Merged Trust average score is below that of England and London SHA average across all domains.

These survey results are also similarly reflected in the maternity, outpatients and A&E surveys, and demonstrate much room for improvement in patient experience. This will be placed at the heart of the Merged Trust’s priorities. Further information regarding this commitment is provided in Section 4.2.3.

Whilst at each of the three trusts there are examples of excellent practice across operational delivery, productivity, quality and patient experience, this section has indicated that this is not recognised consistently across all departments and all indicators. The Merged Trust is determined to address this and aims to provide world class, leading-edge, patient-centred healthcare to transform health services in north east London. Subsequent chapters of this FBC set out the vision and strategy for the new organisation, the enabling activities to deliver standardisation of high quality and operationally efficient care, along with the planned outcomes and benefits for patients.
3.4 Workforce

The three Trusts each experience a number of current workforce challenges:

3.4.1 Vacancies and recruitment

At NUHT and WCUHT there are a number of posts at senior leadership and management level that are filled on an interim basis. The uncertainty of the future for these organisations has been a significant constraint in this regard. Over recent months this has become ever more challenging and poses a significant risk to the organisations’ ability to sustain ongoing delivery and performance.

Both these trusts have a significant number of vacancies, particularly in specialist areas, and experience considerable challenge in attracting and recruiting individuals to key service areas such as A&E, maternity and anaesthetics. As a result, the trusts rely on short term, interim, and locum and agency staff to cover these key roles. This is not only a costly option but can have a negative impact on continuity of care and service provision.

There are also problems in sustaining safe, and consistent levels of 24/7 senior clinical cover. This may not only discourage junior doctors from training in north east London, but also presents a clinical risk that must be addressed to ensure rapid and effective clinical decision making with a consequent improvement in the quality and safety of care.

The reconfiguration of NHS training budgets across London is expected to increase pressure on the existing Trusts to be the focus of learning for trainee roles. In order to continue to attract students, the trusts will need to enhance their educational offerings at a time when funding for education is decreasing.

These vacancy and recruitment challenges are felt most strongly at NUHT and WCUHT. Attracting the best and most talented staff is a challenge for all three trusts in an environment of competition with other major teaching hospitals in the region.

3.4.2 Retention and turnover

The competition environment across London also impacts on the ability of the Trusts to retain staff. Staff turnover across each of the three Trusts is over 10%. While this is not at significant variance with other trusts nationally, there are staff groups where retention can be more challenging:

- there is competition for scarce skills to fill senior nursing positions in specialist areas such as A&E, intensive care and neonatal services
- ancillary staff provide vital support to clinicians and day-to-day operations, however, due to the relatively low pay such positions attract, the existing Trusts are finding it increasingly difficult to recruit and retain these staff
- there are challenges with turnover and competition for managerial, finance, coding and informatics staff.

Ensuring retention of staff in all staff groups will be key to continuing to maintain and develop services of ever higher quality.

The way healthcare is organised is changing in ways that may not be attractive to current and prospective employees. For example, in responding to the needs of 24/7 healthcare (including the provision of emergency out of hours care) staff will be required to adopt new working patterns and develop new skills. Additionally, as we continue to improve productivity and efficiency, we will be working with staff to deliver new patient pathways, adopt new technology and innovation, and learn new ways of working, meeting the increasing demands on healthcare referred to in this FBC, without accompanying increases in resources.
Together these changes present a risk of increasing turnover, risks which we will manage more effectively across the merger.

3.4.3 Requirement for additional staff in the future

The Health for north east London programme requires WCUHT and NUHT to attract additional staff to implement the service reconfiguration plans now approved.

Furthermore, NHS London analysis of emergency care suggests that the Trusts will need to increase consultant workforce numbers to meet the national recommendations across a range of acute specialities including A&E, anaesthetics, general surgery, general medicine, paediatrics and maternity services. Some of these are areas to which there is significant difficulty in attracting and recruiting staff.

The Merged Trust aims to become an exemplar NHS employer – one which attracts, develops and retains the highest calibre staff; plays a key role in its catchment area in terms of the regeneration agenda for the east end of London; influences the local, regional and national health and care agenda; makes a major contribution to education, research and service agendas, and finally one which is nationally recognised for the excellence of its services achieved through the excellence of its staff.

Although the workforce challenges for the new merged organisation are considerable there are significant opportunities and benefits in terms of development, retention and attraction of staff which will have a positive impact on the care of patients in east London.

Recruitment, retention, learning and talent management constitutes one of the key aspects of the Organisational Development strategy which is discussed further in Chapter 9.

3.5 The financial challenges faced by the existing Trusts

3.5.1 Financial position of the existing Trusts

NUHT and WCUHT have been placed in the Challenged Trust regime in NHS London. Their positions are shown in Table 20. Excluding impairments (on an IFRS basis), NUHT made a deficit in each of the previous financial years. WCUHT made a small surplus in 2008/09, 2009/10 and 2010/11. Both organisations have extremely low cash balances (£1.2m and £2.5m respectively). An outflow of assets has occurred due to historical underlying weaknesses in the income and expenditure position.

BLT is on a firmer financial footing with a surplus delivered in the last financial year and a strong cash balance (£62m). Based on its base case LTFM BLT would be viable for authorisation as a Foundation Trust. However, benchmarking shows that BLT would be required to achieve an EBITDA margin considerably higher than that of similar sized trusts in order to meet its Monitor risk rating metrics (as outlined in Chapter 7). As such BLT would need to achieve exceptional operational efficiency compared with its peers. This is due to the high interest charge the organisation will have to service as the new hospitals at The Royal London and at St Bartholomew's come on stream over the next 4 years.
### Table 20: BLT, NUHT and WCUHT Income and Expenditure summary 2010-11

<table>
<thead>
<tr>
<th>I&amp;E summary</th>
<th>BLT</th>
<th>NUHT</th>
<th>WCUHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating revenue and Income,</td>
<td>FY09 716.9</td>
<td>FY09 160.5</td>
<td>FY09 211.6</td>
</tr>
<tr>
<td>total</td>
<td>FY10 707.6</td>
<td>FY10 169.7</td>
<td>FY10 232.7</td>
</tr>
<tr>
<td></td>
<td>FY11 716.3</td>
<td>FY11 166.7</td>
<td>FY11 243.8</td>
</tr>
<tr>
<td>Operating expenses (excluding</td>
<td>FY09 (608.4)</td>
<td>FY09 (140.2)</td>
<td>FY09 (192.4)</td>
</tr>
<tr>
<td>impairments on owned assets, total</td>
<td>FY10 (700.5)</td>
<td>FY10 (155.3)</td>
<td>FY10 (202.6)</td>
</tr>
<tr>
<td></td>
<td>FY11 (702.3)</td>
<td>FY11 (170.0)</td>
<td>FY11 (227.0)</td>
</tr>
<tr>
<td>Other expenses, total</td>
<td>FY09 (8.7)</td>
<td>FY09 (23.1)</td>
<td>FY09 (17.6)</td>
</tr>
<tr>
<td></td>
<td>FY10 (8.2)</td>
<td>FY10 (25.8)</td>
<td>FY10 (29.9)</td>
</tr>
<tr>
<td></td>
<td>FY11 (11.5)</td>
<td>FY11 (7.4)</td>
<td>FY11 (16.5)</td>
</tr>
<tr>
<td>Impairment on owned assets</td>
<td>FY09 (3.0)</td>
<td>FY09 (12.3)</td>
<td>FY09 (3.3)</td>
</tr>
<tr>
<td></td>
<td>FY10 (136.8)</td>
<td>FY10 (15.5)</td>
<td>FY10 (16.2)</td>
</tr>
<tr>
<td></td>
<td>FY11 (0.0)</td>
<td>FY11 (2.8)</td>
<td>FY11 (3.5)</td>
</tr>
<tr>
<td>Surplus (deficit) excluding</td>
<td>FY09 (3.2)</td>
<td>FY09 (15.1)</td>
<td>FY09 (1.7)</td>
</tr>
<tr>
<td>impairments</td>
<td>FY10 (137.9)</td>
<td>FY10 (26.9)</td>
<td>FY10 (16.0)</td>
</tr>
<tr>
<td></td>
<td>FY11 (2.5)</td>
<td>FY11 (7.9)</td>
<td>FY11 (3.1)</td>
</tr>
<tr>
<td>Surplus margin</td>
<td>FY09 0%</td>
<td>FY09 -2%</td>
<td>FY09 1%</td>
</tr>
<tr>
<td></td>
<td>FY10 0%</td>
<td>FY10 -7%</td>
<td>FY10 0%</td>
</tr>
<tr>
<td></td>
<td>FY11 0%</td>
<td>FY11 -6%</td>
<td>FY11 0%</td>
</tr>
</tbody>
</table>

Note: The figures in the table above are stated in IFRS terms and therefore may vary from figures reported under UK GAAP in the annual accounts.

### 3.5.2 Overall challenges

Each Trust has significant, but different financial challenges around:

- Savings required – the Cost Improvement Programme (CIP)
- Infrastructure and investment challenges
- Technical financial challenges.

### 3.5.3 The CIP challenge

Collectively the three existing Trusts face a £227.6m CIP challenge to break even and a further £11.2m challenge in order to make a 1% income and expenditure surplus between 2012/13 and 2016/17. It has been estimated however, that due to the historical record of CIP delivery, the level of CIPs identified to date, and the level of CIPs deemed achievable, based on their existing productivity opportunities in line with NHS London’s scenario modelling, the Trusts will only be able to deliver £208m.

To deliver a 1% surplus:

- WCUHT’s CIP challenge across the period is £61.8m but the Trust is only forecast to achieve CIP delivery of £32.4m
- Similarly, NUHT’s CIP challenge across the period is £33.1m but the Trust is only forecast to achieve CIP delivery of £20.4m
- BLT is forecasting that it will be able to exceed its £144.1m CIP challenge and deliver a surplus of more than 1% by the end of the planning period.

### 3.5.4 The infrastructure and investment challenges faced by the existing Trusts

The existing Trusts also face significant infrastructure challenges relating to their estates portfolios and ICT systems.

#### Suitability of estates for 21st century care

All three Trusts need to ensure that their extensive portfolio of buildings meet the standards of a modern care environment. The need to secure capital investment is common to all Trusts, particularly in the context of the national drive to eliminate mixed sex accommodation and drive down rates of hospital acquired infections through an increase in single rooms and smaller bay wards.
The majority of NUHT’s estate is relatively new and BLT has already occupied the first phase of the re-development of the Barts site and is about to move into the new Royal London Hospital. However, the estate at WCUHT comprises buildings which date from the early 1900s onwards. The age, suitability and condition of the WCUHT estate is highly variable with some areas not meeting the standards of a modern care environment.

Capital investment is required to address these concerns. For WCUHT in particular, the need for this capital investment is particularly critical to meet the implications of implementing the recently approved Health for north east London programme, including the expected increase in maternity and emergency requirements caused by planned changes in use at the nearby King George Hospital.

**Private Finance Initiatives (PFI)**

WCUHT does not have any major PFI schemes within its estates portfolio. However, both NUHT and BLT have entered into PFI contracts as a way to meet their future estates needs.

BLT has a £1.15 billion PFI re-development of its estate which will deliver new hospitals at Barts and The Royal London Hospital sites. The first phase of the Barts redevelopment (Barts Cancer Care) opened in March 2010 with the second phase (cardiovascular services) due to open in 2014. The new Royal London Hospital is complete and services will begin moving in from December 2011, with the moves completed by March 2012.

NUHT has also extended its operational facilities through a £30m PFI contract established in 2004, with two new blocks opening in 2006. These developments allowed for the closure of St Andrews Hospital.

These PFI schemes provide the Trusts with state-of-the-art accommodation and facilities, but at the same time they result in long-term financial commitments that the Trusts need to service. The PFI contracts place constraints on securing cash-releasing cost improvements to the Trusts within the services operated through the PFIs. This is against a backdrop of increased cost-improvement requirements over this period.

After the completion of the PFI development, BLT has significant opportunities to re-develop its vacated land and assets at The Royal London and at The London Chest while minimising its exposure to dilapidation costs as a result of exiting leasehold properties. At both Barts and at the Royal London there is significant scope for further development within the new hospitals.

**Future estates investment**

At BLT, the first phase of the Barts re-development is already in use and the move to the new Royal London Hospital will be completed by the time the merger is expected to take place. The second phase of the Barts re-development is under construction and will be open in 2014. The Trust has a number of other initiatives being developed including the further provision of satellite renal dialysis units in north east London.

NUHT is currently in discussion with its commissioners to finalise the details of an Urgent Care Centre (UCC)/Emergency Department (ED) development to be completed in advance of the 2012 Olympic and Paralympic Games.

**WCUHT estates investment**

At WCUHT a £23m development of A&E and Emergency Assessment facilities is underway. Phase 1 (A&E new build), a £12m development, will be complete prior to the merger and phase II (Emergency Assessment ward), £11m, by early 2013. Additionally, £19.4m of maternity improvements and a further £9m of ward upgrades are planned which will address the deficiencies in the current estate, and are linked to the Health for north east London reconfiguration of services.
These investments are urgent, and a mechanism to confirm the appropriate financing of this capital investment is required. The Trusts, Commissioners and NHS London recognise that the merger provides a potential solution to this. As part of the development of the Full Business Case for this investment, a Strategic Outline Case with the funding requirement over the next five years has been agreed in principle. This would be funded via the prudential borrowing code subject to approval of the appropriate business case. The investment has been modelled within the LTFM for the Merged Trust.

In light of the financial challenges within the NHS, it is important that these large estates investments are implemented as quickly and efficiently as possible and all are built into the long term financial models of the merged organisation.

**ICT Infrastructure**

All three Trusts are facing challenges related to delivering the platform for an electronic patient record. BLT’s main patient system is Cerner Millennium, implemented through the National Programme for IT (NPfIT) in 2009. The system has key functionality including patient administration, order communications, A&E and maternity. The informatics strategy has consolidated as much clinical functionality as possible into the Cerner system, although there are a number of legacy clinical systems which are interfaced with it.

WCUH has not yet implemented the NPfIT Care Records System (CRS) and is currently using McKesson Total Care as its main Patient Administration System (PAS). The WCUH ICT Strategy is to implement ‘best of breed’ solutions with HL7 interfaces to the PAS. The contract for Total Care expires in 2014. As part of the current NPfIT contract, WCUH can implement Cerner Millennium CRS to replace Total Care only if the merger with BLT and NUHT goes ahead. If the merger is not approved, WCUH will need to urgently procure a replacement Electronic Patient Record (EPR) solution.

NUHT procured Cerner Millennium jointly with Homerton Hospital before the national contract, supporting key functionality including order communications. As such, NUHT has a long experience with the product and has been able to customise it extensively to suit local requirements. The NUHT strategy has been to use CRS as the main patient system, although there are still a large number of separate clinical systems with different levels of integration to CRS. The Cerner system is currently still shared with the Homerton, and the system is hosted at the BLT data centre. Discussions are currently underway with BT, the Local System Provider appointed as part of the NPfIT, for the dis-aggregation of Homerton and Newham data and the transfer of hosting from BLT to a BT data centre.

The costs of running systems at BLT and NUHT which were implemented through the NPfIT, are currently met by the Department of Health. However this arrangement will cease from 2015 and the Trusts will become liable for annual running costs and potential purchase and data migration expenses. Procurement is due to start in early 2012 which will determine the capital and revenue implications of the cessation of this contract. These are likely to be significant but will vary depending on which system is procured and the nature of the contract. The costs of a new system for the Merged Trust will almost certainly be significantly cheaper than buying three individual systems.

**Other IT challenges**

The pace and cost of innovation in technology is such that keeping up to date with technological advances is increasingly difficult. All three Trusts need to upgrade their radiology, pathology and imaging systems in the next two to three years due to their age and functionality. In addition there are localised challenges at each of the three Trusts that need to be addressed, such as the need for clinical trials infrastructure at all sites. WCUH needs to upgrade its order communications system, e-procurement and breast screening equipment. The staff rostering system at NUHT is no longer suitable, and they are also experiencing challenges with ageing MRI equipment, and BLT needs to update its dental and orthodontics systems.
Background and the case for change

Technical challenges

All three trusts are required to become Foundation Trusts. In order to be able to do this there are a complex set of financial requirements to be met regarding liquidity, prudential borrowing and financial risk. Neither WCUHT nor NUHT can meet these requirements on their own.

3.6 Why the merger is the best organisational solution to these challenges

As demonstrated by Sections 3.1 to 3.5, the existing Trusts as separate entities face a range of different, but very challenging issues. Two of the three trusts cannot exist as independent organisations. In the coming years all three trusts must maintain and further improve quality in a very tight financial climate. Quality Innovation, Productivity and Prevention (QIPP) must be delivered at a faster pace, and must be delivered not just within NHS organisations, but across them, and across the whole health system.

All patients, wherever they live in east London, will benefit from the merger. It is in no-one’s interest if WCUHT and NUHT enter the failure regime. BLT too, as a major tertiary services provider has a strong interest in ensuring that its partner District hospital services are financially sound, organisationally stable, and provide high quality clinical services.

WCUHT and NUHT have fully appraised other configuration options, in particular exploring the possibility of a merger with Homerton Hospital. No other option appears to offer the same level of clinical and financial benefits as this proposal. The most effective way of being able to address the challenges is by bringing the trusts together to form a new organisation.

3.6.2 Meeting the financial challenges

Each Trust has different financial challenges. This merger will resolve the financial viability issues at NUHT and WCUHT, achieve financial synergies of significant value to each of the three trusts as they tackle the QIPP challenge, and create an integrated organisation of sufficient scale and strength to make the investment required to deliver the quality, range and disposition of services which the people of east London need.

- The QIPP challenge. Any merger option is likely to deliver corporate and back office savings and economies of scale. However, this merger between the three trusts a) delivers more savings than one between two trusts, b) gives opportunities for productivity savings across a wide hospital system, and c) as the QIPP challenge for each individual trust varies between them over the years, this merger enables the annual CIP requirements to be smoothed.

- Infrastructure and investment challenges. The pooling and sharing of resources will allow better use of the estate and further investment in new facilities including IT, particularly at WCUHT. There will be further benefits with FT status, such as the opportunities to retain surpluses and more freedoms to invest.

- Technical requirements. The merger allows the technical financial requirements to become a FT to be addressed. For instance, WCUHT and NUHT have extremely low cash positions whereas BLT has a strong cash position, thus mitigating the weak cash position in the other two trusts.

3.6.3 Meeting the clinical challenges

Regarding clinical benefits, whilst some of the clinical benefits could be delivered without a merger, experience around the country has shown that collaboration on the scale required is a difficult and lengthy process and may never occur as:

- the incentives for the ‘donor’ Trust are often minimal (and would in some cases act to raise competition for the Trust – threatening its financial sustainability)
Background and the case for change

- ‘recipient’ trusts struggle to understand the nuances and complexities of how improvements can be translated without dedicated resources from the donor trust.

A merger would deliver integrated services across secondary and tertiary care for BLT, NUHT and WCUHT accelerating the spread of new practice, improving access to rare technologies, and delivering more patient focused pathways of care across the hospitals. Through supporting clinical leadership across the system, unifying budgets, and better team-working and communication, the Merged Trust will ensure that innovation, improvement and best value will be delivered more rapidly than it has been possible across separate organisations, and that best, cost-effective practice is driven across the hospitals in a systematic and consistent way.

The Trusts have direct experience of the complexities of joint working through (amongst other things) their efforts to establish chemotherapy satellite centres at NUHT and WCUHT. The merger would deliver service improvements and economies of scale faster and quicker than if there was no merger.

The merger has the further advantage of bringing together a major tertiary acute Trust, and its academic partnership (especially Queen Mary University of London) and their founder status within UCLP (one of the UK’s leading academic health sciences systems), with the two local Trusts. Much has already been done to strengthen educational partnerships. This merger provides the opportunity for all three trusts to participate more effectively in research and innovation and to accelerate population and outcome based improvements.

Some of the benefits described in later chapters are essentially only available with this configuration. For instance, the possibility of creating an on-call rota of consultant colorectal surgeons in the three trusts is only possible because there are at least eight colorectal surgeons in the three trusts, sufficient for a sustainable rota 24/7. In addition:

- The patient pathways between hospitals are generally between local Trusts and major acute Trusts (not between local Trusts). Two local Trusts on their own would still leave a ‘risk’ around patient pathways and handovers with the major acute hospital. A merger between a major acute and one local Trust would, again, require additional work to ‘plug in’ pathways for the other local Trust.

- A key advantage of the merger is the opportunity to better train clinicians and staff across all specialties, disciplines and levels. Some benefits would accrue with the merger of two local hospitals but the advantages that will make a real difference will be by rotating staff between a local hospital and a major acute hospital with community services. In this way staff will be able to experience different environments along the whole patient pathway and gain a greater understanding of how patient care can be improved. This training is invaluable when severely ill patients arrive at local hospitals and they need to be stabilised before transfer to a major acute.

- Similarly, in research, a merger that brings together the research strength of a major acute hospital with the wider community of a local hospital would improve the opportunities for patients. Adding a second local hospital adds to that effect, but merging two local hospitals would deliver little, if any, benefit to the hospitals or their patients and communities. If Newham hospital is excluded from the merger the local community are likely to be denied the opportunities of being involved in cutting edge research and trials.

- The merged Trust will also be better able to manage its theatres and beds. These benefits are greatest if NUHT and WCUHT hospitals are integrated with a major acute hospital as the Merged Trust will be able to:
  
  - repatriate patients from St Bartholomews, the Royal London and The London Chest Hospitals. Some patients, once having received their specialist care at the tertiary centre in BLT, are not repatriated back to their local hospital quickly. This occurs for a number of reasons but in particular there are often conflicting priorities and disincentives across organisations, and working through them sometimes delays what
Background and the case for change

is best for the patient. A single integrated organisation across secondary and tertiary care will ensure that the patients interests will always come first

- ensure that patients are cared for in the most appropriate setting in secondary or tertiary care, thereby making sure resources are not blocked for other patients needed access to them in either setting.

- deliver further clinical synergies in elective surgery. While waiting times for elective care at BLT are much better than average in the NHS, as a result of variation in demand and flow at London's largest trauma centre at The Royal London Hospital, elective care for individual patients has been delayed far too often. BLT has specific problems to address, and NUHT can offer specific solutions.

3.6.4 Advantages for patients in specific geographic areas

The overall financial and clinical benefits are described above and in detail in Chapter 6. This section gives some examples of the benefits for residents in different parts of east London.

Patients across the new local catchment will benefit from:

- the sustainability of local services will be strengthened
- much needed investment in estates and facilities
- better and safer emergency and urgent clinical care of a consistently high standard across the system– e.g. more consultant rota providing high quality 24/7 care
- more reliable elective care
- improved safety and quality of maternity services
- improved children’s services
- the opportunity to develop new services at local hospitals
- services working in collaboration with primary and community health teams, distinctively tailored to local needs
- a more sustainable research programme and a greater opportunity to benefit from it as the bigger Trust can retain and win more research funding and offer trials to more patients
- a more sustainable workforce – with greater ability to attract and retain the best clinicians and staff.

Patients of BLT will benefit from:

- improved patient pathways with WCUHT and NUHT hospitals
- improved efficiency and flow for emergency patients and for patients requiring urgent surgery
- opportunities to manage elective care across a wider system
- a more sustainable workforce – with greater ability to attract and retain the best clinicians and staff
- enhanced opportunities to secure and maintain modern diagnostic, imaging and other high cost infrastructure.
Patients who consider NUHT as their local hospital will benefit from:

- the long term sustainability of their hospital. The hospital is one of the most efficient in the country. NHS London’s scenario modelling assessment of the Trust has shown that Newham does not have the opportunity to make the required savings. Therefore, without merger, the Trust would enter the failure regime and patient services would be at risk. The savings that a merger would deliver would achieve the levels required to safeguard the hospital and its services

- more accessible services – e.g. chemotherapy sessions run by Barts clinicians at Newham

- better and safer clinical care – e.g. more consultant rotas providing high quality care 24/7 and less opportunity for patients who do need to go to Barts or The Royal London to ‘fall through the gaps’ when being transferred

- the opportunity to be involved in more clinical trials which have been shown to improve patient care and outcomes

- a more sustainable workforce – with greater ability to attract and retain the best clinicians and staff

- additional investment in new facilities in A&E that will enable the trust to cater for the predicted rise in attendances.

Patients who consider WCUHT as their local hospital will benefit from:

- the long term sustainability of their hospital. The trust cannot meet the financial requirements demanded by Monitor to become a Foundation Trust. Therefore, without merger, the Trust would enter the failure regime and patient services would be at risk. The savings that a merger would deliver would achieve the levels required to safeguard the hospital and its services

- more accessible services – e.g. chemotherapy sessions run by Barts clinicians at Whipps Cross

- better and safer clinical care – e.g. more consultant rotas providing high quality care 24/7 and less opportunity for patients who do need to go to Barts or The Royal London Hospitals to ‘fall through the gaps’ when being transferred

- the opportunity to be involved in more clinical trials

- a more sustainable workforce – with greater ability to attract and retain the best clinicians and staff

- early investment in badly needed new facilities – specifically in maternity suites and new wards - which will be more patient friendly, easier to keep clean and more efficient.

Further details on how the proposed merger will facilitate the achievement of these outcomes as well as the overarching vision and strategy for the new organisation are set out in Chapter 4.

3.7 Maintaining patient choice in north east London

The merger does not plan for any changes to activity flows other than those already assumed by the three individual Trusts - in line with the commissioner’s current intentions and plans. Notwithstanding this, it is recognised that the merger of three Trusts may inevitably raise questions about choice and competition.
It is important to recognise that the healthcare market in north east London will remain vibrant once the merger is completed. Patients will continue to have choice of provider, and be able to access services from a wide range of alternative providers should they wish to do so. Patient choice of provider is strongly championed by local commissioners and patient choice and competition between providers can be expected to increase over time. The Merged Trust will fully support this principle of choice and competition. Further details regarding the safeguarding of patient choice and competition can be found in the trusts’ various submissions to the Co-operation and Competition Panel.

The Merged Trust’s main competitors are listed in the table below, along with a summary of the basis upon which they compete:

Table 21: Patient choice in north east London

<table>
<thead>
<tr>
<th>Provider*</th>
<th>Services</th>
<th>Population</th>
<th>Competition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homerton University Hospital Foundation Trust</td>
<td>Local Acute emergency, A&amp;E, elective and maternity</td>
<td>North West Newham, South Waltham Forest, Tower Hamlets</td>
<td>Very strong</td>
</tr>
<tr>
<td>UCLH Foundation Trust</td>
<td>Local Acute emergency, A&amp;E, elective and maternity. All specialist services</td>
<td>Tower Hamlets, City &amp; Hackney, Waltham Forest, Redbridge, Newham.</td>
<td>Very Strong</td>
</tr>
<tr>
<td>Moorfields Eye Hospital Foundation Trust</td>
<td>Eye surgery</td>
<td>Tower Hamlets, City &amp; Hackney, Waltham Forest, Redbridge, Newham, Barking and Dagenham</td>
<td>Very Strong</td>
</tr>
<tr>
<td>North Middlesex University Hospital</td>
<td>Local Acute emergency and A&amp;E</td>
<td>Waltham Forest</td>
<td>Strong</td>
</tr>
<tr>
<td>Care UK Ltd</td>
<td>Elective day surgery</td>
<td>Waltham Forest, Redbridge, Newham.</td>
<td>Strong</td>
</tr>
<tr>
<td>Guy’s &amp; St Thomas’ Hospitals NHS Foundation Trust</td>
<td>Local Acute emergency, A&amp;E, elective and maternity, all specialist services</td>
<td>Tower Hamlets, City &amp; Hackney, Waltham Forest, Redbridge, Newham</td>
<td>Moderate</td>
</tr>
<tr>
<td>North Middlesex University Hospital</td>
<td>Elective, maternity and specialist cancer</td>
<td>Waltham Forest</td>
<td>Moderate</td>
</tr>
<tr>
<td>Barking, Havering &amp; Redbridge University Hospitals Trust</td>
<td>Local Acute emergency, A&amp;E, elective, maternity, specialist cancer, neurosciences, cardiac and vascular.</td>
<td>Waltham Forest, Redbridge, Newham, Barking and Dagenham</td>
<td>Strong</td>
</tr>
<tr>
<td>Princess Alexandra Hospital (Harlow)</td>
<td>Local Acute emergency, A&amp;E, elective, maternity, specialist cancer</td>
<td>North Waltham Forest, West Essex</td>
<td>Moderate</td>
</tr>
<tr>
<td>Imperial, King’s College, Royal Brompton &amp; Harefield, The Royal Free, St George’s.</td>
<td>All specialist services</td>
<td>Tower Hamlets, City &amp; Hackney, Waltham Forest, Redbridge, Newham</td>
<td>Strong</td>
</tr>
<tr>
<td>Lewisham Hospital, Greenwich Hospital</td>
<td>Local Acute emergency, A&amp;E, elective and maternity</td>
<td>Tower Hamlets, Newham</td>
<td>Weak (but potentially becoming moderate)</td>
</tr>
</tbody>
</table>

Source: Trust view

*Some providers are listed twice, due to different competition characteristics across their services

One concern raised about this proposed merger is that without effective competition for services, there is a risk that increases in price or reductions in the quality of services provided by the Merged Trust will not be constrained.

One of the key factors influencing patient choice, and therefore competition for patients, is the time it takes to travel to alternative providers. The location of BLT and WCUHT, means that there are a number of alternative providers available within short travel times, and that competition for the patients will remain high.
NUHT will lose two of its closest competitors (BLT and WCUHT) after the merger. However analysis shows that within a 30 minute drive time there are six to eight other choices/competitors and within a 45 minute travel time on public transport, there are further alternative providers such as Guy's & St Thomas' Hospitals NHS Foundation Trust, the Homerton University Hospital Foundation Trust and Queen's Hospital, Romford. In addition, there are a number of independent providers offering services to NHS patients.

It is recognised however, that patient choice does not only relate to choice of provider. Choice should also apply to the ability to access specialist care closer to home (e.g. chemotherapy); the ability to choose which setting to receive treatment in (e.g. outpatient or community); and the ability to choose which type of care is most appropriate (e.g. midwifery led or consultant led births). The Merged Trust will provide the broadest range of patient choice and will be better placed to do so than as three individual Trusts by virtue of its size, flexibility and geographical reach. Early service improvement initiatives which will extend patient choice are demonstrated in the CAG priorities, as set out in Section 6.2.

The conclusion from this is that the merger will be able to provide the benefits for patients described in Section 3.6 while ensuring that the Merged Trust faces sufficient competitive pressure to ensure that costs are controlled and quality continuously improved.
4. The new organisation – vision and strategy

Synopsis

The vision of the Merged Trust is to provide the full portfolio of services to meet the needs of the local population, and to provide world class, leading-edge clinical services, research and education.

Four strategic outcomes are identified to meet the challenges set out in the previous chapter and to achieve the Merged Trust’s vision. These include; improving health and reducing health inequalities; providing secure local services with enhanced access to specialist services; better quality and reduced variability; and financial resilience for a sustainable future for acute services in North East London.

The Merged Trust has identified 10 pledges which will be enshrined in everyday activity to meet the Trust’s vision and strategic objectives. Success for the new organisation in achieving its vision and meeting the 10 pledges will be measured over the next five years through:

- Achieving among the lowest rates of hospital mortality
- Achieving among the lowest rates of defects and hospital associated harm in the NHS
- Being a quality leader among NHS Trusts - consistently among the highest ranking in national quality indicators and the top performers in national patient surveys
- Being the employer of choice for staff, supporting their health and wellbeing and helping them to thrive in their work
- Achieving authorisation as a NHS Foundation Trust.

The Merged Trust will provide the comprehensive range of services – from community services in Tower Hamlets, local acute care to North East London Boroughs, and specialist services at a pan London and national level. The scale of the Merged Trust’s activities will be notable, with approximately 1.3m outpatient attendances, 100,000 elective and 140,000 non elective episodes per year, and 15,000 births.

Careful consideration has been given to designing the proposed integration journey. Year 1 will be integration, Year 2 service improvement, and Year 3 onwards will be transformation. During the critical Year 1 of integration, the CIP target will be kept to 4% (3% CIP and 1% merger synergy savings). This is to ensure a realistic and achievable level of savings given the scale of transition required during the first year of integration.

- Section 4.1 sets the vision and aspirations of the new organisation
- Section 4.2 describes the Merged Trust’s four strategic outcomes
- Section 4.3 sets out the role, focus and business portfolio of the existing Trusts and how this will translate into the Merged Trust
- Section 4.3 details the common pitfalls faced by merger programmes and how these lessons have informed integration planning in order to mitigate the risk of failure
- Section 4.4 sets out the high level roadmap for the three phases of the merger – integration (Year 1), service improvement (Year 2) and service transformation (Year 3). Chapter 9 provides further detail on the associated integration planning.
4.1 The vision and aspirations of the Merged Trust

“Our vision is for the Merged Trust to be a healthcare organisation that offers a portfolio of acute, specialist and community services tailored to meet the needs of our local population. We also want the Merged Trust to be recognised locally, nationally and internationally for outstanding clinical services, research and education.”

This vision has been created for the new organisation based upon engagement with a range of staff from across the three existing Trusts. It is designed to provide a clear and compelling description of the purpose of the new organisation and its tripartite mission of service provision, research and education:

- At the heart of the Merged Trust’s vision is an ambition to transform the health of east Londoners by providing world class, leading-edge, patient-centred healthcare. The combined service portfolio of the Merged Trust and the strong partnerships with primary and social care will offer pathways of care which encompass community, general acute and specialist services.

- Through excellent relationships with outstanding academic institutions, and as a member of UCL Partners, a leading Academic Health Sciences System, the Merged Trust will discover and spread leading edge practice and service innovation across all sites and to the wider health service beyond.

- Education offerings will be first class and research will rank with the best in the country. All of the Merged Trust’s hospitals will contribute to maximising the impact of high quality research and education, translating this into improved clinical outcomes.

4.2 The strategic outcomes for the Merged Trust

It is believed that the proposed merger provides a realistic and achievable solution to the deep structural, resource and operational challenges that were set out in the previous chapter. The merger of the three Trusts aims to deliver four strategic outcomes that are essential for addressing these challenges and achieving the organisational vision.
1. A significant contribution to programmes which improve health and reduce health inequalities achieved through joint working with local partners via Health and Wellbeing Boards

2. Secure local acute services, with improved access across north east London to the full range of specialist services supported by enhanced research and education capabilities

3. Better quality as well as reduced variability of clinical outcomes, patient experience and operational performance

4. Financial resilience and a sustainable platform for acute services in north east London.

Underpinning the vision and the strategic outcomes is a commitment to transforming health services in a way that accounts for the unique and challenging health needs of local communities. This commitment is enshrined in the following ten pledges:

1. Patients will be at the heart of everything the Trust does, informing decision-making to ensure that patients feel confident, safe, and cared for

2. The health care provided will be of consistently high clinical quality

3. Standards of patient safety will be continuously improved

4. Excellence in research and development will be sustained and developed

5. Excellence in education and training will be sustained and developed

6. Human rights and equalities will be promoted

7. The Merged Trust will work with Commissioners, GPs and primary care teams, as well as Health and Wellbeing Boards, to improve health and to reduce health inequalities, with an initial focus on older people, on those having babies and on those with cancer, diabetes, and tuberculosis

8. The Merged Trust will work with partners in social care to ensure that the care needed by those who are most vulnerable is not compromised by organisational boundaries

9. The Merged Trust will make best use of the public resources invested by commissioners

10. The Trust Board will be open and accountable to patients and the local population, and will listen to the views of patients and the public in making improvements in the services the Trust provides.

The organisational vision and the ten pledges will be the starting point for all discussions with staff, wider stakeholders and the broader public both during the merger transition and on an ongoing basis.

The Merged Trust will measure its success in delivering its vision and strategic outcomes within the next five years by:
Achieving among the lowest rates of hospital mortality

Achieving among the lowest rates of defects and hospital associated harm in the NHS

Being a quality leader among NHS Trusts - consistently among the highest ranking in national quality indicators and the top performers in national patient surveys.

Being the employer of choice for staff, supporting their health and wellbeing and helping them to thrive in their work

Achieving authorisation as a NHS Foundation Trust.

Monitoring of the strategic outcomes will enable the Merged Trust, its community and stakeholders, to know that the vision is being delivered, that the challenges described in the previous section are being addressed, and that the national and local context are appropriately reflected.

Achievement of the strategic outcomes will provide the basis for high quality and resilient local services, from community to tertiary care, as well as a platform for achieving FT status. The merger allows the formation of a new organisation that places patients and clinicians at the heart of the Merged Trust – a prerequisite for excellent patient care, long term sustainability and FT status.

An overview of the four strategic outcomes is set out in Sections 4.2.1 to 4.2.4 below. Further details of key enablers and clinical benefits, along with CAG specific examples, are set out in Chapters 5 and 6.

4.2.1 A significant contribution to programmes which improve health and reduce health inequalities achieved through joint working with local partners via Health and Wellbeing Boards

Improving specialist hospital services, whilst crucial to the Trust's mission, will not in itself effectively tackle the longstanding health inequalities that characterise north east London.

However, the Merged Trust will have the potential to make a major impact on the health of both patients and staff. The immediate catchment population will consist of over 750,000 people with some of the worst health inequalities seen across England. The creation of a Trust of this scale brings new opportunities, not least as the largest local employer and as a significant procurer of goods and services. The Merged Trust's campaign to improve health will begin with the 15,000 people that it will employ, the majority of whom are part of the populations served.

The Joint Strategic Needs Assessments for the three boroughs, supported by a programme of health equity audits, will be used to inform priorities for health improvement and tackling health inequalities. The Trust will work in partnership with the Health and Wellbeing Boards and GPs:

- To provide high quality care for people with prevalent health problems, such as heart disease, stroke, cancer, HIV, and respiratory diseases such as bronchitis (chronic obstructive pulmonary disease, COPD) and TB
- To work with GPs and patients to co-design clinical pathways which ensure that every opportunity is taken to provide health information and advice, and to support patients in adopting healthy lifestyles
- To integrate prevention initiatives into clinical pathways and providing interventions where appropriate to promote healthy lifestyles, for example, specific smoking cessation support prior to surgery and brief interventions for patients who present at hospital as a direct result of alcohol misuse
The new organisation – vision and strategy

- To broaden health improvement programmes to promote health across the Trust, for example, a smoke-free environment with comprehensive support for staff and patients to stop smoking, healthy hospital food for patients, staff and visitors (that also recognises religious requirements and cultural preferences where possible), and initiatives to promote physical activity for patients, local residents and staff
- To provide a systematic approach to staff health, including recruitment health screening and support, a healthy work environment and a strong occupational health service
- To support the local economy through the procurement of goods and services
- To include a responsibility for health improvement within all job descriptions, and through the selection process, induction, objective setting, appraisal and professional and personal development plans and mandatory training.

This is an ambitious programme, and a commitment from the Trust to work in new ways with partners, to gain new traction on the endemic health inequalities found within north east London.

“North east London faces some of the most profound health inequalities in the country, so it is crucial that all the health sector contribute to improving health and reducing inequalities. The Merged Trust will treat approximately 277,000 inpatient and 1.3m outpatient attendances every year. This affords a unique opportunity to positively influence health inequalities across north east London in partnership with other agencies. The new commitment from the Merged Trust is extremely welcome and could play an important role in closing the health gap.”

Dr Ian Basnett, Director of Public Health, NHS East London and the City
Dr Jane Moore, Director of Public Health, NHS Outer North East London

4.2.2 Secure local acute services, with improved access across north east London to the full range of specialist services supported by enhanced research and education capabilities

Creating a provider of the scale of the Merged Trust will secure and improve access to a comprehensive portfolio of high quality sustainable local and specialist hospital services for north east London. It will also improve education and research, and will open up opportunities for a multitude of innovations and better operating models which have the potential to raise standards to the ‘best in class’. It will do this by:

- Identifying opportunities to streamline and consolidate elective pathways, (supported by patients as part of the Health for north east London consultation). All future pathway redesign will be considered in partnership with patients, local GPs, primary care and community health services and other agencies
- Providing more specialist services locally where applicable, as well as better access to services at the specialist centres (largely the Barts and Royal London sites) through the removal of organisational boundaries. Such developments will not only make the best use of the extensive and expensive facilities but also attract academic and research funding which in turn will attract the best clinical and management talent
- Forming a strong base for a greater research effort and increased synergies between service provision, teaching and research. Increased opportunities for patients to participate in research will be achieved through extending the reach of clinical trials across the Merged Trust’s sites. Additionally, the increased research effort will grow a pool of local research evidence pertinent to the needs of the local population as well as delivering benefits to clinical education. The Merged Trust will be positioned to work very closely with
other research organisations, including University College London Partners (UCLP), and will extend these links over time

- Providing greater capacity for staff to rotate through a wide range of specialties. Together with the expansion of research activities, the new organisation will be able to provide its workforce with unique educational opportunities. This will not only pay dividends for clinical innovation and the quality of care, but it will also support the organisation’s recruitment and retention strategy.

“A merger would make it easier to organise our care so that patients get to the right clinical team more quickly, without the delays of being referred from one organisation to another.”

_Steve Ryan, Medical Director, Barts and The London NHS Trust_

“...The merger will also give us the potential to improve education and training, improve links to specialist services and allow us to learn from each other to further improve our services.”

_Charlene Walters, Senior Physiotherapist, Whipps Cross University Hospital NHS Trust_

4.2.3 Better quality as well as reduced variability in clinical outcomes, patient experience and operational performance

As explained in Section 3.3 there are some excellent examples of leading practice and high quality services across the three Trusts but none of the three can demonstrate consistently high standards across their entire portfolio. Going forward, the Merged Trust will take the best examples of leading practice and will roll these out across the three sites. In doing so the aim will be to raise clinical outcomes, operational performance and patient experience to best in class.

Improving patient experience will be placed at the heart of the Trust with the following approaches incorporated:

- **Co-designing service change** - All pathway redesign and service improvement will involve patients and carers in designing and implementing changes

- **Reflecting patient perspectives in decision making** - All reviews of services, business cases, clinical audit programmes and other relevant service evaluations will cover the priorities and concerns of patients and carers to ensure resultant decisions and actions reflect their views

- **Learning from and acting upon feedback** – Information gleaned from patient experience surveys, complaints, and patient and carer feedback will be disseminated and discussed at Trust-wide, CAG and service level. Action plans will be developed to spread good practice across the organisation and implement corrective action where required. Progress will be monitored at CAG and Board level

- **Embedding patient experience responsibilities into each and every role** – All job descriptions will include a commitment to improve patient experience and this will be reflected in objective setting, and their appraisal and development. Systematic feedback from patients and carers will be included in the appraisal of senior clinical staff and any learning needs will be included in professional development plans.

Through the work of the CAG working groups, significant opportunities have already been identified for improving clinical quality, patient safety, patient experience and operational performance. These are covered in more detail in Section 6.1. Service reconfiguration is not anticipated as part of the merger. If the need arises in the future, appropriate consultation will be undertaken before making any changes.
In addition there will also be a strong focus on building on existing services and relationships with community and primary care services. Greater vertical integration of services will deliver more seamless pathways of care and a better patient experience. It is also recognised that, quite often, partners working in community and primary care are best placed to identify the particular needs of at risk and hard to reach groups and advise acute services accordingly.

“As a single organisation we immediately lose organisational boundaries, with single teams working across multiple sites – without the need for inter-Trust referrals or approvals. In neurosurgery, we will be able to ensure seamless emergency advice and onward care without the need for inter Trust contracts as the neurosurgeon will own the patient and will be part of a single team. For similar reasons the current cancer network will work better, with faster access to experts, diagnosis, and treatments. This will not happen over night! Through the CAG leadership there will be a clear expectation that clinical teams will work to streamline pathways and remove duplication and hand-offs that bring delays to treatment, frustrate patients and builds in unnecessary costs.”

Mike Gill, Medical Director, Newham University Hospital NHS Trust

4.2.4 Financial resilience and a sustainable platform for acute services in north east London

WCUHT and NUHT face serious financial challenges in the coming five years and it is highly likely that, without merger, one or both of the Trusts will end up in the NHS failure regime. This outcome would result in great uncertainty over the future of essential local services such as A&E and maternity in Waltham Forest and Newham.

The increased financial resilience of the combined organisation will reduce the risk of disruption to these services.

Key financial risks facing the existing organisations are:

- A high degree of variability in the year-on-year CIP requirement within the three existing Trusts
- The deliverability of steep CIP requirements
- Delivery of recommendations for staffing out of hours emergency services which constitute a significant cost pressure
- Extremely weak cash positions of WCUHT and NUHT
- Inability to invest in the estates at WCUHT in a timely manner to respond to reconfiguration plans within the Health for north east London programme.

Simply bringing the existing Trusts' financial forecasts together, before beginning to consider cost reduction opportunities resulting from the merger, provides a significantly improved combined financial position. CIP requirements are smoothed, reducing peak requirements. The extremely weak cash positions of WCUHT and NUHT are somewhat alleviated through combination with BLT.

4.3 The role and focus of the new organisation

So far, this Chapter has set out the vision and strategic objectives for the Merged Trust, and has outlined the measures for its success over the next five years. Chapter five will describe how the new Trust will be structured and governed to achieve its vision. Before moving onto Chapter 5, it is important to understand more about the business, role and focus of the Merged Trust.
4.3.1 Balance of local, regional and specialist national activity

Collectively, the three Trusts currently provide a comprehensive portfolio of services which span community care, local secondary care, and specialist services at a pan London and national level. The Trusts sources of income from different geographical areas are set out below.

Table 22: Sources of clinical income by geographical area

<table>
<thead>
<tr>
<th>Source, inner and outer London Boroughs</th>
<th>BLT (%)</th>
<th>NUHT (%)</th>
<th>WCUHT (%)</th>
<th>Merged Trust (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CITY AND HACKNEY TEACHING PCT</td>
<td>8%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>NEWHAM PCT</td>
<td>12%</td>
<td>91%</td>
<td>6%</td>
<td>22%</td>
</tr>
<tr>
<td>TOWER HAMLETS PCT</td>
<td>28%</td>
<td>1%</td>
<td>0%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>49%</td>
<td>92%</td>
<td>7%</td>
<td>45%</td>
</tr>
<tr>
<td>BARKING AND Dagenham PCT</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>HAVERING PCT</td>
<td>4%</td>
<td>0%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>REDBRIDGE PCT</td>
<td>5%</td>
<td>1%</td>
<td>20%</td>
<td>8%</td>
</tr>
<tr>
<td>WALTHAM FOREST PCT</td>
<td>6%</td>
<td>1%</td>
<td>60%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>18%</td>
<td>5%</td>
<td>82%</td>
<td>32%</td>
</tr>
<tr>
<td>LONDON - OTHER</td>
<td>10%</td>
<td>1%</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>EAST OF ENGLAND (INCLUDING ESSEX)</td>
<td>9%</td>
<td>1%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>OTHER UK COMMISSIONERS</td>
<td>14%</td>
<td>1%</td>
<td>1%</td>
<td>9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Trusts’ SLAM Databases: Planned Activity and Revenue Report 2011/12

As shown in Table 22 above, the focus of NUHT and WCUHT is primarily on delivering local acute services; 91% of NUHT clinical income is from Newham, and 80% of clinical income at WCUHT is from Waltham Forest and nearby Redbridge. In contrast, BLT’s provision of local services to the catchment population of Tower Hamlets constitutes just 28% of the Trust’s clinical income. Even taking into account income from the other inner north east London Boroughs, local secondary care services remain a minority stake of the BLT’s clinical income portfolio (49% in total).

Going forward, the Merged Trust will continue to provide the same comprehensive range of services - from community services in Tower Hamlets, secondary care services to inner and outer north east London boroughs and specialist services at a pan London and national level.

Table 23 below illustrates that the Merged Trust will have an operating revenue of £1,167bn, of which 81% will be generated by NHS acute activity, 8% will be from education and training, and 3% from research activities.

Table 23: Forecast outturn operating revenue and income 2011/12

<table>
<thead>
<tr>
<th>Operating Income and Revenue</th>
<th>BLT (£m)</th>
<th>NUHT (£m)</th>
<th>WCUHT (£m)</th>
<th>Merged Trust (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Acute Activity Revenue</td>
<td>579.0</td>
<td>153.0</td>
<td>215.6</td>
<td>947.6</td>
</tr>
<tr>
<td>Non NHS Clinical Revenue</td>
<td>5.0</td>
<td>-</td>
<td>1.7</td>
<td>6.7</td>
</tr>
<tr>
<td>Other Operating income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research and Development income</td>
<td>34.1</td>
<td>0.6</td>
<td>0.5</td>
<td>35.2</td>
</tr>
<tr>
<td>Education and Training income</td>
<td>79.0</td>
<td>7.2</td>
<td>8.8</td>
<td>95.0</td>
</tr>
<tr>
<td>PFI Specific income</td>
<td>17.0</td>
<td>-</td>
<td>-</td>
<td>17.0</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>41.4</td>
<td>12.3</td>
<td>11.5</td>
<td>65.2</td>
</tr>
<tr>
<td>Operating Revenue and Income, Total</td>
<td>755.5</td>
<td>173.1</td>
<td>238.1</td>
<td>1,166.7</td>
</tr>
</tbody>
</table>

Source: Trust LTFMs November 2011.

Local acute services, and local service improvement will remain strategically important to the Merged Trust as illustrated by Figure 3. 77% of the trust’s clinical income will be derived from
Inner and Outer London PCTs which include the immediate catchment populations of Tower Hamlets, Newham Waltham Forest. Referrals for specialist services from other areas of London, Essex and at a national level will constitute 23% of the new organisation’s clinical income.

Figure 3: Projected sources of income for the Merged Trust by geographical area

![Merged Trust Pie Chart]

Source: Trusts’ SLAM Databases - Planned Activity and Revenue Report 2011/12

4.3.2 Balance of elective and non elective services

All three Trusts currently deliver the full range of local acute hospital services, including maternity, paediatrics, urgent and emergency care. With regards to the balance between elective and non elective care there is variation between the portfolios of the existing Trusts, as illustrated by 4.

Table 24: NHS clinical activity 2010/11 by point of delivery

<table>
<thead>
<tr>
<th></th>
<th>BLT</th>
<th>NUHT</th>
<th>WCUHT</th>
<th>Merged Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective (FCEs)</td>
<td>16,387</td>
<td>2,440</td>
<td>6,126</td>
<td>24,953</td>
</tr>
<tr>
<td>Elective - Day Case (FCEs)</td>
<td>30,075</td>
<td>10,239</td>
<td>34,629</td>
<td>74,943</td>
</tr>
<tr>
<td>Non Elective (FCEs)</td>
<td>54,398</td>
<td>38,439</td>
<td>47,012</td>
<td>139,849</td>
</tr>
<tr>
<td>Total (FCEs)</td>
<td>100,860</td>
<td>51,118</td>
<td>87,767</td>
<td>239,745</td>
</tr>
<tr>
<td>% Elective</td>
<td>46%</td>
<td>25%</td>
<td>46%</td>
<td>42%</td>
</tr>
<tr>
<td>% Non-Elective</td>
<td>54%</td>
<td>75%</td>
<td>54%</td>
<td>58%</td>
</tr>
<tr>
<td>Maternity (births)</td>
<td>4,377</td>
<td>6,003</td>
<td>5,541</td>
<td>15,921</td>
</tr>
<tr>
<td>Elective - Regular Day Attendance</td>
<td>21,715</td>
<td>-</td>
<td>-</td>
<td>21,715</td>
</tr>
<tr>
<td>Outpatient Attendances</td>
<td>594,176</td>
<td>242,061</td>
<td>479,342</td>
<td>1,315,579</td>
</tr>
</tbody>
</table>

Source: Trusts Minimum Dataset 2010/11

Services provided by NUHT are predominantly non elective, accounting for 75% of inpatient activity. As a result of projected future demand for non elective care, NUHT is finalising plans for significant capital investment in its emergency and urgent care facilities.

The portfolio at WCUHT and BLT is similarly weighted towards non elective care but proportionately less so than NUHT, 54% of inpatient activity at both Trusts. WCUHT has a greater elective service, including surgical subspecialties such as ophthalmology, ENT, and
maxillofacial services. Support to WCUHT’s non elective role will be enhanced by the capital investment of £23m to upgrade existing A&E facilities that is currently underway.

BLT also provides the full range of acute elective and non elective services to the local communities of Tower Hamlets, and this includes being a major trauma and hyper acute stroke centre. BLT is also a major specialist services provider, receiving pan London and national patient referrals. The growth of specialist services at BLT is evidenced by the capital programmes across the St Bartholomew’s and Royal London sites. A state-of-the-art cancer centre opened at St Bartholomew’s hospital in 2010 complementing the existing breast care centre, and a cardiac centre of excellence is due to open on the same site in 2014. On the Royal London site a £650m new build hospital will include an internationally recognised trauma centre, one of Europe’s largest renal services, as well as other tertiary services such as specialist cancer surgery, vascular services, neurosurgery and paediatrics.

Going forward the portfolio of the Merged Trust will be weighted towards non elective care comprising approximately 58% of activity. The scale of the Merged Trust’s activities will be notable, with approximately 1.3m outpatient attendances; 100,000 elective and 140,000 non elective episodes per year; and 16,000 births.

The overall profile of the Merged Trust’s portfolio comprising elective, non elective and maternity episodes (but excluding outpatient activity) is illustrated by Figure 4 below.

Figure 4: Profile of the Merged Trust’s portfolio by point of delivery

![Figure 4: Profile of the Merged Trust’s portfolio by point of delivery](Source: Trusts Minimum Dataset 2010/11)

4.4 Lessons learned from other mergers

Historical examples of organisational mergers from both the public and private sector demonstrate that integration is a challenging and complex process. The practical demands can sometimes delay or even obviate the benefits that are anticipated. Therefore, the need to plan the integration carefully is imperative, taking into account lessons and evidence from elsewhere.

With this in mind, the integration roadmap set out in Section 4.4, has been strongly influenced by an awareness of the common pitfalls and challenges that mergers face. The aim is to maximise the available benefits of the merger and shorten the time it will take to realise these. This section sets out the key learning from prior merger experience which has been reflected in integration planning activities.
4.4.1 Establishing a manageable transition

Undertaking multiple aspects of organisational change in a relatively short period of time is a common cause of merger failure. With a compact work programme, there is a high risk that the new leadership team will lack the capacity to maintain delivery of safe, high quality and effective services whilst delivering the transition to a new organisation and dealing with the unplanned risks and challenges. In turn this could jeopardise the Trust’s ability to maintain safe and high quality care to patients.

For this reason a phased approach to integration will be adopted, allowing the new organisation to focus on team and process integration in Year 1, service improvement in Year 2 and transformation change in services and infrastructure from Year 3 onwards. This approach will enable the new organisation to integrate quickly, but leaves sufficient headroom for the new leadership team to manage the transition whilst also maintaining operational standards.

Equally, funding support to the transition period has deliberately been sought to reduce the Year 1 CIP requirement. Whilst still ambitious, the cost improvement requirement during Year 1, the critical integration year, will be kept to an achievable and realistic level (3% CIP target with additional merger synergy savings of 1%).

Whilst driving cross trust improvements at a service line and patient pathway level, there is also a risk that essential site based services are overlooked and poorly managed through transition. This can ultimately have a negative impact on the quality of care and patient experience. This may include services such as care records management, portering, and bereavement services which, although small, play a vital role in enabling hospital services to run smoothly. Under the plans for the merged organisation, each hospital site will have a dedicated senior hospital manager who will be responsible for ensuring strong site management.

4.4.2 Focus on clinical leadership and innovation

Clinical support and involvement

It is recognised that for the merger to be successful clinical support and involvement is essential. From the very beginning, clinical leaders and senior operational leaders from across the three Trusts have been involved and integral to the integration planning process. This involvement will continue throughout the transition and beyond. Strong clinical leadership will be at the heart of this merger with each of the eight CAGs led by a Group Director who will be clinically qualified.

The merger programme has been driven by senior clinicians through the development of eight CAG working groups, which have met frequently since May 2011. They are each led by a sponsor who is an executive director from one of the three Trusts, and supported by a lead manager with input from the organisation development team which includes staff from across the three Trusts. The CAG working groups have played a central role in developing the merger proposal, setting the clinical strategic objectives for each CAG, identifying the clinical benefits, developing the integration plans, and raising and mitigating clinical risks. Work has also focussed on developing the structure for each CAG, and identifying the opportunities for standardisation. Since March 2011, there have been nine clinical workshops, open to all clinical staff. These workshops have brought a wide range of clinicians together from across the three Trusts to discuss and contribute to the merger process.

Whilst the initial focus will be on integration, the Merged Trust will encourage and enable evidence-based innovation, together with the development which should follow from

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1 In the OBC, 11 Clinical Groups were originally set out. These were consolidated into eight CAGs following feedback from clinical groups and clinical sponsors regarding the key links and interdependencies between services.
The new organisation

research. Each of the CAGs will have a lead for research and education, and clinical teams will be encouraged to be involved with accredited research programmes. Innovation will also be promoted through service transformation, using established improvement methods such as Lean.

Clinical leadership

The transformation in healthcare delivery and health outcomes for the local population will not be achieved without accompanying transformations in clinical leadership. Clinical leadership must have a multi-professional and a multiple stakeholder perspective - absolutely putting the public and patients at the centre of care.

Leaders will be selected with the right attributes and they will be supported and developed to enable them to achieve their potential. Furthermore, as with other areas of transformation and improvement, an evidence-based approach will be undertaken to develop clinical leaders. In respect of medical clinical leaders, the latest research such as ‘Engaging Doctors: What can we learn from international experience and research evidence?’\(^2\) and ‘Can doctors influence organisational performance?’\(^3\) will be utilised. In respect of nursing leadership, the Directors of Nursing of the 19 partner organisations that make up University College London Partners (UCLP) have commenced work on developing an academic career pathway for nurses and midwives across UCLP, ensuring the future development of clinical academic leaders. This work will commence with a focus on the selection, assessment and development of existing and future Senior Sisters (Team Leaders) and Charge Nurses.

The new organisation will focus on bringing these developments together to form a platform of multi-professional and system-wide leadership which extends beyond organisational boundaries. Organisations are based on systems but they are built on their culture delivered through leadership and followership. Clinical leadership is a key part of the Merged Trust’s Organisational Design strategy as outlined in Section 9.6.

4.4.3 Post merger integration planning

A common cause of merger failure is poor post merger integration planning. This can have the effect of slowing progress to the end state, increasing transition costs, and most importantly distracting from the delivery of safe, high quality, patient-centred care.

To mitigate the risk of this occurring, a programme management approach has been applied to pre-merger preparations and to post-merger implementation. This structure will ensure rigorous and consistent planning across all clinical and corporate workstreams and will also provide the framework within which the financial and non-financial benefits of the merger will be tracked. As a result of this approach, the new organisation will reach its end state structure within the first year of operation.

4.4.4 Arrangements for decision making and strong leadership

Delayed or protracted decision making processes immediately before and after a merger is another common cause of merger failure. It is imperative that a new organisation has a clear leadership and decision making structure during the transition to guarantee effective risk management, financial control and operational excellence.

With this in mind, the Merged Trust will have a clear governance structure in place for Day 1 as set out in Section 5.3. A single Board will be established and supported by a number of sub-committees, each with robust terms of reference, lines of reporting and accountability. The governance structure will provide a clear distinction between executive decision making

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\(^2\) Chris Ham and Helen Dickinson, NHS Institution for Innovation and Improvement, 2008

\(^3\) Patricia Hamilton, Peter Spurgeon, John Clark, Julie Dent, Kirsten Armit, NHS Institute for Innovation and Improvement, 2008
groups and committees, and those committees which provide a fundamental assurance role to the Board.

Additionally, decision making will be informed by the detailed project plans prepared by each clinical and corporate workstream during the integration planning phases. These plans will be critical to overcome any confusion or uncertainty regarding transition priorities and will therefore facilitate the delivery of planned immediate benefits post merger.

4.4.5 Estimation of merger synergies and benefits

It is common for mergers to be cited as failures when the originally intended benefits, financial and otherwise, fail to materialise. This is often due to over estimation of synergies and benefits.

From the outset a prudent and rigorous approach has been taken to identifying and quantifying potential merger benefits. Benchmarking relevant to the type and size of the Merged Trust has been employed accompanied by bottom-up rather than top down calculations of productivity opportunities and savings.

Additionally the merger benefits have been developed by clinical and corporate staff who have provided significant challenge and scrutiny, not only to their own proposals but to those of other workstreams. This approach will ensure that the identified synergies and merger benefits are both realistic and achievable.

4.4.6 Other considerations

Analysis of past mergers in the public and private sector has shown there are other factors that contribute to the failure of mergers. A summary of these and the mitigations in place within the merger programme is shown below.

Table 25: Other causes of merger failures and mitigating actions

<table>
<thead>
<tr>
<th>Causes of failure</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of clarity about the strategic rationale for the merger</td>
<td>The top team have clear, agreed and explicit objectives. A Programme Board was set up in the early stages of the process and regular meetings have taken place to ensure optimal alignment of objectives during the process. The governance structure of the programme also incorporates representatives from all three organisations in order to allow the objectives of the merger to be disseminated to the individual trusts.</td>
</tr>
<tr>
<td>Too much emphasis on commercial due diligence, whilst neglecting clinical and HR issues</td>
<td>At the same time as the Due and Careful Enquiry reviewing financial and commercial issues, there will also be external clinical due diligence undertaken in line with the Addendum to the Department of Health’s Transaction Manual. This will include areas such as governance, clinical risk management, clinical leadership, patient and user experience, infection control, safeguarding arrangements and staff training and induction etc.</td>
</tr>
<tr>
<td>Lack of clear messages and quick decision making from the top management team</td>
<td>The merger team has understood the importance of communicating clearly to all stakeholders and the Communications and Engagement workstream has been established early to ensure that consistent and clear messages are communicated to all parties. Communication and stakeholder activities and feedback received is set out in Chapter 8.</td>
</tr>
<tr>
<td>Failure to resolve cultural differences</td>
<td>The programme management approach has utilised workstreams containing staff from each of the three trusts, in order to make sure that there is early input and involvement from each organisation in the development of plans. The HR&amp;OD workstream recognises that there is significant culture change required and has identified this within the resource requirements for transition going forwards.</td>
</tr>
<tr>
<td>Failure to maintain financial and operational performance</td>
<td>Before Day 1, a single reporting system will be in place in shadow form to monitor the performance across four quadrants of Quality, Workforce, Finance and Activity. Chapter 5 sets out further details.</td>
</tr>
<tr>
<td>Poor communications and inductions to new policies</td>
<td>The communications and quality governance workstreams have collaboratively developed a robust process to ensure new policies are widely available in advance of Day 1 where necessary, and to clarify how all new policies will be communicated. This includes removing old policies to avoid confusion.</td>
</tr>
<tr>
<td>Lack of knowledge transfer</td>
<td>Knowledge transfer has been considered and the approach that will be used is described in Section 9.7</td>
</tr>
</tbody>
</table>
4.5 The integration roadmap to achieve the Merged Trust’s vision and strategic outcomes

In the context of the lessons learnt from other mergers, careful consideration has been given to designing the proposed integration journey. In addition to ensuring the engagement of the clinical leadership from the very start, a pragmatic approach has been adopted to ensure integration is achieved early and quickly.

Year 1 – 2012/13 - Integration

During its first year of operation, the Merged Trust will focus upon integration and the move from three leadership and management structures to one integrated team in order to maintain clinical, operational and financial control. The new leadership and management team will focus on maintaining safe, high quality services. Financially the new Trust will focus on delivering flow through from the cost improvement programmes started in 2011/12 and realising additional savings from the integration of corporate and clinical management teams. Preparation work will also take place for planned service improvements. All other change will be kept to a minimum to ensure day-to-day clinical service responsibilities, patient safety and the achievement of operational and financial targets are not compromised.

Year 2 – 2013/14 - Service Improvement

By Year 2 the functional integration programmes will be completed and the focus will turn to service improvement. A number of programmes will be implemented across the CAGs to deliver patient experience improvements and financial benefits including productivity initiatives driven by clinical standardisation and changes to clinical pathways identified by CAGs in their pre-merger planning work. Such productivity initiatives will begin to move the Merged Trust to a position of ‘best in class’ across all specialties. Additional short-term improvements identified during the ongoing clinical strategy development process will be implemented whilst medium to long-term schemes are finalised.

Year 3 to 5 – 2014/15 to 2016/17 - Service transformation

From Year 3 onwards, the new organisation will enter a period of transformation including larger scale pathway redesign, informed by the finalised clinical strategy, and developed in partnership with patients and commissioners.

Integration of Informatics systems will take place, including the consolidation of the Care Records Systems. From Year 4, the CRS and PACS systems will be re-procured for the Merged Trust. This will also be a time when the trust will be able to build upon a year’s worth of financial data to refine Service Line Reporting, which will underpin effective Service Line Management in the organisation.

The agreement of the overarching clinical strategy during Year 2 will inform the development and delivery of the estates strategy in Years 3-5. Key decisions will be made around estates renewal and utilisation. At the same time, the large scale redevelopment of Barts and The Royal London Hospitals will be completed along with other capital investment schemes at WCUHT and NUHT enhancing emergency and urgent care facilities at those hospitals.

By taking a phased approach of integration, improvement and transformation, headroom will be maintained to ensure the Merged Trust is able to respond to immediate priorities, risks and challenges as they arise along the integration journey. It is well understood that getting the basics right in Year 1 will continue to pay dividends in the years to come.
5. **The new organisation – structure and governance**

**Synopsis**

The Merged Trust has designed its organisational and governance structure against a suite of agreed design principles, which will establish the new organisation like a Foundation Trust from the beginning. Executive and non executive portfolios are clearly delineated, as are executive decision making groups and committees, and those committees which provide a fundamental assurance role to the Board. Accountability from the Board to the ward / point of service delivery via the Clinical Academic Groups (CAGs) and service lines is clearly visible.

The eight CAGs will provide the engine room to the new Trust delivering the vision and strategic objectives set out in Chapter 4 aided through a suite of five enablers to drive the highest levels of quality across clinical services, research and education.

The Merged Trust will have a clear and coherent performance management framework that ensures an integrated approach to managing performance across quality, workforce, finance and activity. Existing early warning systems in place and proving effective at BLT (Safetynet) will be adopted for the Merged Trust to highlight areas of risk that require immediate action. Responsibility for operational performance will be devolved to the lowest possible level in the organisation, namely the ward / service / department providing the direct care to patients. With a system of devolved autonomy there needs to be a clear intervention process and this is set out in the failure regime for the Merged Trust.

- Section 5.1 sets out the design principles used to inform the development of the new structure and governance arrangements
- Section 5.2 provides an illustration of the Merged Trust’s organisational structure and summarises the roles and portfolios of executive and non executive directors
- Section 5.3 explains the governance structure of the new organisation
- Section 5.4 introduces the eight CAGs within which services will be organised.
- Section 5.5 sets out the core values of the CAGs
- Section 5.6 explains the key enablers which the CAGs will use to achieve the Trust’s vision and strategic outcomes
- Section 5.7 sets out the risk management arrangements for the Merged Trust
- Section 5.8 outlines the business planning and contracting process
- Section 5.9 provides an overview of the reporting and performance management framework.

**5.1 Design principles**

The merger has provided the opportunity to involve clinicians and staff in building a structure for the Merged Trust that can best meet the needs of the population, and improve health and healthcare.

This merger is not an acquisition or an informal collaboration; it is a full integration of the three acute providers which also includes Tower Hamlets Community Health Services. The merger provides the opportunity to start with a clean slate and design a structure that is fit for purpose – one that ensures that the organisation can meet the challenges of the future and achieve its objectives. The structure of the Merged Trust has been designed to be robust and
The new organisation – structure and governance

capable of taking it through a successful merger, demonstrating sound performance within the first year and achieving Foundation Trust status by December 2014.

The new organisation aims to achieve Foundation Trust status by the end of 2014. The organisational structure (Board and management level) has been designed to be consistent with this aim. The corporate governance and organisational design features of the new organisation will be fit for FT authorisation, with other aspects of FT governance developing as soon as possible (for example, in relation to membership arrangements for patients, the public, and staff).

In order to develop the structure for the Merged Trust, a range of models within the UK and internationally have been considered. The result is a model that best fits local needs and the future requirements of Monitor.

This structure is underpinned by ten design principles which were initially identified as a foundation for the design:

1. Patient care, service delivery and education and research will be embedded into management structures and processes
2. Clinical leadership will be visible, multi-professional and aligned to the organisational vision
3. Management will be structured to achieve a balanced span of control – with no more than four layers and ten direct reports
4. Responsibilities will be devolved to local business units wherever possible
5. Clear lines of accountability will exist between the Board and the Ward
6. A clear set of behavioural standards will underpin the organisational values and form the basis of performance and talent management
7. Services must support seamless patient pathways across sites and services – vertically and horizontally
8. Each major site will have a senior responsible manager
9. Single trust-wide policies, systems and processes will be aligned to the organisational vision
10. Communications will be directed laterally across groups and sites, vertically through the hierarchy, and outwardly towards networks, commissioners and other stakeholders.

5.2 Organisational structure

The Merged Trust will be organised into eight CAGs. The organisation’s corporate functions will be overseen by the Executive Team as shown in Figure 5 below.
The new organisation – structure and governance

Figure 5: Organisational structure of the Merged Trust

The constitution of services within CAGs was developed with clinicians and managers from across the three trusts and the provisional allocation of services was confirmed in July 2011. A review of the proposed CAGs has since taken place and has highlighted several aspects which are receiving further consideration. The fine detail of the constitution of the CAGs is likely to continue to evolve.
5.2.1 Non executive and executive directors

From Day 1, the new Trust Board, comprising non executive and executive members, will be in place and accountable for overall Trust performance. It will govern the Trust effectively, setting the strategic direction and values of the organisation and providing assurance on delivery of the Trust's objectives (including in relation to workforce, clinical quality and safety, patient experience, finance and activity). The Board will also lead on engagement with external stakeholders.

Non executive membership will consist of a non executive Chair and six other non executive directors, including a nominated appointment from Queen Mary University of London. From Day 1, voting executive members will comprise the Chief Executive, Chief Financial Officer, Medical Director, Chief Nurse and Chief Operating Officer. Non-voting executive membership will comprise the Director of Human Resources and Organisational Development, Director of Strategy, Director of Education, Research and Development and the Director of Corporate Affairs/Trust Secretary.

Chief Executive Officer

The Chief Executive Officer (CEO) will be accountable to the Chairman and the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board. The CEO will have overall responsibility for the delivery of the Trust's strategy and objectives. The CEO will be responsible for ensuring that the Trust meets all legal, contractual and financial obligations placed upon the organisation. The CEO will ensure that effective management systems and corporate governance structures are in place. The CEO will ensure that Trust staff:

- have a clear view of their objectives and how their achievement of these objectives will be measured
- are assigned well-defined responsibilities for making the best use of resources
- have the information, training and access to the expert advice they need to exercise their responsibilities effectively.

The CEO will be the Accountable Officer of the Trust with responsibilities as set out in the Accountable Officers Memorandum issued by the Department of Health.

The following executive directors will report directly to the CEO:

Medical Director

The Medical Director will provide medical leadership, working with partners to establish and sustain the vision and strategy of the Trust. Alongside the Chief Nurse, The Medical Director will provide assurance to the Trust Board that planned service changes will deliver improvements in clinical quality, safety, patient experience, and in value for money and will contribute to improvements in health.

The Medical Director will provide medical leadership for all Trust doctors, ensuring their commitment to the evolving clinical strategy. The Medical Director will provide professional leadership for the Group Directors, Clinical Directors and Clinical Leads. They will also oversee job planning and will lead the introduction of revalidation (demonstration of fitness to practice) of doctors. The Medical Director will work closely with the HR directorate in this capacity.

The Medical Director will also work in collaboration with the Chief Nurse to deliver the governance agenda. Specifically, they will provide leadership for clinical audit, together with aspects of infection control and patient safety.

The Medical Director will provide clinical leadership for strategic partnerships with key stakeholders in primary and community care, local public health teams, commissioning, local
government, NHS London and the Department of Health. This will include interfacing with primary care commissioning and provision, with input from a Director of Primary Care and a small team of colleagues. The Director of Public Health, also accountable to the Medical Director, will co-ordinate the health improvement agenda, drawing on the expertise and resources within the public health teams. Both post-holders could hold academic contracts with the Department of Primary Care and Public Health at QMUL.

The Medical Director will lead the Directorate of Medical Informatics, ensuring that Trust information systems support both clinical services and corporate teams. The Medical Director will be accountable to the Board for the development and implementation of the Trust’s Informatics Strategy. Day to day responsibility will sit with a Director of Informatics who will report directly to the Medical Director.

Chief Nurse

In accordance with the statutory responsibilities set out in the NHS Act 2006, each Trust must identify an accountable officer for Infection Prevention and Control (IPC), Controlled Drugs, and Safeguarding (adults and children). The Merged Trust has determined that this accountable officer will be the Chief Nurse. The Chief Nurse will be the most senior nurse employed by the Trust and their role will be to serve the organisation in both a nursing and managerial capacity as Head of Nursing, Midwifery and Allied Health Professional Staff.

The Chief Nurse will be responsible for promoting excellence in all areas of nursing, midwifery and allied health professional clinical practice and patient care. This includes ensuring appropriate professional standards and practices are maintained, as well as adherence to statutory regulations. Effective leadership arrangements will be implemented which support professional development, effective working arrangements and service delivery at all levels. The Chief Nurse will develop an inter-professional strategic direction for nursing, midwifery and allied health professionals, which is research and evidence based, and in line with the Trust’s future strategy. This will include ensuring that these professions increase their capability and capacity to undertake research programmes and to develop a sustainable academic career pathway. The Chief Nurse will work closely with the universities in both the undergraduate and postgraduate programmes to promote and develop the roles of nurses, midwives and allied health professionals.

The Chief Nurse will be accountable for the development and implementation of a robust quality governance framework across all areas of the Trust’s business. This work includes involvement of patients and their representatives throughout the organisation and development and delivery of the patient experience strategy. Such activities will be integral to achieving the vision of effective and safe patient care.

The management portfolio of the Chief Nurse will include quality governance; safeguarding adults and children; falls; continence; nutrition; infection control; and tissue viability.

Chief Operating Officer

The Chief Operating Officer (COO) will be responsible for the operational leadership and management of the eight CAGs across the Trust’s geographic locations. The CAG Group Directors will be accountable to the COO for the performance of the CAGs and for the successful delivery of the Trust’s clinical operations including delivery of all national and local targets. CAGs will have responsibility for the implementation of the Trust’s clinical services strategy as well as ensuring the continuation of ‘business as usual’ day-to-day operations. The COO will also be responsible for ensuring that the Trust has robust business continuity arrangements in place.

The COO will also lead on modernisation and process redesign initiatives and the management portfolio of the COO will include the Service Transformation team. The purpose of this team is to support the design, implementation and monitoring of key service development and service change projects. The COO will manage the estates and facilities function, enabling the requirements to be directly aligned to the day-to-day clinical and operational services.
In addition to the CAGs, the COO will also be accountable for the site specific services. There will be strong site and hospital management, with a senior hospital manager at each main site reporting to the COO. This will ensure that the necessary infrastructure, resource and support for the CAG services are provided at each site in a timely, efficient and high quality manner. This will include management and provision of key services such as outpatients, discharge and bed management, site management, bereavement and chaplaincy services. The COO will also be the Executive lead for equalities and diversity.

**Chief Financial Officer**

The Chief Financial Officer (CFO) will be responsible for managing the financial performance of the Trust through effective planning, forecasting, budgeting and delivery. The CFO will hold have responsibility for commissioning and contracting, business planning, and procurement, and will lead the development of new commercial opportunities for the Trust.

The CFO will provide objective financial analysis in support of decision-making, ensuring that all opportunities and risks are fully appraised and that decisions made are fully aligned with the Trust’s overarching strategic objectives. In particular the CFO will be responsible for ensuring that capital programmes are underpinned by rigorous value-for-money analysis.

The finance directorate will follow leading practice by embedding key finance staff within clinical management teams to add insight and challenge in support of operational and strategic decision-making. Responsibilities for generating target income will be devolved to the CAGs, providing greater transparency regarding the relative cost and profitability of services. Service line management and patient level costing will also support this process.

The CFO will also lead on value-for-money and cost effectiveness, and on the centralisation of transactional functions such as accounts payable.

**Director of Human Resources and Organisational Development**

The Director of Human Resources and Organisational Development (HR and OD) will be responsible for developing the workforce strategy, policies and procedures that align with and support organisational development and the organisation’s overall strategic aims and objectives. The Director of HR and OD will play a key role in ensuring the Trust is fit for purpose and can respond quickly to service developments and changes.

The objective of the future HR and OD directorate will be to support the creation of a high performing workforce that achieves excellent clinical, operational and financial outcomes. The HR strategy aims to create an environment that supports personal development and promotes the Merged Trust as an employer of choice locally and nationally. The strategy also seeks to drive efficiency and continuous improvement through integrated HR systems and a robust framework.

Transactional and specialist HR services will be centralised, whilst HR Business Partners will operate alongside CAG Managers to provide high quality and accessible HR advice and support. This dedicated support will enable the CAGs to operate effectively and assist them in achieving their strategic objectives and clinical and financial benefits arising from the merger.

**Director of Strategy**

The portfolio of the Director of Strategy will include service strategy, business development, marketing, and communications and engagement.

The strategy directorate will serve as a corporate resource to the CAGs and the Trust Board in determining the strategic direction of the Trust and the supporting plans and developments. The Director of Strategy will therefore lead major initiatives that have implications for the size, shape and strategic direction of services, for example service designation and reconfiguration within and beyond the Trust. The directorate will also lead on the development of strategic partnerships and relationships within the local and wider health economy and it is anticipated that the directorate will coordinate the Trust’s future application for FT status.
The directorate will work closely with the CAGs, providing a capability to develop plans and strategies (informed by and responding to commissioning plans, service line economics and service reviews) that address clinical and commercial priorities. A key role for the directorate will be developing the strategic capability of CAGs and over time, some functions and capacity within the strategy directorate may be devolved to the CAGs.

The communications and engagement function will encompass media and stakeholder relations, publications, reputation management, intranet and website content, internal communications and social media. The team will also support GP communications and marketing initiatives (including social marketing).

**Director of Education and Research**

The Director of Education and Research will be responsible for developing and implementing the Trust's Education and Research & Development (R&D) strategies and ensuring that the Trust meets its obligations as both a sponsor and host provider of Education and R&D activities and a member of the UCL Partners (UCLP) Academic Health Sciences System. A key part of the role will be managing relationships with external partners such as the Queen Mary University of London (QMUL), UCLP and representatives from other universities.

The Trust's R&D activities will be managed through a joint R&D office operated in partnership with QMUL. The R&D team will support and advise researchers in meeting the requirements of UK regulatory frameworks. The team will negotiate contracts with external organisations for commercial and non-commercial trials and will also carry out risk assessments on sponsored and hosted clinical trials. The R&D team will include a finance function which will provide support in costing studies and managing the accounts for commercial and non-commercial trials.

The Director of Education and Research will oversee and have responsibility for the governance of the multi-professional education and learning directorate (MELD which will include the following functions: learning and development; simulation and clinical skills; knowledge services; nursing, midwifery, and allied health professional education; lead provider services; post graduate medical education; under- and post-graduate dental training; and undergraduate medical training.

**Director of Corporate Affairs/Trust Secretary**

The Director of Corporate Affairs will be responsible for establishing and maintaining high standards of corporate governance in the Trust and for working with and in support of the Chair and CEO to meet their obligations to ensure that the Trust complies with all statutory and regulatory requirements. They will establish and manage procedures for the sound corporate governance of the organisation and advise the Trust Board and individual executive and non executive directors on corporate governance issues as well as supporting the Chair in the development and appraisal of the Board.

The Director of Corporate Affairs will manage the Trust Secretariat, ensuring that effective support is provided to the Trust Board and its committees, and will coordinate the Trust’s Board Assurance Framework and policy development and approvals processes. They will hold and maintain all necessary registers and act as the initial point of contact with regulatory bodies including the Care Quality Commission and, in due course, Monitor. They will also be responsible for compliance with the Freedom of Information Act.

They will be responsible for the development and implementation of the Trust’s FT membership strategy and the management of the membership function.
5.3 Governance arrangements

5.3.1 Board structure

The outline structure for the Merged Trust shown in Figure 6 is in keeping with the structures used within FTs. The structure is streamlined and designed to provide clear accountability for all aspects of the Merged Trust's operations. The sub-committees are focused on providing assurance to the Board, and the structure as a whole is intended to clearly define executive and management responsibilities.

Figure 6: Outline board structure of the Merged Trust

This structure will enable the Trust Board to gain assurance over all aspects of governance, risk management and internal control through the Audit and Risk Committee and the Quality Assurance Committee.

The Finance and Investment Committee will provide an independent and objective review of financial and investment policy and performance issues. The Nominations Committee will oversee the appointment of the CEO and Executive Directors while the Remuneration Committee will determine the remuneration policy and set individual remuneration arrangements for the Trust's senior managers. (Further information about the Equalities Committee is provided in Section 5.3.3).

As the new organisation approaches FT status, the structure will be adapted to include a Council of Governors which will be the formal link to its staff, public and patient membership.

A key feature of this structure is that the five groups which will operate within each CAG also report to a committee with the same focus which takes a Trust-wide view over that area. These committees then report to the Management Board and the CEO who in turn reports to the Trust Board. This provides a clear line of accountability and ensures that these key subjects are governed consistently.
5.3.2 Quality governance

The proposed governance framework takes into account Monitor’s effective quality governance parameters: strategy; capability; structure & processes; and measurement. It is also underpinned by the following three key principles:

- Patients (their safety and experience) are central to, and drive quality governance in the newly merged organisation
- There is integration of operations, quality, and governance at CAG level
- The CAG leadership team have shared co-responsibilities for quality and governance delivery.

The proposed Quality Governance Framework comprises three interlinking component parts as shown in Figure 6:

1. Quality Governance at Board sub-committee level
2. Governance Group reporting structure at Management Board level
3. Quality and Governance accountabilities and structures at CAG and Service Line level.

Given the level of assurance required for patient experience performance indicators and to ensure that patients and carer’s needs are central in the new organisation, a Patient Experience Improvement Group is proposed. It is envisaged that the Patient Experience Improvement Group will be chaired by the patient experience and engagement lead, who will report directly to the Chief Nurse, and the group will include patient and lay members. The involvement model is still being developed with the patient advisors group for the merger. The lead and membership may therefore be subject to change.

The proposed governance framework seeks to significantly increase patient engagement and membership on key quality and improvement groups both at corporate and service (Clinical Academic Group) level.

1. Quality Governance

Each sub-committee of the Board will provide assurance that the organisation is on track to achieve its objectives, and to meet standards of patient care and patient safety.

2. Governance groups

Tier 2 is a Management Board reporting structure with the expectation of delivery against objectives, focusing on operational performance, quality and safety. Reports will go in a standard format and by exception to the Trust Management Board.

3. Clinical Academic Group and Services Governance Framework

Each CAG will form a CAG Board chaired by the CAG Group Director and with a core membership of the Director of Nursing and Clinical Governance, an Operations Director, and a CAG Governance Manager. The guiding principles for these Boards will be taken from the good governance parameters identified by Monitor and included as part of the organisation’s overall quality strategy.

The CAG Governance Manager role will be a senior management post to reflect the level of leadership, coordinating and negotiating skills and experience the post requires.

Additional CAG Board members will vary according to the size and clinical services but typically service managers, clinical leads, AHPs and matrons from the clinical services will attend CAG Board meetings and all will have responsibilities and objectives for quality improvement defined in their roles.
The CAG Board will develop a supporting Governance sub-group structure, as a minimum to include the five groups shown in Figure 7.

**Figure 7: Quality and safety structure – CAG and services governance**

Each of the CAG Boards will be responsible for the following four areas which correspond to Monitor’s Quality Governance Framework and will be delivered through the governance structure described above.

**Figure 8: CAG responsibilities for quality and governance**
5.3.3 Governance framework for promoting equality for the Merged Trust

It will be imperative that the promotion of equality, diversity and human rights is incorporated into all consultation, decision making and action taken in the new organisation with due regard given to the needs of at risk and vulnerable groups as well as the mainstream population.

Like all public authorities, the Merged Trust will have specific obligations in relation to these agendas, but irrespective of this it is recognised that having due regard for the needs of all sections of the community, will be a key enabler for improving patient care, achieving health improvements, and reducing health inequalities. This will require a focus on staff as well as patients.

Specifically, the Public Sector Equality Duty requires authorities to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act in both service delivery and as an employer
- advance equality of opportunity between people who share a protected characteristic and those who do not. These characteristics include age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation
- foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three arms of the general equality duty. Having due regard for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Consideration is currently being given to commissioning a rapid review of the Merged Trust's catchment population by protected group, in terms of the population served, community groups, and the profile of employees. This analysis will provide key baseline information for supporting meaningful equality analysis and effective community engagement. Further details of how health inequalities impact upon protected characteristics is set out in Appendix C.

In designing the merged organisation and delivering the transition, difficult decisions will be made which may result in staff re-locations and staff redundancies. In the context of the public service equality duty such decisions must be made in a fair, transparent and accountable way, and with due regard for the needs and the rights of different members of the community. Failure to meet the equality duty may result in public authorities being exposed to costly, time-consuming and reputation-damaging legal challenges.

Equality analysis measures the impact that changes to policies and practices could have on different protected groups. Equality analysis is not just something the law requires but is a positive opportunity for public authorities to ensure they are making better decisions based on robust evidence. The practice of undertaking equality analysis will help the new organisation demonstrate compliance by ensuring that:

- decision-making includes a consideration of the actions that would help to avoid or mitigate any negative impacts on particular protected groups
• there is a written record of the equality, diversity and human rights considerations taken into account in the decision-making process

• the decision-making process is transparent and based on evidence.

Guidance has been issued to the CAGs and corporate workstreams to assist them in meeting the new organisation’s equality, diversity and human rights agenda. This framework approach covers six areas - developing leadership, strategic planning, community engagement, workforce and partners, use of data and evidence and culture and values. A summary of these six areas within the guidance for CAGs is set out in Appendix D.

Equality leads from the three existing Trusts have also undertaken an initial screening equality impact assessment (EIA) of the Outline Business Case. The purpose of this screening exercise was to inform the development of integration plans and the organisational design processes being undertaken by clinical and corporate workstreams. An overview of the key recommendations from the initial screening along with how the FBC addresses these is set out in the table below.

Table 26: Equality recommendations for integration planning

<table>
<thead>
<tr>
<th>Equality Recommendation</th>
<th>Action Taken</th>
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<tbody>
<tr>
<td>Recognition in the design of the new organisation that advancing equality and human</td>
<td>Advancing equality and human rights has been included in the risk register such that mitigating actions in this area can be monitored and managed</td>
</tr>
<tr>
<td>rights is subject to statutory measures and scrutiny, and any significant underperformance</td>
<td>going forwards. Additionally, a working group consisting of the Equality Leads from each Trust has been established to develop documentary guidance for the workstreams.</td>
</tr>
<tr>
<td>in this area would appear on the Trust’s risk register.</td>
<td></td>
</tr>
<tr>
<td>Workstreams must give due consideration to equalities impact assessments in the design</td>
<td>E&amp;D leads have developed specific guidance on meeting the equality, diversity and human rights agenda as explained Section 5.3.3.</td>
</tr>
<tr>
<td>of new clinical pathways.</td>
<td></td>
</tr>
<tr>
<td>Specific actions to tackle health inequalities must appear in the FBC and CAG work</td>
<td>Examples of trust-wide opportunities to address health inequalities are set out in Section 4.2.1 and the CAGs have incorporated additional service specific opportunities within their integration plans, summarised in Section 5.5.1.</td>
</tr>
<tr>
<td>programmes.</td>
<td></td>
</tr>
<tr>
<td>Models of partnership working between relevant stakeholders in north east London must</td>
<td>The Medical Director will have executive responsibility to develop and sustain partnerships. They will be supported by the Director of Public Health who is responsible for working jointly with colleagues internally and externally across the health and social care community on health improvement and equalities initiatives.</td>
</tr>
<tr>
<td>be defined.</td>
<td></td>
</tr>
<tr>
<td>The new organisation’s Equality, Diversity and Human Rights function must have both a</td>
<td>This has been confirmed and will be referenced specifically within the terms of reference of the Equalities and Diversity Committees and working groups described on the next page.</td>
</tr>
<tr>
<td>workforce and patient service remit.</td>
<td></td>
</tr>
<tr>
<td>The organisational structure must explicitly state where executive accountability for</td>
<td>Executive accountability for leadership on equality will sit with the Chief Operating Officer.</td>
</tr>
<tr>
<td>leadership on equality sits.</td>
<td></td>
</tr>
<tr>
<td>An Equality and Human Rights Committee must be established which reports directly to</td>
<td>The governance structure includes a sub-committee of the Board with a remit for equality, diversity and human rights to ensure the agenda is driven forward.</td>
</tr>
<tr>
<td>Trust Board.</td>
<td></td>
</tr>
<tr>
<td>Data collection and risk management systems must be put in place to monitor, identify</td>
<td>An agreed framework for identifying objectives and measuring success will be addressed by the implementation of an equality delivery system which has been endorsed by the three merging Trusts. Objectives will be developed and incorporated within the reporting arrangements for Day 1 of the new organisation.</td>
</tr>
<tr>
<td>and support the management of emerging equality and human rights issues.</td>
<td></td>
</tr>
</tbody>
</table>
Equalities and Diversity Committee

The Merged Trust’s commitment to meeting its legal obligations and to creating an ethos of inclusion will be demonstrated by the establishment of an Equalities and Diversity sub-committee of the Board in the new governance structure. Its remit will be to provide assurance to the Board that the Trust is meeting its objectives with regards to equality, diversity and human rights and to ensure that it is meeting its legal duties.

The committee will also be responsible for developing and implementing the Trust’s equality, diversity and human rights strategy and adoption of an equality delivery system. This delivery system will set out how the Trust will meet its statutory obligations under equality legislation and how it will make a real and positive difference to the experiences of patients and staff.

The Equalities and Diversity Committee will play an integral role in overseeing the design and delivery of initiatives to address health inequalities at an organisational level and at a CAG level, as set out in Section 5.5.1. The CAGs will report on their activities to the Equalities and Diversity Committee which will monitor the progress in developing and delivering schemes and also on changes in health outcomes.

5.4 Clinical Academic Groups

5.4.1 The design of the eight Clinical Academic Groups

The Clinical Academic Groups (CAGs) will be “the engine” of the new organisation, driving up the quality of clinical services in line with the ten pledges. As illustrated by Figure 5, Page 57, clinical services will be organised into eight CAGs. These are:

- Ambulatory care
- Cancer services
- Cardiovascular services
- Children’s services
- Clinical support services
- Emergency care and acute medicine
- Surgery
- Women’s services

The table below sets out the size and scale of the CAGs. All are substantial units, ranging in size from 811 WTEs to 2,572 WTEs, and with an annual expenditure between £47.0m and £162.4m.

Consideration was given to combining the four smaller CAGs into two (a Cancer and Cardiovascular CAG and a Children and Women’s CAG). However, this option was not pursued in order to provide strong clinical leadership for the eight different areas of health care, research and development, and education and learning.
Table 27: Size and scale of CAGs by expenditure and WTEs, 2010/11

<table>
<thead>
<tr>
<th>CAG</th>
<th>Pay and Non Pay Expenditure (£m)</th>
<th>Total WTEs</th>
<th>BLT WTEs</th>
<th>NUHT WTEs</th>
<th>WCUHT WTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory care</td>
<td>108.5</td>
<td>2,150</td>
<td>1,976</td>
<td>92</td>
<td>82</td>
</tr>
<tr>
<td>Cancer services</td>
<td>67.3</td>
<td>524</td>
<td>433</td>
<td>28</td>
<td>62</td>
</tr>
<tr>
<td>Cardiovascular services</td>
<td>63.4</td>
<td>880</td>
<td>735</td>
<td>77</td>
<td>68</td>
</tr>
<tr>
<td>Children's health services</td>
<td>47.0</td>
<td>810</td>
<td>540</td>
<td>140</td>
<td>130</td>
</tr>
<tr>
<td>Clinical support services</td>
<td>103.1</td>
<td>2,118</td>
<td>1,204</td>
<td>242</td>
<td>672</td>
</tr>
<tr>
<td>Emergency care &amp; acute medicine</td>
<td>162.4</td>
<td>2,574</td>
<td>1,097</td>
<td>575</td>
<td>903</td>
</tr>
<tr>
<td>Surgery</td>
<td>124.5</td>
<td>1,879</td>
<td>933</td>
<td>274</td>
<td>672</td>
</tr>
<tr>
<td>Women’s health including maternity</td>
<td>72.7</td>
<td>1,167</td>
<td>381</td>
<td>431</td>
<td>355</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>748.8</strong></td>
<td><strong>12,102</strong></td>
<td><strong>7,299</strong></td>
<td><strong>1,859</strong></td>
<td><strong>2,944</strong></td>
</tr>
</tbody>
</table>

NB: The figures contained above have been arrived at based on a budget mapping process of the existing trust’s finance ledgers. The WTE numbers exclude corporate services roles, roles within the COO structures, externally funded roles and research and governance roles which have been included within the broader corporate services structures. Please note that the above table does not directly reconcile to the numbers used for sizing of the individual CAGs as the above numbers include 1127 WTEs for Community Health Services and 1357 Junior Doctor roles which rotate among the CAGs. WTEs at bands 1-6s have been taken from cost centre budget information only. WTEs at bands 7-9, Career Grade and Consultant level have also been subject to a line-by-line validation by CAGs at a point in time. These may change with any changes to the constitution of the CAGs, and as work is undertaken to move to one finance ledger.

The design of the CAGs was led by clinicians including doctors, nurses, midwives, and allied health professionals, with the leadership of a Sponsor (an Executive Director from one of the three trusts) supported by a Lead Manager for each CAG. Using a set of design principles (summarised in Section 5.1 and set out in full in Appendix E) together with parameters agreed by the current Chief Operating Officers, and nursing advice from the current Chief Nurse/Directors of Nursing from the three trusts, the structure of the CAGs and the distribution of services was developed.

The CAGs designed their structures through a series of clinically led workshops. Where necessary, the design principles, parameters and advice were interpreted to ensure they are fit for purpose for the specific CAG. The proposed structures were validated through a detailed line-by-line allocation of all staff within each of the three Trusts for Bands 7 to 9 together with consultant and career grade doctors. Each CAG Sponsor and Lead Manager signed off the staffing levels and management time estimates.

The proposals were reviewed by the Chief Operating Officers and Chief Nurse/Directors of Nursing. Each CAG proposal was then scrutinised through a gateway review meeting, which included the Chief Executive and Director of HR and OD.

The eight CAGs have identified savings of approximately £2m from synergies arising from the integration of management structures and roles from across the three existing Trusts. There may be some further evolution to ensure that the design of the CAGs best reflects the inter-dependencies between clinical services.

The principle of integration has the key benefit of optimising the opportunities for standardisation to the best in Trust, and enabling service line reporting and service line management (SLM). SLM is the management framework for FTs promoted by Monitor and will enable the Merged Trust to better understand and manage its income, costs and performance, resulting in better patient care and sustainable efficiencies.
5.4.2 CAG leadership

Strategic leadership

Each CAG will be led by a Group Director, supported by a Director of Nursing and Clinical Governance, an Operations Director, and a Lead for Research and Education. This team will bring a breadth of strategic vision, a culture of innovation, and a track record of challenging and leading changes in existing practice, including research and education and learning. They will provide clinical, managerial and professional leadership to the Service Lines within the CAG. CAG Group Directors will be accountable to the Chief Operating Officer for all aspects of clinical, operational and financial performance. They will also work collaboratively with other CAGs to ensure cohesive operational performance across the Trust, and will be the external face of the CAG interfacing with commissioners and other stakeholders.

Service line leadership

Each service line will be led by a Clinical Director and Service Manager, and the larger services also have a dedicated Lead Nurse. They will be directly responsible for service improvement and transformation, with a focus on clinical quality, patient safety, and patient experience, reporting to the CAG Group Director. Each service line will shape their clinical strategy, working with service users, commissioners and wider partners as appropriate. They will prioritise health improvement, in the context of local health needs, as well as health care.

Site based clinical leadership

At a site level each service line will be managed by a Matron and a Patient Pathway Team Leader, accountable to the service line service manager for delivery of services. Although the primary organising principle is to integrate across service lines, some clinical services will also identify a named consultant to provide site-based leadership.

5.4.3 Corporate Support for the CAGs

A key element of the organisational design process has been the identification of specific corporate resources to work directly with each CAG. Corporate posts will be designed to operate in one of four ways

- Localised, and aligned to a specific CAG. For example, each CAG will be supported by an HR Business Partner team that is co-located with the CAG senior management team
- Centralised, and aligned to a specific CAG. For example IT User support staff will be centralised in a call centre but will be organised to deliver remote and desk side support to particular CAGs
- Localised, but not aligned to a particular CAG. For example a materials management team will be located at each site and will work across all wards to monitor and replenish stock
- Centralised, but not aligned to a particular CAG. For example, the accounts payable functions within Finance will be centralised and the staff will be organised to process payments for certain suppliers (most likely on an alphabetical basis) rather than processing payments on a CAG basis.

5.5 The CAG core values

The Merged Trust pledges to provide commissioners and patients with a range of services to a high standard of clinical quality, ensuring patient safety, and delivering best value for money. Services will be provided to the highest standards of clinical and cost effectiveness, nationally and internationally, working with partners to achieve continuing service improvement and transformation. Patient safety will be an absolute priority, with each member of staff taking responsibility for reporting untoward incidents, taking forward the learning, and, when necessary escalating their concerns.
In addition the ten pledges commit the Trust to working in new ways to provide services which also:

- Promote health improvement and the reduction of health inequalities
- Improve the experience of patients and carers
- Promote equalities and human rights, for patients and for staff.

This new emphasis on health improvement, on patient experience, and on equalities will be embedded in these core values of every CAG. Ensuring that their achievement translates from intent to reality will be a priority for every member of every clinical team, with senior staff consistently demonstrating their personal commitment to these core values.

5.5.1 Promote health improvement and the reduction of health inequalities

This is one of the four strategic outcomes for the Trust, working in partnership with the local Health and Wellbeing Boards, as summarised at Section 4.2.1.

This will need to be embedded in the work of each CAG. The aim is that every patient receives the highest quality of clinical care through clinical pathways, which always include appropriate interventions to promote and maintain health, and to prevent deterioration, as far as this is possible.

The CAGs will also be responsible for playing their part in enabling staff to recognise their own health needs, and to access the support provided to reduce any health risks.

Each CAG will take this forward within their early priorities, developing medium and longer term plans which will contribute to the Trust's strategic outcome. For example:

- The Ambulatory Care CAG will ensure that the patient pathway for diabetes includes the interventions to reduce the risk of future complications
- The Cancer CAG will strive to reduce any delays in access to assessment, diagnosis and treatment
- The Cardiovascular CAG will ensure that patients with heart disease are offered every support to reduce their risks of future problems
- The Children’s CAG will develop the patient pathway for children with sickle cell disease, to enable every child to live as a life which is as healthy and fulfilling as possible
- The Clinical Support Services CAG will support other CAGs in reducing barriers to investigation e.g. through the further development of “one stop clinics”
- The Emergency Care and Acute Medicine CAG will ensure that the needs of acutely ill older people are understood and met, so that they can recover and return home as quickly as possible
- The Surgery CAG will tackle the need to help patients who smoke to stop smoking before an elective operation
- The Women’s CAG will ensure that risk is systematically assessed in early pregnancy, and each woman’s antenatal care is personalised to meet their individual needs.

Each CAG will work closely with the Director of Primary Care and the Director of Public Health to take this agenda forward.
5.5.2  **Improve the experience of patients and carers**

A step change improvement in patient experience is also a strategic outcome for the Trust as outlined in Section 4.2.3. At present too many patients are critical of the services they receive, highlighting concerns which cover clinical care, communications, and staff attitude and behaviour. Additionally, not all the Trust’s staff would necessarily recommend the hospital they work in as a place to receive treatment.

As set out in Section 4.2.3 each CAG will be expected to work with patients and carers in any service improvement and transformation. The information, which is already available through media such as patient surveys, comments cards, complaints and compliments, and via patient groups, needs to be reviewed systematically within each CAG, which will be responsible for agreeing any action required and being openly accountable for this.

The CAGs will establish a Patient Promise by Day 100 of the Merged Trust. These Promises will underpin every aspect of the treatment and care patients and carers can expect, for example, good communication, kindness and courtesy, dignity and respect, and a clean and comfortable care environment.

The Patient Experience Team will provide expert support for the CAGs, and will also assure the complaints process, so that the Trust Board can be confident that learning from complaints is disseminated and acted upon.

5.5.3  **Promote equalities and human rights for patients and staff**

In order to improve health and to improve patient experience, each CAG will be proactive in engaging with people, and/or their representatives, with protected characteristics including those with disabilities, and people of different ages, ethnicities, religions, genders, and sexual orientations.

Sensitivity towards the needs of high risk and vulnerable groups will be particularly important given the demographic profile of the catchment, as outlined in Section 3.1. The new organisation will be better placed to adapt to the needs of at risk and vulnerable groups due to its size and scale, and it will be important to do so due to the critical mass of patients with such needs.

For example, timely access to care for older people has a direct bearing on rehabilitation potential and maintenance of independence. Ensuring access to emergency surgery within 48 hours, particularly for fractured neck of femur, will improve health outcomes for older people. At present 58% of patients with fractured neck of femur at NUHT, 30% at WCUHT, and 17% at BLT are not treated within this timeframe. The Surgery CAG has agreed an early focus on increasing theatre utilisation to identify additional capacity for urgent operations.

Numerous studies have also demonstrated how people with learning disabilities have unmet health care needs. Key areas of concern include:

- The limited skills of hospital staff in communicating with people with learning disabilities
- An absence of decision making support
- Lack of adapted facilities
- Malnutrition and dehydration
- Failure to prescribe required medications
- Boredom that leads to challenging behaviour and consequently use of sedation
- Carers being fearful of leaving patients in the care of acute hospital staff who do not understand their needs.
Within hospital services, many staff are not confident in their skills to meet the special needs of people with learning disabilities, or indeed other disabilities. This can be improved through a programme of mandatory staff training, together with the support of a liaison service.

The Merged Trust will work to ensure all reasonable adjustments are made to its facilities, so that they are both accessible and appropriate for the needs of those with protected characteristics.

At the same time, the CAGs will play an important part in the achievement of the Trust’s equality, diversity and human rights policy, as it applies to staff. Through the OD equality specialist and the OD Support Team, each CAG (as well as the corporate areas), will be provided with expertise regarding leadership development. All staff will receive equality and diversity training.

Again, it will be crucial that senior staff demonstrate their commitment to the equalities programme. The specific priorities will vary with each CAG expected to develop its own programme to identify the mechanisms best suited to its needs.

5.6 CAG enablers

A suite of enablers have been developed to achieve the Merged Trust’s vision and strategic outcomes, and to assist the CAGs in delivering early clinical benefits. These are set out below.

5.6.1 Standardisation of clinical practice to best in class – zero tolerance of continuing and unwarranted variations

The Merged Trust’s early focus will be to standardise care across the three organisations, consolidate clinical support services, and remove duplication to eliminate unwarranted variations and drive consistent improvements.

This is an essential programme of work to deliver financial viability and sustainability. In addition, more efficient clinical services can also provide higher clinical quality and better patient experience. Tackling the variations in quality, patient experience and performance will enable early improvements in the care of those who use the services of the new organisation and contribute to securing the required financial stability.

Whilst improvements in care processes could continue to be made if the three organisations remained independent, the merger will remove organisational barriers to change and will provide strong and consistent leadership. This will deliver faster and more substantive change. The Merged Trust will achieve standardisation of care through:

- Corporate targets that set the trajectory for standardising clinical, quality and financial performance at service line level to “Best in Trust”, and that ensure accountability for the delivery of these targets

- A programme of continuous quality improvement that spans clinical and management practice, linked to education and research, and to education and training

- A performance management framework that aligns personal, team and CAG accountabilities to the strategic objectives and recognises and rewards achievement.

The three current organisations perform strongly in some areas, but none does so consistently; each can learn from the others. As per commissioner intentions and created and delivered in partnership with GPs, primary care and patients the Merged Trust will:

- improve the acute care pathway, enabling earlier recovery and thereby reducing length of stay across the three organisations. This will be achieved through pathway redesign, ensuring, for example, that each patient is seen by a senior decision maker and accesses
the right care, promptly after admission to hospital, and that those with complex needs are assessed and cared for by a multi-disciplinary team

- develop more ‘one stop’ clinics and planned pathways to ensure that patients access specialist hospital care when required, and community and local hospital follow-up where appropriate. Standardising practice to ‘best in class’ will ensure appropriate discharge from, and better access to, specialist clinics

- maximise theatre utilisation to improve access for both emergency and planned surgery, enabling improved patient outcomes through earlier treatment, and reducing late cancellations. The Merged Trust will implement key areas of improvement across the three organisations e.g. timely start and finish times, improved booking, and standardised pre-assessment processes

- provide a wider spectrum of diagnostic tests for all patients so that fewer tests need to go to external providers, and overall costs are reduced.

5.6.2 Agreed clinical pathways to enable access to consistent specialist care supported by consistent information and integrated informatics systems

This merger will remove the current organisational barriers which have led to variations across the three boroughs in access to specialist services. Although some progress has already been achieved through the establishment of clinical networks, especially for patients with cancer or heart disease, much more can be done to ensure that all communities can access the specialist services they need, on a 24/7 basis.

At present there are too many delays in patients reaching specialist diagnostic and treatment services. For example, patients may be admitted to a hospital which does not have a particular speciality, and then have to wait to be transferred to the appropriate unit. If a patient who is already receiving specialist care presents to another hospital as an emergency, there are delays in obtaining the necessary clinical information to ensure that safe and effective treatment can be provided in a timely manner.

The aim is to ensure that every patient, wherever they live, is cared for by the right person, in the right place, and at the right time. Whilst some ‘hand-offs’ (the point at which a patient is handed from one member of staff to another) are inevitable, it is well established that these are always times of risk for the patient. Within the new organisation ‘hand-offs’ will be minimised as far as possible, through well organised clinical pathways. There may also be limited scope to extend the range of specialist services provided.

Over time the planned improvements to information systems and technology will be a key enabler for delivering streamlined care. For example, through the development of the integrated care record system both clinicians and patients will have access to the right information at the right time across the Merged Trust’s sites. Such developments will also lead to the potential for more seamless information sharing between primary care, community health, and specialist health services.

Some specialist care will always need to be provided in the most specialised hospital, but the CAGs will be challenged to identify opportunities, when clinically appropriate, to improve geographical access to services. This may include shifting services from the specialist centre to local hospitals, or from hospital to community settings, accessed by phone, email or video conference, as well as in person. New staff rotations, beyond those currently available for doctors in training, will strengthen the concept of a single team.

5.6.3 Effective clinical leadership embedded within the CAGs

The Merged Trust will place accountability for clinical quality, patient experience, and financial control as close to the point of service delivery as possible. There will be a direct line of sight between the teams accountable for delivering high quality services and the Board.
Each CAG will be led by a Group Director, a senior clinician, who will bring a breadth of vision, a culture of innovation, and a track record of challenging and leading changes in existing practice. They will be expected to lead by example across the tripartite mission of service provision, education and research, thereby aspiring to excellence in their own clinical practice, and valuing excellence and effort in others. They will challenge and change poor practice, and they will expect innovation to be recognised and built into day-to-day practice, so that services become increasingly leading edge and support the Trust’s ambition to help reduce health inequalities in north east London.

At the service line, clinical leadership will also be crucial, as it will be here that service improvement and transformation will be driven. And for some services, there will also be site-based leadership. These posts provide the opportunity for those aspiring to clinical leadership roles to develop their skills and gain experience, with the support of the Trust.

The Group Director will be accountable for the overall performance of their CAG. Developing clinical leadership will be an important contributor to the success of the new organisation and the draft organisational development strategy (summarised in Section 9.6) will include this as a priority.

5.6.4 Clinical and management improvement through a cycle of innovation and accredited research programmes

Research and development will be an important focus for the Merged Trust, building on the achievements of the legacy Trusts. Each CAG will have a Lead for Research and Education.

The clinical teams and service lines within each CAG will be expected to identify the opportunities for evidence-based innovation within their clinical area. This will improve clinical quality and patient experience, and will be an important symbol of the new clinical culture within the Merged Trust. This culture of innovation will be welcomed by clinical staff who will be supported and enabled to develop their service within a managed framework of guidance.

Taking part in research can be an empowering experience for patients, increasing their and their family’s sense of control. Moreover, there is a virtuous circle for the NHS. In the short term the benefits include access to novel drugs, together with the opportunity to test treatment programmes which may be more clinically and more cost effective.

Moreover, it is known that not only the healthcare but also the health outcomes for patients enrolled in clinical trials are better, irrespective of whether they are in research intervention or control groups. This has been particularly illustrated in the treatment of cancer.

These have been the major drivers for the National Institute of Health Research (NIHR) in its implementation of the Government’s Best Research for Best Health strategy since 2005. Key to this is increasing the number of patients in accredited clinical trials across the UK, and particularly in published clinical priority areas.

The new organisation will be able to extend current clinical trials taking place in existing Trusts to all eligible patients across all sites. This will build on the current strategy at WCUHT for every patient to have access to a research trial and will ensure that all patients can enjoy the very best outcomes. The new organisation will also be able to attract more commercial, NIHR and Medical Research Council (MRC) research trials because of the larger patient population. The contractual leverage as a much larger organisation will also be greater, since numbers of patients enrolled will increase and time to trial completion will be faster.

The opportunities to achieve critical mass for important areas of unmet need are considerable in the Merged Trust. There are, for example, many unanswered questions about the optimal treatment of critically ill patients. Effective clinical trials in specialist areas, such as intensive care, have been difficult because of the small numbers of patients seen in most hospitals. Running trials across the new, larger patient base will achieve a unique critical mass and so allow more trials to take place in specialist areas. The Merged Trust will work very closely with other research organisations including partner organisations within UCL Partners. This
will mean that the new organisation will be uniquely placed in the UK to get quicker answers to questions about health and healthcare. This may include questions which specifically relate to health inequalities which disproportionately impact particular communities, such as sickle cell disease, and diabetes. Outreach into community based trials and engagement with communities is important in relation to improving access. NUHT has a track record of engaging a diverse community in research and development, which can be disseminated through the Merged Trust.

If the new organisation is to achieve a national and international reputation for excellence, clinical teams will need to consciously adopt the innovation cycle, and to engage in accredited research programmes. The strong academic links as part of UCL Partners Academic Health Sciences system, but also QMUL, City University, London South Bank University and the University of East London, as well as other partners, provides the platform for this.

Partnership working is particularly important in modern day research, where programmes of discovery link to translation into treatment, and subsequent validation through clinical trials. Investment in the most up-to-date research technology, database support and bioinformatics is much more cost effective when working at larger scale, and large scale trials are more effective and efficient than multiple small trials. Building on academic partnerships from the three trusts, including founding membership of UCL Partners, will create a new organisation with considerable research power that can attract increasing levels of research investment, increasing local research expertise and generating economic growth at a local and national level. Along with the research investment, academic output will grow, making the new institution increasingly attractive in the healthcare environment, allowing us to recruit world class research leaders.

5.6.5 A focus on learning and education

Excellence in education and training will improve the quality of patient care and experience by ensuring optimal service delivery by highly trained and skilled staff. The scale of the Merged Trust, and the opportunity to rotate through a wide range of specialities, will make it an attractive employer to qualifying students and doctors in training. Similarly NHS management trainees will have an opportunity to develop their careers in one of the largest and most complex health providers in the country.

All education and training will be developed and delivered to the best possible standards appropriate to the diverse needs of the workforce, in order to provide the best possible educational experience and to support staff in developing their careers within the NHS.

The merger provides the opportunity to use economies of scale to bring together a portfolio of education offerings that will cater for all staff, increasing multidisciplinary interaction and opportunities, and building courses which are accessible to many more groups, and more courses that are adaptable to flexible working and personal needs. Links with academic institutions will enhance the quality of the education for trainers, and the range of accredited courses that will help develop staff qualifications. The content of the portfolio will be linked to clinical needs, commissioned education programmes in all disciplines, organisation development, and personal development.

5.7 Risk management arrangements

Following the successful delivery of the merger, it is vital that the organisation has robust processes in place to identify risk and that the Trust Board has established processes by which it can receive assurance that the Trust is operating safely and effectively during a time of considerable change.

This section sets out the arrangements that will enable the Trust to operate effectively from Day 1.
5.7.1 **Board assurance framework**

The organisation at Board and sub-committee level will maintain and review the Board Assurance Framework (BAF). The BAF will incorporate the principal risks to achieving the organisation’s strategic objectives, and importantly it will document the key controls and assurances, both internal and external. Also evident within the BAF will be any gaps in control or assurance and these will inform risk management action plans that aid progress towards full assurance and delivery of strategic objectives.

Based on good practice from BLT, each strategic objective within the BAF will be aligned to the organisation’s current performance, to provide the Board and relevant sub-committees with visibility of objectives, risks and performance within one single framework.

5.7.2 **Organisation risk management**

The organisation will be supported corporately by the Integrated Quality and Risk Department reporting to the Chief Nurse who has executive responsibility for clinical quality and risk.

The leadership within CAGs will be accountable and responsible for managing and reporting their risk management activities to the Audit and Risk Committee where the risks they face could threaten the achievement of objectives or significantly damage performance of the Trust. The CAG’s will create their risk registers by considering existing risks identified at the three existing Trusts, and importantly supplementing these with any new or emerging clinical or business risks. Service line managers will be responsible for risk registers in their own areas.

The Head of Governance at CAG level will meet quarterly with the Integrated Quality and Risk Manager to review risks, ensuring consistency of scoring along with robust risk management plans.

The Risk Management Board will report by exception to the Quality Assurance Committee for clinical risks and to the Audit and Risk Committee for business risks. These sub-committees will hold to account the executive body and seek assurances that reported risks are being managed in a robust and appropriate manner. The sub-committees will also challenge and seek an assurance that lower level risks are being managed through twice yearly CAG and corporate risk register reviews.

The Trust will use a single risk management system, currently in use across all three separate organisations. The familiarity of this system will assist with containing the burden of work associated with the merger and ensure the organisation does not lose sight of risks. The risk management system is an integrated system and has transparency with the added protection of delegated access permissions.

Governance arrangements for the transition will ensure that the risks currently detailed in the risk registers of BLT, NUHT and WCUHT continue to be managed and mitigated. Some of the highest rated risks currently facing each of the existing Trusts principally relate to financial performance and the achievement of in-year cost improvement plans. It will be vitally important for the existing Trusts to achieve their forecast financial plans for 2011/12 in order to keep the five year financial plan for the new organisation on track. Additionally, it will be vital to ensure that other clinical and non-clinical risks continue to be managed to guarantee safe and effective care throughout the transition and thereafter.

5.7.3 **Audit arrangements**

**Internal audit**

Ongoing assurance over key risks, governance and controls will be available from an Internal Audit team which will be appointed to develop a three year strategic audit plan in line with the requirements of the Audit and Integrated Quality Assurance Committees. In line with good practice, the audit plan will be risk based, with an initial focus on the immediate risks associated with merging the organisations, which will include:
● The trust's core financial systems
● Other systems (including ICT and Information Governance systems)
● Corporate governance and Board Assurance Framework
● Operational reviews.

External audit
An external auditor will be appointed for the new entity once approval for merger has been secured. In the interim, however, account will be taken of the outcomes of the most recent external audits of the three organisations and ensure that these are addressed in Day 1 plans where they are material to the control of the merging organisation.

5.8 Business planning and contracting
A strong internal business planning structure will be established in the new organisation which will be led by the finance directorate, working closely with the strategy directorate and each CAG.

The Board will agree a business plan containing objectives for service delivery and improvement in the January of each year, to apply to the forthcoming financial year. This will incorporate the NHS Operating Framework and commissioner intentions.

Underpinning the business plan, each corporate function and CAGs will develop annual operating plans which the Board will agree alongside. This will contain objectives for service delivery and improvement, CIP delivery plans, and resource changes. These plans will be subject to confirm and challenge sessions by peers before being agreed by the Management Board in March and the Trust Board in April.

Contracting processes will be centralised under a contracting and commissioning function, led by the finance directorate.

5.9 Reporting and performance management framework
Ensuring an integrated approach to managing performance
The Performance Management Framework (PMF) will be based upon four quadrants which will provide an integrated approach to performance management reporting. These four quadrants are:

This approach will mean that:
● The PMF will look at all aspects of performance management and allow the Trust to identify any interrelated performance issues
Responsibility for operational performance in the new structure will be devolved to the lowest possible level in the organisation, namely at ward/service/department and it is these levels within the organisation which will be responsible for the delivery of operational performance.

Through local multi-disciplinary team working at the lowest level (i.e., ward/service/department) combined with devolved corporate functions, operational performance will be delivered across the four quadrants of quality, workforce, finance and activity.

The performance management cycle for the Merged Trust

The Trust will develop and then annually update its Integrated Business Plan (IBP) which sets out its strategy on a rolling five year basis. However the Performance Management Framework will focus on the operational delivery of the first year of the IBP. The Cycle will have three components:

**Plan**

The Board will agree a draft range of objectives for service delivery and improvement in January of each year for the following financial year. This will incorporate the NHS Operating Framework and commissioner intentions. Each corporate service function and CAG will develop an operating plan for the following year that clearly sets out how the objectives will be met, how CIPs will be delivered and any consequent resource implications. These plans will be subject to confirm and challenge sessions by peers before being agreed by the Management Board in March and the Trust Board in April.

**Execute**

Corporate service functions and CAGs will be accountable for delivery of their plans and the monthly integrated performance reporting covering the four quadrants of Quality, Workforce, Activity and Finance; will enable the tracking of delivery.

One of the key steps that must take place in order to make performance reporting meaningful is the identification of the Key Performance Indicators (KPIs) and the selection of appropriate performance thresholds. This will be done by first considering the performance measures used across the three existing organisations (e.g., Exec scorecard, Matron’s scorecard, Quality accounts, A&E targets, CQC, etc.) and identifying which of these are appropriate for the Merged Trust and identifying where, perhaps, new performance measures are needed. This will result in a final list of performance indicators across the four quadrants. KPIs relating to the Trust’s ambition to reduce health inequalities and to promote human rights, equality and diversity will be included within these four quadrants.

**Review**

Every month each CAG will meet with the CFO and COO to review performance across each of the quadrants for the period to date. This will be done at a time to enable the outputs from
these meetings to inform the reporting to the Management and Trust Boards. There will be a formal quarterly review of each CAG’s operating performance led by the CEO and supported by the executive team. Similarly each CAG will undertake a review of the service line delivery within their CAG. As a minimum, bi-annually there will be a formal review of corporate services functions led by the CEO and supported by the CAG directors.

While CAGs remain within the boundaries of acceptable performance (the criteria for which can only be established once the KPIs have been identified and targets set), they will continue to follow the cycle of monthly review with the CFO and COO, and quarterly review with the CEO supported by the executive team.

However, if their performance falls below the level defined as acceptable, the CAG will enter a failure regime (set out below) whereby more intense performance management is applied.

**Key performance indicators**

Developing a set of key performance indicators will enable both management and staff to have a clear and common understanding of the key areas of performance of the Trust. The KPIs will be structured around the Performance Management Framework endorsed by the Merger Team. Current KPIs from each of the trusts have been reviewed and combined with external guidance from sources such as the Intelligent Board⁴. This suite of KPIs will be reviewed and validated by each trust following which the final suite of KPIs will be selected using a workshop-based approach with the Medical Directors, Chief Nurses, Director of Finance, and Directors of HR & OD. See Appendix F for draft KPIs to be reviewed and amended during November and December 2011 to enable shadow reporting from January 2012.

**Failure regime**

Within a system of devolved autonomy there needs to be a clear intervention regime, should the expected level of performance not be delivered. The review process within the cycle outlined above will use a two tiered failure regime. Failure to reach the pre-defined performance standards, based on the selected KPIs, will lead to CAGs entering the first tier of the failure regime, which results in formal monthly reviews led by the CEO and the wider executive team. It is expected that the extra level of scrutiny and the support offered by the CEO and executive team will mean that performance can be improved to acceptable levels and that the CAG can then return to normal monthly monitoring by the CFO and COO.

In extreme cases, where performance of a CAG is below the pre-defined limits of Tier 1, or a CAG remains in Tier 1 performance management for an extended period of time, Tier 2 intervention will be triggered. This will result in the CAG or corporate service being placed into turnaround with a series of targeted support interventions being led by the relevant director. Once performance improves, the CAG will return to Tier 1 or normal monitoring as appropriate.

**Interim performance management arrangements**

In the first six months, it is anticipated that the performance management processes will become the responsibility of the new management team and this approach will ensure that the accountability for performance is in place from Day 1.

This approach will be, to a large extent, dependant on the availability of management information that is accurate and consistent across the legacy organisations. To do this and

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⁴ The Intelligent Board series from Dr Foster gives practical, focused advice for NHS trust board members on the kind of information they should be using to understand and oversee their organisations’ performance.
make sure the right information is available and understood the following steps are planned as part of the performance management transition:

1. Alignment and sign-off of interim performance management metrics and governance process, including required KPIs – November and December 2011

2. Design, development and testing of interim reports and sign off – November 2011 to January 2012

3. Review reports and monitor performance of the three individual Trusts and interim performance management structures to work with the business-as-usual performance management arrangements in the three organisations, in readiness for Merger on 1 April 2012 – February 2012 through to April 2012

In the period between January and March 2012, shadow arrangements will be in place to refine the collation and escalation of performance data, so that the process will be ready to operate on Day 1.

**Early warning systems**

During the initial months of the Trust there will be a significant level of change which could impact operational standards and the quality of care provided. This risk needs to be managed and in the short term, an additional risk management process will be introduced that will enhance existing risk management arrangements across the three Trusts.

From an operational perspective this will involve the creation of a dashboard that will focus on safety, quality and workforce at a ward level. The safety monitoring tool will build on the Safetynet system currently in place at Barts and The London NHS Trust and will be produced automatically on a weekly basis. It will highlight areas of risk through a traffic light system to indicate areas that require immediate action.

The dashboard will be easily accessible at a ward and also consolidated at a CAG level, allowing relevant information to be accessed at the necessary levels of the Trust.
6. Clinical and Financial benefits

Synopsis
This chapter will explain the clinical and financial benefits arising from these new arrangements.

Without a merger, the trusts will be challenged to achieve, consistently across the three separate trusts, the service standards outlined in NHS London’s recently published acute medicine and emergency general surgery specification; and the current severe pressure on recruiting and retaining staff in many areas will become even more acute. This challenge is greatest at Newham and Whipps Cross. Put simply, the quality of care for patients is at risk.

The merger will enable the trusts to pool their resources and so provide higher-quality services, 24/7 for residents across the whole of east London.

The financial challenge is immense and neither WCUHT nor NUHT are able to meet Monitor’s requirements to become a Foundation Trust. Without a merger they would enter the failure regime. In a merged Trust, the long term financial viability of the new Trust’s hospitals would be secured and local services would be more sustainable.

- Section 6.1 sets out the principle clinical benefits
- Section 6.2 CAG work programme and priorities
- Section 6.3 provides an overview of the financial benefits.

6.1 Clinical benefits

Chapter 4 described the strategic outcomes that the new Trust will expect to see under four headings:

- Improving health and well being and reducing inequalities

  The new Trust will be able to bring together a wealth of tertiary, secondary and community clinicians and pool resources to work with local partners via Health and Wellbeing Boards. By doing so the Trust will be able to develop campaigns, pathways of care and programmes of work that really tackle the health inequalities so prevalent in the area and improve the health of the population and improve the lives of the thousands of people with long term conditions. Patients, not hospitals or clinicians, will be at the centre of healthcare. The Trust will also work with local businesses, colleges and universities to improve employment in the area and make east London the place to do business.

- Securing local acute services, with improved access to the full range of specialist services supported by enhanced research and education capabilities

  Quite simply, the creation of a new Trust avoids the need for Whipps Cross and Newham to enter the failure regime and improves the sustainability of services. The new Trust would improve access to (and choice of) specialist services and significantly improves the opportunity to improve research and education in the area - patients are almost always better off being part of a research programme where their condition is treated by highly specialist healthcare professionals using the latest technology and techniques.

- Improving the quality as well as reduced variability of clinical outcomes, patient experience and operational performance
The existing Trusts face significant challenges in maintaining the quality and safety of services. By merging the trusts can address these challenges and improve the patient experience by, for instance, sharing rotas to provide consultant cover for more hours in the day and retain and recruit staff of the highest quality; make better use of resources such as theatres and beds; pool resources to invest in better IT, and centralised services; and share knowledge to improve services to the best performing trust.

- **Strengthening the financial resilience of the trusts and establishing a sustainable platform for acute services in north east London.**

  The operational economies that would accrue to the merged Trust (such as pooled rotas, better use of resources etc) would strengthen the sustainability of services in all three trusts. The financial advantages are described in section 6.3.

CAGs have already looked out how they can achieve these outcomes and begun to develop proposals to deliver some early clinical benefits. Examples are set out below.

### 6.1.1 Meeting the needs of acutely ill patients

Bringing together the workforce from the three Trusts will create a more flexible workforce in some specialties. NHS London has highlighted the importance of ensuring that all acutely ill patients are assessed by a senior decision maker within 12 hours of admission. This standard will be driven by commissioners from April 2012.

At present it is not possible for all of the three Trusts to meet the standard for all acutely ill patients. However, post merger, the new organisation would establish consultant teams with more scope to deliver the defined standards across acute care.

Achieving these standards will raise quality of care and improve patient experience, as patients will have timely access to specialist expertise, which will speed their recovery and reduce their length of stay.

### 6.1.2 A sustainable workforce

The three existing Trusts currently face a number of difficulties in continuing to provide safe staffing levels in all clinical services. These include problems in recruiting to full establishment with persisting vacancies, which can require the use of bank, agency and locum staff incurring additional costs. Moreover, the need to work around vacancies is stressful for clinical managers, and, most importantly, the inevitable lack of continuity of care can expose patients to clinical risk.

There are also specific problems in some specialities in providing out-of-hours cover. This is in part due to the pressure to increase the consultant presence out of core working hours, with the aim that every acutely ill patient be seen within 12 hours by a senior decision maker. At the same time, with the reductions in the number of doctors in training, it is becoming particularly difficult to recruit to middle grade posts and thus there are increasing problems in sustaining the middle grade out of hours rota. One specific example is paediatrics, in a community where local access to high quality children’s services is crucial.

Through the association with Barts and the relationships the new trust will have with Queen Mary University of London and other academic institutions, its membership status in UCLP, the scale and scope of services within the trust, and its relationships NHS and other partners, the new organisation will be better able to:

- **Maintain and improve standards of practice and continuity of care** – drawing on the larger staffing pool, the new organisation will be better able to cover vacancies, sickness and absences, and peaks in demand, rather than revert to high cost locum, bank and agency staff. This will avoid disruption to continuity of patient care, enable consistent service quality, and minimise unplanned costs. It will also reduce the stress on staff, who have highlighted the difficulties of working in clinical areas with long term vacancies, and an ingrained dependence on temporary cover.
• **Provide more sustainable 24 hour clinical out of hours cover** – particularly in services such as A&E and interventional radiology which are most at risk through general current staffing shortages and ill health due to the pressures of intensive clinical rotas. Other services reliant on a diminishing source of trainees will similarly have access to a larger pool of staffing resources. This will enable the new organisation to maintain safe clinical practice and ensure its workforce retains a healthy work-life balance.

• **Fully comply with the requirements of the training regulators and with best practice guidelines** – providing safe levels of clinical cover, as well as the clinical experience to meet medical training requirements. For example the merger will allow full emergency cover by colorectal consultant surgeons across all sites.

• **Offer staff more interesting and more rewarding work** – in addition to the changes in clinical culture, the Merged Trust will be able to offer a greater proportion of staff the opportunity to apply for posts on rotational programmes which will be both interesting and rewarding for them. The Merged Trust will acquire a reputation as an attractive employer, increasingly able to recruit and retain the best clinicians and managers from a diverse and wide pool of talent. This will help to overcome existing difficulties in achieving optimal staffing levels at the three existing Trusts, particularly in the areas of paediatrics, emergency surgery and intensive/critical care.

The new organisation will have strength in breadth and depth across the full range of clinical and non-clinical disciplines. The merger provides a unique opportunity to develop these in a way to achieve the clinical vision, and at the same time provide clinical experience and career development in what will be one of the largest and most exciting health care organisations in the country.

### 6.2 CAG work programme and priorities

The CAGs have undertaken a comprehensive suite of work over the last three months to benchmark performance, identify opportunities for standardising and improving services to the best across the three existing trusts, and to agree associated clinical and financial benefits to be delivered through the merger. Each CAG has reviewed and prioritised their suite of benefits and proposed a set of initial priorities for implementation. These have been discussed with external stakeholders, including patients and their representatives, GPs and commissioners, and local government colleagues.
The CAGs have already begun to develop proposals to deliver some early work. Examples of these are set out below.

### 6.2.1 Better clinical care and reduced length of stay for acutely ill patients

The three Trusts currently have significant variations in the length of stay experienced by their non-elective inpatients. This merger is an opportunity to standardise services to raise them to the best practice model at NUHT.

Using this model across all the Trusts will have a positive impact on patients by:

- Reducing the time until patients are first seen by a specialist or senior clinician
- Ensuring patients are admitted under the care of the right consultant, and to the right clinical area
- Shortening the gap between admission and definitive treatment, particularly in the case of surgery
- Ensuring that patients with complex needs are assessed by a multi-disciplinary team
- Enabling rapid recovery and rehabilitation, thereby lowering the risk of hospital-related infection.

Shorter length of stay would also deliver significant cost efficiencies by reducing the number of beds a Trust needs and reducing the financial impact of hospital acquired infections.
6.2.2 Reconfiguring pathology services

The Merged Trust will be able to redesign the pathology service across its sites. This will achieve the economies of scale identified by the Carter Review and in the subsequent plan for London, without in any way compromising patient care.

The Royal London Hospital already provides a significant proportion of the pathology investigations required across the three hospitals. Core pathology services will be further concentrated on the Royal London site, while maintaining urgent and other essential services at the Whipps Cross and Newham sites.

The Merged Trust will also pool resources to make more effective investments in new IT and automated systems, and will re-profile the workforce to enhance the development opportunities for staff, as well as improving recruitment and retention.

6.2.3 Improving access to cancer care

It is envisaged that this merger will substantially enable the delivery of the standards in the London Integrated Cancer System. Removing organisational boundaries between the trusts will smooth and speed up patient access to specialist care.

At the same time, the Merged Trust will be able to:

- Deliver more non-complex chemotherapy in settings closer to patients’ homes
- Establish an Acute Oncology Service covering the three trust sites
- Simplify pathways for patients, reduce ‘hand offs’ and improve access to specialist care.

This would significantly improve patient experience, and will also contribute towards improvements in clinical outcomes.

6.2.4 Better care for people with diabetes

High levels of deprivation, together with a high concentration of ethnic groups susceptible to Type II diabetes, have combined to make diabetes prevalence in north east London amongst the highest in England.

Helping people with diabetes manage their own disease will not only improve their quality of life, but can also help limit the impact of the prevalence of diabetes on the community both in terms of use of health resources and in terms of the wider impacts on incapacity and unemployment.

The merger will enable the Trust to draw upon best practice from each organisation, working with primary care, and ensuring access to specialist services when these are required, thereby reducing the need for emergency hospital admissions.

6.2.5 Bringing specialist staff together

Bringing together the workforce from the three Trusts will create a more flexible workforce in some specialties. NHS London has highlighted the importance of ensuring that all acutely ill patients are assessed by a senior decision maker within 12 hours of admission. This standard will be driven by commissioners from April 2012.

At present it is not possible for each of the three Trusts to meet the standard for all acutely ill patients. However, post merger, the new organisation would establish single consultant teams with more scope to deliver the defined standards across acute care.

Achieving these standards will raise quality of care and improve patient experience, as patients will have timely access to specialist expertise, which will speed their recovery and reduce their length of stay.
6.3 **Financial benefits**

The merger will offer additional opportunities to achieve the savings required for the Trusts to be financially viable, and improve the financial resilience of the Trusts so that, within the new trust, all services will operate under Foundation Trust status.

The new Trust will be able to bring forward investment at WCUHT in maternity and inpatient wards, significantly improving the patient experience and will also have greater “headroom” in some of the key financial metrics which would underpin a Foundation Trust application.

The three Trusts need to make savings of some £238.8 million over the next five years. Individually the Trusts have not been able to identify sufficient savings to close this gap, and they believe that further savings required as standalone trusts will threaten both the viability and quality of services.

This merger will give the Trusts the immediate opportunity to achieve an initial £31.8 million (3% of turnover) of synergistic cost reduction opportunities not achievable within the three existing organisations. For WCUHT and NUHT, this merger is the only means by which the level of CIP savings required can be achieved without significant reconfiguration.

After the merger, further opportunities are likely to be identified as a single trust. The remainder of the new Trust’s CIP programme for 2012/13-2013/14 will be made up of CIPs identified within the existing Trusts. This section provides an overview of the merger synergy savings in their entirety and the wider CIP programme for 2012/13-2013/14.

The rest of this section explains how the savings have been calculated.

**Table 29: Summary of merger synergy and CIP savings**

<table>
<thead>
<tr>
<th>Workstream (figures in £k)</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>Total (real terms)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Merger Synergies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Corporate pay</td>
<td>3.6</td>
<td>6.2</td>
<td>2.2</td>
<td>1.1</td>
<td></td>
<td></td>
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<td>2. Corporate non pay</td>
<td>1.3</td>
<td>0.9</td>
<td>0.5</td>
<td>1.4</td>
<td></td>
<td></td>
<td>4.1</td>
</tr>
<tr>
<td>3. CAG Pay</td>
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<td>1.0</td>
<td></td>
<td></td>
<td></td>
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<td>4. Clinical standardisation</td>
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<td>5. Merger Synergies Total</td>
<td>8.8</td>
<td>17.1</td>
<td>3.5</td>
<td>2.5</td>
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<td>6. Merger Synergies Cumulative</td>
<td>8.8</td>
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<td>29.3</td>
<td>31.8</td>
<td>31.8</td>
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<tr>
<td><strong>Existing and developing Cost Improvement Savings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td>7. Planned flow through</td>
<td>14.4</td>
<td>3.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17.5</td>
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<tr>
<td>8. New Schemes (cross-trust)</td>
<td>21.5</td>
<td>17.2</td>
<td>2.7</td>
<td></td>
<td></td>
<td></td>
<td>41.3</td>
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<tr>
<td>9. New Schemes (cross-trust)*</td>
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<td></td>
<td></td>
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<td>10. Benchmarked productivity opportunity (schemes to be developed)</td>
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<td>52.3</td>
<td>38.7</td>
<td>32.7</td>
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<td>11. CIPs Total</td>
<td>35.8</td>
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<td>32.7</td>
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<td>12. CIPs Cumulative</td>
<td>35.8</td>
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<td>136.6</td>
<td>175.4</td>
<td>208.1</td>
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<tr>
<td><strong>Total Cumulative Savings</strong></td>
<td>44.6</td>
<td>107.4</td>
<td>165.9</td>
<td>207.1</td>
<td>239.9**</td>
<td></td>
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</tr>
</tbody>
</table>

*£25.5m of new schemes have been entered into the LTFM, however the Trusts have identified a total of £26.4m of new schemes.

** £239.9m of CIPs and merger synergies have been identified by the Trusts and incorporated into the LTFM. The requirement over the next five years is actually £238.8m.

Note that the above figures may differ from the LTFM outputs detailed in section 7. This is due to numbers being presented here in real terms whilst the LTFM outputs are in nominal terms.
6.3.1 Merger savings

Corporate pay and non-pay savings

The merger will enable a 22% reduction in pay costs (£13m) across all corporate areas including HR, IT, Finance, Estates and Procurement as shown in Table 29.

A large proportion of these savings will be from management roles as the merger of three organisations will lead to a streamlined single management structure compared to the three individual structures that are currently in place.

Figure 9 below compares the cost of the future corporate functions (as a percentage of revenue) to national QIPP data (for functions where these benchmarks are available). The functions of the Merged Trust sit between the mean and least expensive quartile, demonstrating the future organisation will operate lean corporate functions while retaining sufficient management capacity.

Figure 9: The future cost of corporate functions post merger, benchmarked against national QIPP data

The merger will also enable £4.1m of non pay savings, primarily relating to consolidation of IT systems as well as Estates, Procurement and Audit fee savings.

CAG Structures

£2m of savings have been identified within the CAGs. These savings solely relate to decreased management costs as a result of economies of scale achievable in the new organisation. No changes to non-management posts within the CAGs (Bands 1 to 6) are anticipated.

The savings of £2m are net of an investment in increased clinical leadership capacity for the CAGs which will enable the successful delivery of the merger and the future goals of the organisation.

To date, the organisation design has focused on the CAG leadership structures particularly considering the new structures required for Bands 7 to 9. The next stage of the organisation design will be to concentrate on validating the merged structures for Bands 1-6 and to check that the spans of control and qualified to unqualified ratios are sufficient to meet required clinical safety standards and to deliver high quality, patient-centred care. As the next stage is undertaken the Bands 7 to 9 structures will be re-visited to ensure they remain fit for purpose. Revisions to the structures (including those that may increase the management and clinical costs, or identify further savings) may be made at this time, prior to finalising structures ready for consultation.

Clinical standardisation opportunities

The clinical standardisation opportunities have been identified and developed through identification of best practice performance and processes across the three Trusts, with a view
to improving performance to a consistently high level in order to deliver the best patient care, reduce inequalities in care across NEL and realise financial benefits through improved efficiency.

Clinical standardisation opportunities total £12.7m, the merger will also bring about additional productivity savings from pathway re-design and service developments. At this stage however, work is ongoing to work up these schemes and so the financial benefits for some of these opportunities are yet to be costed.

All saving opportunities have been grouped into five workstream areas which are clinical productivity, workforce, clinical support services, non-merger related corporate services efficiencies and income. The clinical standardisation opportunities are made up from schemes which fall into clinical productivity, workforce and clinical support services workstreams.

6.3.2 Existing and developing cost improvement savings

The merger places the existing Trusts in a stronger position to deliver steep cost improvements through increased capacity, flexibility and economies of scale.

Some of the following savings could be delivered by the Trusts individually. However they will be much easier to deliver in one organisation. Other savings would be unlikely to be delivered in separate Trusts as they require significant collaboration. However, technically they are not dependent on merger so have been excluded from the direct savings.

The total cost improvement schemes consist of planned flow through (£17.5m) which are schemes from the three Trusts’ 2011/12 savings plans which will deliver in 2012/13, new schemes (£41.3m) which the Trusts have identified for delivery in 2012/13 – 2014/15 and new cross-trust schemes (£25.5m) which have been identified through a joint trust savings identification session.

All saving opportunities apart from the new cross trust schemes have been through a RAG rating process to take into account the likelihood of deliverability in line with planned trajectories, the savings have been adjusted to reflect these RAG ratings (additional detail provided in appendix K). A process for identification of any scheme savings which overlap with each other (double counts) has also been carried out and the savings have been adjusted to reflect this.

As mentioned in section 6.3.1 all schemes including the clinical standardisation opportunities have been categorised into five workstream areas:

- clinical productivity
- workforce
- clinical support services
- corporate services efficiencies
- income.

These workstream areas are described in more detail in the following section.

The new cross trust schemes (£25.5m) have been identified and worked up at a high level but have not gone through the same validation process as all of the other cost improvement schemes. Over the next few months these schemes will be worked up in more detail. All schemes, over the next few months, will go through a process of further work up to develop detailed implementation plans to ensure delivery can begin from April 2012 or in line with the planned trajectory.
Clinical productivity

Clinical Productivity savings have been identified across the following areas:

- Beds / Length of stay (LOS) - Standardise LOS to London / national benchmarks through improved discharge processes and pathways in order to release excess bed capacity
- Outpatients – Standardise new to follow-up ratios and increase efficiency in clinics, for example through reductions to DNA rates and reductions in excess capacity
- Theatres – Improve theatre utilisation through streamlining processes and reducing hospital cancellations. Excess capacity will be utilised to repatriate activity currently sent to the private sector
- Pathways/ service development – standardising pathways in line with best practice across all three Trusts to improve patient flows and increase efficiency opportunities.

Workforce

The Trusts currently have varied structures and skill-mix which would benefit from standardisation across sites to ensure the right people are in place to carry out the right tasks. Additionally temporary staffing use, controls and sickness absence vary across the Trusts currently.

Savings have been identified to improve workforce productivity and structures which support clinical pathways. This in turn will enhance the delivery of patient care. Schemes include:

- Skill mix/ structures – standardise and implement best practice workforce structures and skill mix which align with improved models of care
- Temporary staffing/vacancies – reduce bank, agency and local spend through improved vacancy control and recruitment processes
- Contract review – standardise medical contracts and develop a medical workforce structure which complements new and improved models of care
- Sickness absence – Improve sickness absence rates in line with national upper quartile performance. Implement robust and consistent sickness absence monitoring and management systems to support staff to return to work.

Clinical support services

Savings have been identified from across all clinical support service areas; pharmacy, pathology, radiology, therapies and clinical physics. Schemes include:

- Clinical physics – introduce systematic contract management across all sites, thereby realising financial benefits e.g. downgrading contracts to more appropriate levels or bringing maintenance in house
- Imaging – Pay and non pay savings from repatriation of activity and standardisation of staffing and on call arrangements
- Pathology – implement recommendations from the Carter Review as part of pathology modernisation, and repatriation of activity
- Pharmacy – roll out of inpatient and outpatient drug spend initiatives (including standardisation and rationalisation across sites)
- Therapies – Standardisation of therapies structure and on call rotas. Standardise the issue and ordering of equipment and review agreed suppliers to benefit from non pay savings.

Corporate services efficiencies
In addition to merger related corporate savings set out in Section 6.3.1, additional corporate cost reduction opportunities have been identified by the three existing Trusts within their new cost improvement schemes for 2012-14. These schemes include:

- Corporate – reduction in directorate management pay
- Estates and facilities – facilities management opportunities to bring services back in house, use estate for commercial rental opportunities and manage contracts more rigorously
- Procurement – a number of schemes including roll-out of smart card stock control, managed services contracts, and contract standardisation and rationalisation.

Income

Income opportunities have been grouped into three sub-categories; clinical, non-clinical and commercial:

- Clinical – repatriation opportunities through a review of all spend with other NHS trusts with a view to bringing activity back into the merged organisation
- Non clinical – a number of schemes including retrieval of the overhead element included in contracts for all trials
- Commercial opportunities such as development of a private patient wing which are being investigated specifically by BLT.
7. Long term financial model

Synopsis

This chapter summarises the long term financial model and looks at the Merged Trust's projected financial performance and position over the period 2012/13 to 2016/17.

Neither WCUHT nor NUHT are financially viable without a merger. WCUHT (in particular) and NUHT (to a lesser degree) require cash funding in order to resolve current financial difficulties. BLT needs to find £144m of savings over the next five years to be viable assuming 4% efficiency improvements.

If the Trusts do not merge, WCUHT and NUHT will need to make significant savings in patient services and care and are projected to have a combined deficit of £38m by FY 2017 (even if funding can be found to resolve the current cash requirement).

A new Trust would require transitional funding of £76.4m in the early years from FY13 to support the cost of change. However the Trust would then be viable and profitable from FY 2015. The proposed merger will result in a significant return on investment for the taxpayer.

Receipt of the outlined financial support will allow the new organisation to focus on realising merger synergies while maintaining quality, safety and control.

Under a set of downside assumptions, further work would be required to identify internal mitigations to maintain financial stability. Should sufficient internal opportunities to secure additional efficiencies and reduction in expenditure at an individual department and service line level not be found, it is possible that service reconfiguration would be required. However, it is important to note that there are no current plans to make any service reconfigurations as part of the merger. Any service reconfiguration that proved to be necessary at a later date, would be subject to statutory consultation on this topic.

- Section 7.1 explains the issues that have made it necessary to update the financial figures provided in the OBC
- Section 7.2 explains how financial viability is calculated in the context of the Monitor financial risk rating
- Section 7.3 demonstrates that neither Newham nor Whipps Cross are financially viable
- Section 7.4 demonstrates the financial viability of the Merged Trust
- Section 7.5 sets out the Merged Trust's need for funding support to help put it on a firm financial footing
- Section 7.6 sets out the amount of financial support required by the new organisation
- Section 7.7 sets out what happens if the projections for the new Merged Trust are wrong and discusses the assumptions underpinning this forecast and the key risks and mitigating actions.

7.1 Background and context

In the OBC document (dated 22 July 2011) a financial case outlining both the imperatives for the merger as well as the financial benefits was set out. Since the OBC was finalised a number of events have occurred which have resulted in the updated financial model presented here. These include:

- In year financial performance resulting in WCUHT and NUHT re-forecasting considerably worse year end positions
• NHS London concluding its scenario modelling which has provided a context for assessing the level of cost reduction which can be safely delivered in each of the standalone organisations (CIPs modelled are broadly in line with this analysis)

• Quantification of the “cost of quality” in emergency care as new clinical standards come into place

• Inflation continuing to run considerably ahead of the 2.5% set out in the FY12 NHS Operating Framework, which along with other economic indicators suggests that the financial landscape facing all NHS trusts is likely to remain extremely challenging for the foreseeable future

• Confirmation of approval to implement recommendations from the Health for north east London programme, and agreement for the subsequent estates requirements at WCUHT which are built into the LTFM working to the timelines that will be required.

This section demonstrates that while the above factors increase the challenge faced by the proposed Merged Trust, the merger is more than ever essential to financially safeguarding the provision of healthcare in east London.

7.2 Calculating financial viability

All NHS trusts must achieve authorisation as Foundation Trusts. To do so each organisation must demonstrate financial viability to Monitor and the independent assessors who operate on Monitor’s behalf.

Financial viability is assessed by the ability of an organisation to achieve a Financial Risk Rating (FRR) of three in the first five years of operation (subject to tests for resilience to sensitivities). The Monitor risk rating is derived from a weighted assessment based on the metrics set out in the table below.

Table 30: Metrics for calculating Monitor’s risk rating

<table>
<thead>
<tr>
<th>FRR criteria</th>
<th>Weight (%)</th>
<th>Metric to be scored</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement of plan</td>
<td>10</td>
<td>EBITDA achieved (% of plan)</td>
<td>100</td>
<td>85</td>
<td>70</td>
<td>50</td>
<td>&lt;50</td>
</tr>
<tr>
<td>Underlying performance</td>
<td>25</td>
<td>EBITDA margin (%)</td>
<td>11</td>
<td>9</td>
<td>5</td>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Financial efficiency</td>
<td>20</td>
<td>Return on capital employed (%)</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>-2</td>
<td>&lt;2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I&amp;E surplus margin net of dividend (%)</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>-2</td>
<td>&lt;2</td>
</tr>
<tr>
<td>Liquidity</td>
<td>25</td>
<td>Liquidity ratio (days)</td>
<td>60</td>
<td>25</td>
<td>15</td>
<td>10</td>
<td>&lt;10</td>
</tr>
</tbody>
</table>

In order to achieve an overall risk rating of three in a given year, a Trust must:

• Achieve a rating of three or more on at least three out of four metrics (return on capital employed, greyed out on the above table, is not counted towards the overall FRR within Monitor’s model)

• Achieve no lower than a two on any individual metric (other than return on capital employed, which again is not counted towards the overall FRR within Monitor’s model)

• Be within at least a Tier 2 Prudential Borrowing Limit/Code (PBL/PBC). The prudential borrowing limit itself is derived from a further four metrics which measure a Trust’s ability to cover the interest and repayments on loans and working capital facilities, as set out in Table 31.

**Note:** EBITDA achieved (% of plan) is automatically assumed at 100% for future years, unless plan has not been achieved in year 0, in which case a score of 0% is achieved for Year 1.
Table 31: Prudential Borrowing Code/Limit Metric

<table>
<thead>
<tr>
<th>Prudential Borrowing Code (PBC)/Prudential Borrowing Limit (PBL) metric</th>
<th>Tier 1 limit</th>
<th>Tier 2 limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dividend cover</td>
<td>&gt;1.0x</td>
<td>&gt;1.0x</td>
</tr>
<tr>
<td>Interest cover</td>
<td>&gt;3.0x</td>
<td>&gt;2.0x</td>
</tr>
<tr>
<td>Debt service cover</td>
<td>&gt;2.0x</td>
<td>&gt;1.5x</td>
</tr>
<tr>
<td>Debt service to revenue</td>
<td>&lt;2.5%</td>
<td>&lt;10%</td>
</tr>
</tbody>
</table>

In the tables on the following pages, where the FRR criteria, individually or collectively, are not met or where PBL/PBC criteria or the test to confirm if CIPs are prudent are not met, this has been flagged by highlighting the relevant cell in red. The following section demonstrates the financial challenge for the three existing Trusts.

7.3 Financial viability of the current trusts

As depicted in Figure 10 below, the three existing organisations collectively face a £227.6m challenge to break even, and a further £11.2m challenge in order to make the 1% surplus required by Monitor (2012/13 to 2016/17). This is generally driven by:

- Deflation of the Payment By Results (PBR) tariff (4% per annum) reducing NHS income
- Reductions in education income
- Trusts not achieving current cost improvement targets
- Loss of income, as commissioners switch services into the community or don’t commission treatments with limited benefit. It is not always possible to balance this loss by equivalent cuts in costs
- Inflation of pay and non-pay costs
- Increased operational and interest costs at BLT as the new Royal London Hospital PFI comes online.

Figure 10: CIP challenge facing the three Trusts
A full set of assumptions upon which this forecast is based is included in the appendices to this document.

Based on the following factors the three standalone trusts will only be able to deliver £208.1m of CIPs over this period:

- Historical delivery of CIPs
- The level of CIPs identified to date (management view of what is achievable)
- The level of CIPs safely implementable as indicated by NHS London’s analysis.

Without an alternative strategy this will result in a deficit across the three organisations in every year from FY13 onwards, which is £19.6m collectively by FY17.

Figure 11: Collective deficit of the three Trusts by FY17

![Chart showing surplus/deficit for FY12 to FY17]

As shown in Table 32 and Table 33 on the next page, the overall picture hides large and increasing deficits for both WCUHT (£27.1m) and NUHT (£11m) by FY17 and they are clearly not viable as standalone organisations.
The deteriorating cash position at both WCUHT and NUHT reflects the level of I&E deficits being generated, necessary capital investment, repayment of loans, and ratification of working capital issues. Section 7.6 gives further quantification of these challenges, along with analysis of the cash and revenue support required.

BLT’s I&E forecast suggests it would be viable as a standalone NHS trust. Based on its base case LTFM, BLT would also be viable for authorisation as an FT as shown in Table 34. However, benchmarking shows that BLT would be required to achieve an EBITDA margin considerably higher than that of similar sized trusts in order to meet its Monitor risk rating metrics. As such BLT would need to undertake more aggressive cost reduction programmes than similar peers (as shown in Table 35). This is due to the large PFI interest charge the
organisation will have to service. Servicing these interest payments would be far less onerous spread across the larger cost base of the proposed merged organisation, and as such all three existing trusts have a strong incentive to go ahead with the proposed merger.

Table 34: BLT surplus / (deficit)

<table>
<thead>
<tr>
<th>I&amp;E (£m)</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus (deficit) excluding impairments</td>
<td>11.3</td>
<td>4.3</td>
<td>5.9</td>
<td>13.1</td>
<td>13.6</td>
<td>18.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CIPs</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>In year CIP modelled (£m)</td>
<td>41.2</td>
<td>40.8</td>
<td>26.9</td>
<td>37.3</td>
<td>28.4</td>
<td>21.9</td>
</tr>
<tr>
<td>CIP as a % of costs excl. impairments</td>
<td>5.5%</td>
<td>5.4%</td>
<td>3.6%</td>
<td>5.0%</td>
<td>3.9%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk rating metrics</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDA achieved (% of plan)</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>EBITDA margin (%)</td>
<td>8.2%</td>
<td>10.4%</td>
<td>10.8%</td>
<td>13.1%</td>
<td>13.6%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Return on capital employed (%)</td>
<td>9.8%</td>
<td>95.9%</td>
<td>140.7%</td>
<td>-42.6%</td>
<td>-27.5%</td>
<td>-42.8%</td>
</tr>
<tr>
<td>I&amp;E surplus margin (%)</td>
<td>1.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.7%</td>
<td>1.8%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Liquid ratio</td>
<td>22.4</td>
<td>17.8</td>
<td>17.9</td>
<td>17.0</td>
<td>22.2</td>
<td>24.5</td>
</tr>
<tr>
<td>PBC passed?</td>
<td>TRUE</td>
<td>TRUE</td>
<td>TRUE</td>
<td>TRUE</td>
<td>TRUE</td>
<td>TRUE</td>
</tr>
<tr>
<td>Overall Risk Rating</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash (opening)</td>
<td>62.0</td>
<td>62.0</td>
<td>62.0</td>
<td>62.0</td>
<td>62.0</td>
<td>62.0</td>
</tr>
<tr>
<td>Cash (closing)</td>
<td>62.0</td>
<td>62.0</td>
<td>62.0</td>
<td>62.0</td>
<td>62.0</td>
<td>62.0</td>
</tr>
</tbody>
</table>

BLT have modelled a cash position that remains flat over the 5 years due to:

- Increased cash outflow in relation to PFI loan and interest repayments increasing from £25.6m in 2011/12 to £72.6m by 2016/17
- Capital investment is capped at a level funded solely by depreciation and amortisation
- Working capital improves in the final three years as creditors are reduced.

Table 35: Benchmarking of BLT EBITDA forecasts

<table>
<thead>
<tr>
<th>TRUST</th>
<th>% EBITDA FY11</th>
<th>% EBITDA FY12</th>
<th>% EBITDA FY13</th>
<th>% EBITDA FY14</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLT</td>
<td>6.7</td>
<td>8.2</td>
<td>10.4</td>
<td>10.8</td>
</tr>
<tr>
<td>UCLH</td>
<td>9.1</td>
<td>8.1</td>
<td>8.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Guys and ST Thomas</td>
<td>7.2</td>
<td>8.1</td>
<td>8.5</td>
<td>8.8</td>
</tr>
<tr>
<td>Sheffield</td>
<td>5.9</td>
<td>5.0</td>
<td>5.5</td>
<td>5.7</td>
</tr>
<tr>
<td>Newcastle</td>
<td>7.2</td>
<td>6.9</td>
<td>7.5</td>
<td>8.2</td>
</tr>
</tbody>
</table>

7.4 Financial viability of the merged Trust and return on investment

As described above, the financial forecasts of the existing organisations clearly demonstrate the need for change. The proposed merger will give the Merged Trust access to synergistic financial savings not available to the standalone organisations. These savings will result in an organisation which is financially stable in the long term and able to achieve authorisation as a Foundation Trust.
However, in the short term, migration costs and disruptions to business as usual as a result of the merger will increase the need for financial support. This section sets out:

- Migration costs
- Disruptions to business as usual CIP delivery
- Merger synergies – the financial benefits of the merger
- The net impact of these, and the return on investment of the merger.

### 7.4.1 Migration costs

As demonstrated in Figure 12 below, migration costs will increase the financial challenge faced by the Merged Trust up to 2014/15. These costs include redundancy costs and project costs essential to the successful integration of the Merged Trust.

**Figure 12: In the absence of external funding, the financial gap faced by the new organisation would be increased due to migration costs**

![Graph showing financial gap](image)

It should be noted that the costs in FY12 are already being funded by Commissioners. Project and other integration costs include project management costs of £15m and IT investments including amongst other investments, a consolidated CRS system, and consolidated radiology and pathology information systems, amounting to £21m.

### 7.4.2 Disruption to business as usual cost improvement programmes

As the management team of the Merged Trust focuses, in the initial years, on successfully implementing the merger while maintaining quality, safety and control, the capacity to
implement business as usual cost improvement programmes will be impacted, and will result in delayed delivery of planned CIPs.

As shown in Figure 13 below, while delivery of business as usual CIPs will come back in line in later years, it will be reduced in 2012/13, increasing the need for short term financial support.

Figure 13: The capacity to implement business as usual CIPs will be reduced in 2012/13

7.4.3 Merger synergies – the financial benefits of the merger

Whilst there are additional costs in the short-term, the merger will result in a number of synergistic cost reduction opportunities which would not be available to the stand-alone organisations. These are shown in Table 37 (and were referenced in Table 29 in Section 6.3), and fall into four broad categories:

- **Corporate pay**: economies of scale in corporate functions will result in significant reductions in management overheads

- **Corporate non-pay**: through the integration of systems and processes the new organisation will also be able to reduce non-pay costs such as facilities and estates, IT systems and audit fees

- **CAG management**: in addition to corporate pay savings, economies of scale within the CAGs will also allow for further reduction in management costs

- **Clinical standardisation**: while there are no plans for major clinical reconfiguration within the new organisation, there is considerable scope to standardise practice in order to increase efficiency and improve patient care.

<table>
<thead>
<tr>
<th>Table 37: Merger synergy savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figures in £m</td>
</tr>
<tr>
<td>Total (real terms)</td>
</tr>
<tr>
<td>FY12</td>
</tr>
<tr>
<td>Corporate pay</td>
</tr>
<tr>
<td>3.6</td>
</tr>
<tr>
<td>Corporate non pay</td>
</tr>
<tr>
<td>1.3</td>
</tr>
<tr>
<td>CAG Pay</td>
</tr>
<tr>
<td>1.0</td>
</tr>
<tr>
<td>Clinical standardisation</td>
</tr>
<tr>
<td>2.9</td>
</tr>
<tr>
<td>Total merger synergy savings</td>
</tr>
<tr>
<td>8.8</td>
</tr>
<tr>
<td>Cumulative merger synergy savings</td>
</tr>
<tr>
<td>8.8</td>
</tr>
</tbody>
</table>
The impact of these merger synergies will mean that in the long term the Merged Trust will be able to achieve greater cost reduction than otherwise possible, as shown in Figure 14. Merger synergies also partly offset the effect of delayed business as usual CIP delivery in FY 13.

Figure 14: Merger synergies will result in significantly higher CIP delivery in the Merged Trust

Return on investment

The net effect on the bottom line of the new organisation each year from the above savings and transition costs is set out in Table 36. Based on a 3.5% cost of capital, this equates to a £47.56m return on investment as shown in Table 38.

Table 38: Projected net financial benefit of the merger

<table>
<thead>
<tr>
<th>Nominal terms in £m</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total NET in year effect of merger related savings (including delayed delivery of business as usual CIPs)</td>
<td>(7.50)</td>
<td>18.48</td>
<td>31.06</td>
<td>34.57</td>
<td>35.43</td>
<td>112.03</td>
<td></td>
</tr>
<tr>
<td>Non-recurrent migration costs (Real terms)</td>
<td>(10.19)</td>
<td>(26.32)</td>
<td>(11.27)</td>
<td>(3.12)</td>
<td>(0.04)</td>
<td>(0.04)</td>
<td>(50.98)</td>
</tr>
<tr>
<td>Non-recurrent migration costs (Interest)</td>
<td>0.00</td>
<td>(0.66)</td>
<td>(0.57)</td>
<td>(0.24)</td>
<td>0.00</td>
<td>(0.01)</td>
<td>(1.48)</td>
</tr>
<tr>
<td>Net cash flows</td>
<td>(10.19)</td>
<td>(34.48)</td>
<td>6.64</td>
<td>27.70</td>
<td>34.52</td>
<td>35.38</td>
<td>59.58</td>
</tr>
<tr>
<td>Present value of cash flows at 3.5% cost of capital</td>
<td>(10.19)</td>
<td>(33.31)</td>
<td>6.19</td>
<td>24.99</td>
<td>30.08</td>
<td>29.79</td>
<td>47.56</td>
</tr>
<tr>
<td>Cumulative return on investment</td>
<td>(10.19)</td>
<td>(43.50)</td>
<td>(37.30)</td>
<td>(12.32)</td>
<td>17.77</td>
<td>47.56</td>
<td></td>
</tr>
</tbody>
</table>
Figure 15: Return on investment from the merger at 3.5% cost of capital

The next section details the impact of the above financial flows on the long term financial model of the merged trust, and how this results in a financially sustainable organisation.

7.5 The Merged Trust’s need for financial support

The preceding analysis demonstrates that the proposed merger delivers a significant return on investment. The financial model for the new organisation demonstrates that the synergies of the merger also result in a sustainable new organisation. The Merged Trust will make recurrent surpluses from FY15 onwards, in stark contrast to the deficits forecast across the existing organisations, specifically, WCUHT and NUHT (as per Figure 16 on the next page). However, the early years will be extremely challenging for the new organisation, and significant support will be required in order to realise the merger synergies successfully while maintaining clinical quality and safety along with organisational control.
In its first year the Merged Trust will need to focus on integration of management structures while maintaining safety, quality and control. Disruption created by the change in management structure will mean the delivery of some of the CIPs planned by the three existing organisations will be delayed until future years (although this is partly offset by the realisation of the first tranche of merger synergies). This combined with the costs of the migration itself will mean significant support is required in 2012/13.

2013/14 will be the highest year of cost reduction for the new organisation as remaining merger synergies are realised and the organisation implements CIP plans delayed from 2012/13. This is the first year in which financial performance of the new organisation is expected to exceed that of the three preceding trusts even before any support is received and despite continuing migration costs.

2014/15 – 2016/17

The new organisation moves into financial surplus, which reaches 1% by 2015/16. This allows the focus to shift from cost reduction to the ongoing development of clinical services.
7.6 **Amount of financial support required**

During the transitional period, the Merged Trust will require significant financial support in order to:

- Fund migration costs
- Offset short term deficits while merger benefits are realised
- Fund historical liquidity issues and capital investments planned by the existing trusts, in particular those at WCUHT which are necessary to respond to the Health for north east London programme (see Section 3.5.4 for further detail).

Tables 39 and 40 set out funding required by the Merged Trust, while Table 41 demonstrates that with this support, the Merged Trust is able to meet its required financial metrics ahead of the planned date for authorisation as a Foundation Trust (December 2014).

Total funding included within the model is £86.5m cash backed I&E support, and £64.7m additional cash support. This is based upon the assumption that the outstanding NHS Bank PFI support of £20M is made available as per the existing agreement.

**Income and expenditure funding**

Support of £10.1m for FY12 has already been agreed by the Sector Commissioners.

For the remaining £76.4, further support has been agreed in principle through the Sector commissioners to fund the integration costs of £15.1m, £10.6m and £3.4m in FY13, FY14 and FY15 respectively subject to approval of the FBC. In principle the providers will commit to a risk sharing arrangement for 2012/13, 2013/14 and 2013/14 in return for this support.

The balance of I&E funding required (£47.3M), is the subject of ongoing discussions with NHS London and the Department of Health. Confirmation is expected ahead of the Department of Health’s Transaction Board in January 2012.

**Table 39: I&E funding requirement**

<table>
<thead>
<tr>
<th>Reason for I&amp;E funding requirement (£m in nominal terms)</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migration costs: redundancy</td>
<td>10.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10.8</td>
</tr>
<tr>
<td>Migration costs: integration project costs</td>
<td>10.1</td>
<td>15.1</td>
<td>10.6</td>
<td>3.4</td>
<td>0</td>
<td>0</td>
<td>39.2</td>
</tr>
<tr>
<td>Increased NHSLA/CNST costs</td>
<td>1.2</td>
<td>1.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.5</td>
</tr>
<tr>
<td>Transition costs: funding of gap to breakeven</td>
<td>21.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>21.3</td>
</tr>
<tr>
<td>Transition costs: funding of gap to 1% surplus where required</td>
<td></td>
<td></td>
<td>9.7</td>
<td></td>
<td></td>
<td></td>
<td>9.7</td>
</tr>
<tr>
<td>Adjustment where total funding results in greater than required surplus</td>
<td></td>
<td></td>
<td></td>
<td>(2.4)</td>
<td>0</td>
<td>0</td>
<td>(2.4)</td>
</tr>
<tr>
<td>Sub-total</td>
<td>10.1</td>
<td>48.4</td>
<td>21.6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>81.1</td>
</tr>
<tr>
<td>Increased PDC dividend costs of additional cash holdings (estimate)*</td>
<td>1</td>
<td>2.2</td>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
<td>5.4</td>
</tr>
<tr>
<td>Total I&amp;E support required</td>
<td>10.1</td>
<td>49.4</td>
<td>23.8</td>
<td>3.2</td>
<td>0</td>
<td>0</td>
<td>86.5</td>
</tr>
</tbody>
</table>

**Additional cash funding**

Of the additional cash required (£64.7m) shown in Table 40, the Whipps Cross capital funding (£14m) is subject to business case approval and the CTB funding of £26.3m (£25.3m for WCUHT and £1m for NUHT) is subject to CTB approval. The balance of the additional cash funding required (£24.4m) is the subject of ongoing discussions with NHS London and the Department of Health.
Table 40: Cash funding requirement

<table>
<thead>
<tr>
<th>Driver of cash funding requirement</th>
<th>Value</th>
<th>Expected funding type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whipps Cross 5 year capital programme shortfall*</td>
<td>£14m</td>
<td>PDC funding</td>
</tr>
<tr>
<td>Whipps Cross and Newham repayment of historical loans</td>
<td>£26.3m</td>
<td>CTB</td>
</tr>
<tr>
<td>Whipps cross historical liquidity/working capital issues</td>
<td>£10m</td>
<td>PDC funding</td>
</tr>
<tr>
<td>Newham historical liquidity/working capital issues</td>
<td>£8m</td>
<td>PDC funding</td>
</tr>
<tr>
<td>Whipps Cross funding to achieve pre merger breakeven</td>
<td>£6m</td>
<td>PDC funding</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>£64.3m</strong></td>
<td></td>
</tr>
<tr>
<td>Remaining liquidity gap</td>
<td>£0.4m</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£64.7m</strong></td>
<td></td>
</tr>
</tbody>
</table>

*subject to agreement of business cases

Table 41: Merged Trust financial position including assumed funding as per above

<table>
<thead>
<tr>
<th>I&amp;E summary (£m)</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus (deficit) excluding impairments</td>
<td>5.4</td>
<td>0.2</td>
<td>11.8</td>
<td>11.5</td>
<td>11.7</td>
<td>13.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CIPs</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>In year CIP modelled (£m)</td>
<td>73.2</td>
<td>44.5</td>
<td>63.5</td>
<td>59.7</td>
<td>42.2</td>
<td>33.6</td>
</tr>
<tr>
<td>CIP as a % of costs excl. impairments</td>
<td>6.2%</td>
<td>3.7%</td>
<td>5.5%</td>
<td>5.3%</td>
<td>3.8%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk rating metrics</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDA achieved (% of plan)</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>EBITDA margin (%)</td>
<td>6.8%</td>
<td>8.4%</td>
<td>9.9%</td>
<td>10.9%</td>
<td>11.3%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Return on capital employed (%)</td>
<td>3.4%</td>
<td>3.0%</td>
<td>8.1%</td>
<td>8.9%</td>
<td>10.3%</td>
<td>11.3%</td>
</tr>
<tr>
<td>E&amp;E surplus margin (%)</td>
<td>0.5%</td>
<td>0.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Liquid ratio</td>
<td>13.5</td>
<td>6.9</td>
<td>10.1</td>
<td>10.0</td>
<td>16.7</td>
<td>17.5</td>
</tr>
<tr>
<td>PBC passed?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Overall Risk Rating</strong></td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash (opening)</td>
<td>65.7</td>
<td>55.3</td>
<td>64.4</td>
<td>64.4</td>
<td>80.0</td>
<td>70.7</td>
</tr>
<tr>
<td>Cash (closing)</td>
<td>55.3</td>
<td>64.4</td>
<td>64.4</td>
<td>80.0</td>
<td>70.7</td>
<td>64.6</td>
</tr>
</tbody>
</table>

It should be noted that the cash funding outlined above in Table 40 would be required by the three individual trusts, and as such this need is not created by the merger. The only funding requirement which is directly attributable to the merger is the funding of migration costs and the delay to routine CIP delivery. However, the value of these costs is more than offset by the improved financial performance of the combined organisation in subsequent years due to merger synergies. In short, the merger reduces the overall cost pressure and requirement for ongoing financial support across the three existing trusts.

7.7 What happens if the projections for the new Merged Trust are wrong?

Table 42 sets out a number of risks facing the merged organisation along with a number of mitigating actions.
<table>
<thead>
<tr>
<th>Category</th>
<th>Context</th>
<th>Risks</th>
<th>Impact of Risk</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income price growth</td>
<td>Base case includes a 1.5% tariff deflator partially offset by 1% growth due to expected improvements in coding (as per commissioner CSPs)</td>
<td>• Merger activities distract from programmes to improve coding, meaning the 1% is not delivered.</td>
<td>• Lower than forecast income for the same level of activity</td>
<td>• Maintain separate activity, income and contracting systems for year 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Merger activities distract from programmes to improve coding, meaning the 1% is not delivered.</td>
<td>• Lower than forecast income for the same level of activity</td>
<td>• Offset loss of income by increasing CIPs</td>
</tr>
<tr>
<td>Cost Improvement Plans (CIPs)</td>
<td>High CIP target for FY14</td>
<td>• Target can not be met through recurrent measures alone, resulting in an increased target for FY15 (post merger)</td>
<td>• Increased cost base in FY15</td>
<td>• Increase CIP targets in FY15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Target can not be met through recurrent measures alone, resulting in an increased target for FY15 (post merger)</td>
<td>• Increased cost base in FY15</td>
<td>• Identify other areas to make up shortfall</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Target can not be met through recurrent measures alone, resulting in an increased target for FY15 (post merger)</td>
<td>• Increased cost base in FY15</td>
<td>• Increase levels of activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Target can not be met through recurrent measures alone, resulting in an increased target for FY15 (post merger)</td>
<td>• Increased cost base in FY15</td>
<td>• Maintain non-recurrent measures into FY15, so the cost base can be reduced over multiple subsequent years</td>
</tr>
<tr>
<td>PFI inflation</td>
<td>PFI operating costs linked to RPI</td>
<td>• RPI remains higher than modelled, resulting in increased PFI costs from FY13 onwards</td>
<td>• Non-influencable PFI costs increase</td>
<td>• Identify other areas of cost base for increased CIP</td>
</tr>
<tr>
<td></td>
<td>Base case assumes 3.5% inflation on PFI costs in all periods</td>
<td>• RPI remains higher than modelled, resulting in increased PFI costs from FY13 onwards</td>
<td>• Non-influencable PFI costs increase</td>
<td>• Bring services in house where possible to increase influence over cost base</td>
</tr>
<tr>
<td></td>
<td>RPI currently running circa 5%</td>
<td>• RPI remains higher than modelled, resulting in increased PFI costs from FY13 onwards</td>
<td>• Non-influencable PFI costs increase</td>
<td>• Bring services in house where possible to increase influence over cost base</td>
</tr>
<tr>
<td>Activity Growth</td>
<td>Activity growth currently modelled as per Commissioner’s Strategic Plan (CSGs)</td>
<td>• Activity does not increase due to factors such as GP commissioning</td>
<td>• Reduction in income</td>
<td>• Engagement with GP commissioners to build and enhance relationships</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Activity does not increase due to factors such as GP commissioning</td>
<td>• Reduction in income</td>
<td>• Remove excess capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Activity does not increase due to factors such as GP commissioning</td>
<td>• Reduction in income</td>
<td>• Focus on tertiary services and private patient income growth</td>
</tr>
<tr>
<td>General non-pay inflation</td>
<td>General non-pay inflation modelled at 2.5% in base case as per operating framework</td>
<td>• Inflation higher than the 2.5% modelled</td>
<td>• Increased non-pay costs</td>
<td>• Conduct procurement analysis and switch to lower cost unbranded goods</td>
</tr>
<tr>
<td></td>
<td>RPI currently 5.2%</td>
<td>• Inflation higher than the 2.5% modelled</td>
<td>• Increased non-pay costs</td>
<td>• Increased CIP targets</td>
</tr>
<tr>
<td>Increased capital spend / decreased funding</td>
<td>Significant capital investment taking place, especially at WCUHT site</td>
<td>• Capital projects are more expected than forecast</td>
<td>• Increased non-I&amp;E cash outflows</td>
<td>• Increase working capital facility</td>
</tr>
<tr>
<td></td>
<td>Land sale at WCUHT valued at £18m</td>
<td>• Capital projects are more expected than forecast</td>
<td>• Increased non-I&amp;E cash outflows</td>
<td>• Reduce scale of investment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Capital projects are more expected than forecast</td>
<td>• Increased non-I&amp;E cash outflows</td>
<td>• Reduce other areas of capital spend such as IT purchases</td>
</tr>
</tbody>
</table>
Based on a combination of a number of these risks a downside financial model has been produced, as set out in Tables 43 - 46. Please note that this is a hypothetical model and an assessment of risk. It is used to test the robustness of the Trust’s plans. Even if the risks materialised there may be other influencing factors that mean the Trust would take different actions than those specified below.

Under the downside scenario, the merged organisation would be in deficit from FY13 (Table 44). Table 45 shows a possible scenario of remedial action that the Trust could take to improve its financial position and enable the new organisation to achieve break even in FY13, 14 and 15 and to generate a surplus of at least 1% from FY16. A limited range of tactical mitigations have been identified to date, and in the first instance, the Trust would explore options to secure additional efficiencies by reviewing and reducing expenditure at individual department and service line level. However, if the downside scenario arose in full and these additional opportunities did not prove adequate to mitigate its impacts, it is possible that service reconfigurations would be required. However, it is important to emphasise that there are no current plans to make any service reconfigurations. Should service reconfiguration prove to be necessary at a later date, this would be subject to statutory consultation on this topic at that time.

Table 43: Downside assumptions

<table>
<thead>
<tr>
<th>Category</th>
<th>Base Case Assumptions</th>
<th>Downside Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income price growth</td>
<td>• Achieve 1% growth through coding improvements (partially offsetting 1.5% tariff deflator)</td>
<td>• No coding improvements in FY14. NHS income reduced by 1%.</td>
</tr>
<tr>
<td>CIPs</td>
<td>• CIP targets met recurrently</td>
<td>• £5m slippage of FY14 CIP schemes into FY15</td>
</tr>
<tr>
<td>Non pay inflation – PFI</td>
<td>• Inflation at 3.5%</td>
<td>• Inflation matches current RPI of 5.2% for FY13</td>
</tr>
<tr>
<td>Other non pay inflation</td>
<td>• Inflation at 2.5%</td>
<td>• All periods inflation increased to 3.5%</td>
</tr>
</tbody>
</table>
Table 44: Downside model outputs (unmitigated)

<table>
<thead>
<tr>
<th>I&amp;E summary (£m)</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus (deficit) excluding impairments</td>
<td>5.4</td>
<td>(3.1)</td>
<td>(7.3)</td>
<td>(4.8)</td>
<td>(7.0)</td>
<td>(7.2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CIPs</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>In year CIP modelled (£m)</td>
<td>73.2</td>
<td>45.0</td>
<td>59.0</td>
<td>66.0</td>
<td>43.6</td>
<td>35.1</td>
</tr>
<tr>
<td>CIP as a % of costs excl. impairments</td>
<td>6.2%</td>
<td>3.7%</td>
<td>5.1%</td>
<td>5.8%</td>
<td>3.9%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk rating metrics</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDA achieved (% of plan)</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>EBITDA margin (%)</td>
<td>6.8%</td>
<td>8.1%</td>
<td>8.3%</td>
<td>9.6%</td>
<td>9.7%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Return on capital employed (%)</td>
<td>3.4%</td>
<td>1.6%</td>
<td>0.8%</td>
<td>2.3%</td>
<td>1.6%</td>
<td>1.8%</td>
</tr>
<tr>
<td>I&amp;E surplus margin (%)</td>
<td>0.5%</td>
<td>-0.3%</td>
<td>-0.6%</td>
<td>-0.4%</td>
<td>-0.6%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Liquid ratio</td>
<td>13.5</td>
<td>6.9</td>
<td>8.9</td>
<td>2.1</td>
<td>2.7</td>
<td>(3.3)</td>
</tr>
<tr>
<td>PBC passed?</td>
<td>TRUE</td>
<td>FALSE</td>
<td>FALSE</td>
<td>FALSE</td>
<td>FALSE</td>
<td>FALSE</td>
</tr>
</tbody>
</table>

| Overall Risk Rating | 3  | 2  | 2  | 2  | 2  | 2  |

<table>
<thead>
<tr>
<th>Cash (£m)</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash (opening)</td>
<td>65.7</td>
<td>55.3</td>
<td>61.4</td>
<td>42.7</td>
<td>43.2</td>
<td>15.5</td>
</tr>
<tr>
<td>Cash (closing)</td>
<td>55.3</td>
<td>61.4</td>
<td>42.7</td>
<td>43.2</td>
<td>15.5</td>
<td>(11.4)</td>
</tr>
</tbody>
</table>

Please note the CIPs modelled in Table 44 amount to £322.0m which is £5.3m higher than the £316.7m shown in Table 41. This is due to non pay inflation being increased as a downside assumption, which in turn increases the non pay CIP schemes.

Table 45: Mitigations

<table>
<thead>
<tr>
<th>Mitigations (£m nominal terms)</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Recurrent schemes</td>
<td>3.1</td>
<td>7.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Outsourcing of back and mid office</td>
<td>2.1</td>
<td>2.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Service Reconfiguration</td>
<td>2.9</td>
<td>16.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3.1</td>
<td>7.3</td>
<td>5.0</td>
<td>18.5</td>
<td></td>
</tr>
</tbody>
</table>

NB As stated on Page 105, there are no current plans to make any service reconfigurations as part of the merger. Table 45 above models a theoretical mitigation to offset the downside assumptions. The figures used are balancing figures to meet the downside savings requirement, and are purely illustrative.
**Table 46: Model outputs (mitigated)**

<table>
<thead>
<tr>
<th></th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I&amp;E summary (£m)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus (deficit) excluding impairments</td>
<td>5.4</td>
<td>(0.0)</td>
<td>(0.0)</td>
<td>0.2</td>
<td>16.7</td>
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<tr>
<td>In year CIP modelled (£m)</td>
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<td>48.1</td>
<td>66.3</td>
<td>71.0</td>
<td>62.3</td>
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<td>4.0%</td>
<td>5.7%</td>
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<td>5.6%</td>
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<tr>
<td>EBITDA achieved (% of plan)</td>
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<td>100.0</td>
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<td>EBITDA margin (%)</td>
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<td>8.9%</td>
<td>10.0%</td>
<td>11.8%</td>
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<td>2.9%</td>
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<td>4.5%</td>
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<td>14.3%</td>
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<td>I&amp;E surplus margin (%)</td>
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<td>Cash (opening)</td>
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<td>Cash (closing)</td>
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<td>53.0</td>
<td>57.3</td>
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*NB Under this mitigated downside scenario, the surplus achieved in FY17 is £17.5m which is higher than shown in Table 41. This is as a result of the requirement to improve the liquidity ratio in FY17 to achieve an FRR of 3. This improvement results in an increased surplus.*

Under the assumptions of the mitigated downside model the combined organisation remains in surplus from FY14 onwards, with this surplus exceeding 1% in FY16 and FY17.
8. Listening and valuing feedback

Synopsis

Following the approval process for the OBC the merger team proactively undertook a 16 week programme of structured engagement to collect the views of key stakeholders to inform the FBC.

Over 200 formal responses were received via meetings and events, roadshows and in letters and other communications, and the feedback can be grouped into six main themes:

- A request and desire to understand the financial environment and pressures facing the three Trusts
- A requirement to meet commissioner intentions for delivering care closer to home
- Clarification of how the Merged Trust will work with local partners including neighbouring hospital trusts such as Homerton University Hospital NHS Foundation Trust and Barking, Havering and Redbridge University Hospitals NHS Trust
- An expressed desire to be involved in the development of metrics which will measure the benefits realisation from the merger
- A need to improve communication
- A plea to include and engage staff, and take them on the journey.

This chapter also outlines how the merger team and ultimately the Merged Trust will continue to listen to and engage with stakeholders prior to Day 1, and beyond.

- Section 8.1 explains the engagement activity undertaken
- Section 8.2 provides an overview of the feedback received from stakeholders as part of the engagement, and actions taken as a result
- Section 8.3 explains how the Merged Trust will continue to listen, change and respond to stakeholder feedback post-merger.

A key component of integration planning for the Merged Trust has been to ensure the views of local stakeholders are understood and incorporated. As such the future organisational design and merger transition plans have been developed through a thorough and on-going engagement process with a diverse range of audiences.

Engagement initiatives commenced with the formation of the merger programme team in March 2011 and have included over 100 meetings with MPs, local authority officers and councillors, GPs, current and future commissioners, union representatives and the public. A series of roadshows for staff, patients and the public have also taken place between August and November 2011. Clinical workshops with hundreds of clinicians from across the three Trusts have occurred in addition to regular CAG meetings, three trust staff engagement events and a quarterly senior leadership forum.

This section provides an overview of the engagement undertaken, the feedback received and how integration plans have been altered as a result.

8.1 Engagement activity

With the formation of the merger programme team in March 2011, the three Trusts began an engagement programme to actively seek views on the proposed merger. Following the approval process for the OBC the team then proactively undertook a 16 week programme of structured engagement to collect the views of stakeholders in order to inform the FBC.
A summary OBC, the prospectus, was published electronically on 29 July 2011 and in hardcopy on 5 August 2011. The prospectus provided detail of the proposed merger and invited comment from the 26,000 recipients across all areas of the community. Recipients included:

- Barts and The London (approx. 6000) and Newham membership lists (approx. 1,000)
- All GP practices in City and Hackney, Newham, Tower Hamlets and Waltham Forest. Smaller quantities were sent to practices in Redbridge, Havering and Barking and Dagenham and GP commissioners in inner and outer north east London
- MPs, Local assembly and GLA members, community groups and libraries
- Patient forums and panels and Local Involvement Networks (LINks) in north east London and West Essex
- NHS Outer North East London and NHS East London and the City Boards and executive teams; NHS London executive team and DH executive team
- Regulators and influencers including the Care Quality Commission
- Local authorities – elected mayors, chief executive, chair of overview and scrutiny committee, cabinet member for health, social care directors and other key personnel

The prospectus has been made available to download from Trust and cluster websites and intranets. It is also available in large print, audio, Braille or in a variety of languages on request. An easy read version was published on 8 August 2011 and sent to LINks and patient panels. Health and social care organisations, clusters and LINk partners have been requested to publish the prospectus on their website

A video explaining the merger was launched on 15 September 2011 at an external stakeholder event and on 21 September 2011 at a staff engagement event. The video has been made available on the trust websites and has been shown at other key events such as the Medicine for Members event at Barts and The London NHS Trust, the Annual General Meetings of both Whipps Cross and Newham Hospitals and the Waltham Forest LINk members meeting on 12 October 2011

A range of posters and postcards for each trust has also been produced along with banners for common areas within each of the trusts

The merger leadership team have attended over 100 meetings with stakeholders including overview and scrutiny committees, LINks, health and wellbeing boards, clinical commissioning groups and patient representative panels in addition to one-to-one meetings with MPs and GP commissioners

Letters have been written to all community groups, GPs, the membership lists from Newham and Barts and The London, LINks and local authority colleagues inviting them to attend specially convened stakeholder events or expressing an interest for merger representatives to attend local established groups or forums

Staff have been kept up to date with monthly staff newsletters, email updates to senior colleagues and generic text has been supplied for internal bulletins and updating intranets. A range of events have also been arranged for staff and stakeholders including:

- three senior leadership forums (a fourth planned for early December 2011) where guest speakers have covered lessons learnt from the Heart of England NHS Foundation Trust and Boots Opticians mergers
- two ‘open invite’ events for staff from across the three trusts (a third planned for December 2011) – and a variety of events for staff in each trust to speak directly to members of the executive teams as well as discussions within service lines and team meetings
- Stakeholder events on 15 September, 20 October and 3 November were also well attended by staff representatives
Nine clinical workshops have taken place since March 2011, at which clinicians from across the three trusts have helped develop the integration plans.

- Six dedicated borough based events for stakeholders have been undertaken and four north east London wide events have taken place (including one dedicated event on finance), with over 300 people attending including GPs, councillors, LiNk members, patient representatives and a local MP attending.

- A merger project website was launched on 15 November 2011 as a key information portal for staff, patients and the public to find out more about the proposed merger and to have access to key documentation and updates. The website content has been developed in partnership with local patients. Each of the existing Trusts’ websites provides navigation to this dedicated website.

- A public friendly clinical benefits prospectus has been developed to provide some key examples of the clinical and healthcare benefits of the proposed merger. Printed copies of this document have been made available to all GP practices, professional bodies, NHS partners and throughout each hospital, to local authorities, MPs and LiNks. The clinical prospectus is also available to download from the merger website.

- A series of 25 drop-in information stalls have been held within the three trusts between August and November 2011 for staff, patients, visitors and the public to find out more about the merger, ask questions and give their feedback for consideration. Over 2,000 people (staff, volunteers, visitors and patients) have been engaged in these roadshows. More dates are planned for early 2012.

Work has also been undertaken with local and health media who have had access to clinicians from across the three trusts, met with chief executives and generally raised awareness of the proposed merger. Articles have signposted the merger roadshows and also focussed on the investment at each of the hospitals: the opening of the new Royal London hospital in December 2011; the A&E build at Whipps Cross hospital and the extension and upgrade of both the maternity and A&E services at Newham hospital. More work is planned in the coming weeks and months with a particular focus on local ethnic media.

### 8.2 Listening and responding to feedback

Engagement is only worthwhile for parties if the issues raised are properly considered and, where appropriate, taken on board. The engagement process has not been entered into lightly and the feedback received has been provided to the appropriate corporate service or CAG for consideration and, where relevant, inclusion within integration plans.

On reviewing the feedback received since the formation of the merger programme there are clear lines of enquiry from key stakeholders. This feedback can be grouped into six key themes which encompass the views that have been expressed at meetings and events (105 responses), road-shows (72 responses) and in letters and other communications (40 responses). This section also details how the transition plans and approaches have incorporated suggestions highlighted during the engagement.

#### 8.2.1 Theme One: Financial sustainability for future generations

There has been a frequently raised view and desire to understand the financial environment and pressures under which the three trusts currently operate: what alternatives to the merger would be possible for each of the organisations and how the private finance initiative (PFI) at Barts and The London NHS Trust in particular would impact on the proposed new hospital trust.

Stakeholders have been quick to recognise that the NHS is not immune to the financial difficulties that the current economic climate has highlighted and understand that the NHS must become more efficient, whilst continuing to provide patient centred and value for money services. There is a clear wish within the health and social care economy to agree an
approach for local hospital services which will secure the future of locally accessible services and a financially stable system for future generations.

**Action taken in response:**

Throughout the development of the FBC, the three existing Trusts have been open and transparent regarding their current financial uncertainties, the impact of PFI arrangements and the potential sources of funding to close the financial gap which will remain for the new Merged Trust. Reviews have been undertaken by several borough-based overview and scrutiny committees and a financial due diligence process has been led by an external company. The senior leadership and financial teams from the Trusts have attended meetings with local partners and a dedicated stakeholder event has been hosted solely on finance.

The merger team has been and continues to be actively engaged with the Department of Health and NHS London to find a financial solution which meets the needs of the local health economy and will ensure the resilience of local services for future generations. A stable financial health economy within five years is outlined within the financial planning for the Merged Trust following discussions with regulators to smooth the costs of transition and the efficiency savings that all NHS trusts are being asked to make year on year. The greater risk to the health economy is if the merger does not proceed as outlined at the financial stakeholder event hosted on 20 October 2011.

GP commissioners and local authority partners have stressed the need for the new trust to be financially independent. The model described in the long term financial planning meets these expectations and reflects the ongoing dialogue with regulators.

**8.2.2 Theme Two: Delivering care closer to home**

Commissioners have been clear in their guidance that the existing and/or new organisation must respect commissioning intentions. Central to these commissioning intentions is the premise that more care should be provided closer to home and that hospital is not always the answer.

**Action taken in response:**

The OBC and FBC have each been informed by the latest information available in the commissioning strategic plans for north east London. The new Merged Trust integration plans demonstrate this and the commitment to moving care into the community.

The published commitments from the Merged Trust to local people have been outlined as follows:

- to ensure long term continuity of excellent and comprehensive local access; and
- improved access to specialist services throughout north east London

The Merged Trust is clear that services need to be provided locally where possible and there is a drive to devolve specialist services closer to home where it is clinically appropriate to do so; for example providing chemotherapy at Whipps Cross for patients who currently travel to The Royal London hospital.

To make a range of services available closer to home each service will need to be evaluated on its own merits on the basis of patient safety and value for money among other prioritisation criteria. The new trust has committed to doing so in partnership with key stakeholders in the local health and social care economy as demonstrated by the 3 November stakeholder event where the key areas for improvement within the new Trust were discussed with a view to prioritisation and action.

The integration of Tower Hamlets Community Health Services to Barts and The London NHS Trust in July 2011 also provides a valuable rich source of information on how best to integrate services in a more community based setting and efforts to engage with primary care colleagues to develop services have been enhanced in recent months.
Further to this, and linked to the financial theme (and the cost of the Barts and The London PFI) is a concern by numerous stakeholder groups that the financial case for change will lead to a reconfiguration of services in the future and in particular the centralisation of services to the new Royal London hospital.

**Action taken in response:**

The new Trusts commitment to ensuring long-term continuity of local services is emphasised by the continued investment in the estate throughout the proposed new trust. The new Royal London hospital is opening in December 2011, a new A&E is due to open at Whipps Cross hospital in January 2012 and the maternity unit extension and new emergency services department will come on-line at Newham hospital in 2012.

Each of the three trust boards have also outlined the terms under which they would authorise the merger on behalf of the local people they represent and these include, but are not limited to; smoothing of the cost improvement programmes required of all NHS trusts, payment via the Challenged Trust Board of the historical deficits at both NUHT and WCUHT and a clear funding solution for maternity services at WCUHT.

Each of the senior leadership teams have expressed the ongoing commitment to local people that although the merger provides the opportunity to undertake centralisation of service there are no such plans to do so as the strategic review of services has been undertaken as part of the recently approved Health for north east London programme. The new Trust has also outlined that should service changes be proposed in the future that all appropriate measures of consultation and engagement will be undertaken with local stakeholders.

**8.2.3 Theme Three: Partnership working**

The proposal to bring together the three hospital trusts would see the creation of one of the largest hospital trusts in the country. There are a large number of benefits which this can bring due to the size and scale of the new organisation in terms of patient care, outcomes and opportunities to staff.

Acknowledging this, stakeholders have asked how the new Trust will work with local partners including neighbouring hospital trusts such as Homerton University Hospital NHS Foundation Trust and Barking, Havering and Redbridge University Hospitals NHS Trust. Stakeholders have also wanted to understand how local decisions will be taken and how local commissioners, patients and local authority partners will be able to influence local decision making.

Additionally feedback received from patients has highlighted that there is much more to be done to improve the experience of hospital services.
**Action taken in response:**

The transitional management team understands that improving the health of local people cannot be done in isolation and requires the collaboration of local health and social care partners and the involvement of the local community.

The Merged Trust is committed to working with and involving local partners in all that it does, for instance in designing new care pathways with the priorities for change identified in partnership with primary and community care colleagues and local people – the first opportunity to do so being the stakeholder event on 3 November 2011.

The new organisation is looking to strengthen relationships with current and future commissioners, local authorities and local involvement networks. To aid this, an inclusive structure has been developed where local GPs will have a formal role in the organisation working alongside the Medical Director and a monthly meeting of GP commissioners and the medical directors of each of the three trusts has been initiated. The medical director and strategy directorates in the new organisation will also focus on the health of the local community and work with local partners on the public health agenda; an example being the recent small c campaign.

A patient-centred approach to transition planning and service design has also been adopted with the engagement of a patient advisors group to work as part of the integration planning team. The knowledge and insight of the patient advisors has helped shape the new organisation’s commitment to deliver on the health bill commitment of ‘no decision about me without me’, the patient involvement programme and ensuring that front line teams have patients’ needs and interests at the heart of all that they do. Details on the patient-centred approach built in collaboration with the patient advisors group are outlined in Section 4.2.3 for example, patient experience metrics will be incorporated into how the Trust evaluates workforce performance. The patient advisors will continue to guide the new organisation throughout the transition process and ensure that the new Trust has a robust involvement model in order to make a seamless transition to foundation trust arrangements following authorisation.

Partnership working also encompasses the new Trust approach to staff representation and a new way of working has been developed with full time and local union officers through a workshop approach in recent months. A further aspect of partnership working is ensuring that the new Trust communicates and engages effectively - as a result of positive feedback the number of roadshows held in recent weeks has been doubled and more are planned for 2012.

The new organisation is also looking to work with Homerton University Hospital NHS Foundation Trust to cooperate where it is in the best interests of patients and taxpayers. This approach is also being extended to Barking, Havering and Redbridge University Hospitals NHS Trust, local mental health trusts and other local healthcare providers. Working together to share best practice, and to develop and build on existing clinical networks, can only be of benefit to local people.

As expressed above, access to services closer to home is a guiding principle for the new organisation, as is the ability for local people to influence local hospital decisions. As a direct response to feedback throughout the engagement process there will now be very senior local personnel based at each hospital site. Not only will these key individuals have local intimate knowledge of their hospital but they will also be tasked with enhancing local relationships with health and social care colleagues.
8.2.4 Theme Four: Realising the benefits

A range of stakeholders have expressed a desire to work with the merger team to be involved in the development of metrics which measure benefits realisation. Other stakeholders would simply like to know the methodology and metrics that will be applied to ensure standards and timescales are met.

**Action taken in response:**

It is critical for any organisation to be clear about its objectives, its performance and to ensure constant evaluation in order to maintain and enhance its reputation and level of services. The new organisation is developing a performance framework and benefits realisation programme that will complement local stakeholder requirements and ensure that it delivers on all of its potential - on time and to the highest possible standards.

The performance metrics will also be published accordingly in order to enhance transparency and enhanced communications will enable partners to review, understand and provide feedback to the new trust.

Another strong recurring theme throughout the engagement concerns the potential name of the new organisation with a strong preference to reflect local ownership of services and to capture existing goodwill and practices from each of the hospital sites.

**Action taken in response:**

The name Barts and East London Healthcare merger project was adopted by the programme on an interim basis whilst the approvals process and necessary integration plans were developed. During the integration journey very strong preferences have been heard for the new Trust name and as such a commitment has been made by the three Trust boards that the individual hospital names will remain. The only change being the parental, overarching Trust name.

An engagement programme specifically on the new Trust name has been undertaken with staff representatives, merger advocates, senior managers and some external partners, including the patient advisors group. The outcome of this engagement and the selection of a new name will take place by the three trust boards alongside their consideration of the FBC.
8.2.5 Theme Five: A need to improve communication

A wish for more opportunities to raise anxieties, seek reassurances and suggest solutions across the trust service lines was a frequent request. A number of stakeholders also acknowledged improvements made in this area recently by some services.

*Action taken in response:*

Communication is central to the success of a new organisation. The engagement undertaken to date has highlighted that each of the legacy Trusts could significantly improve communication, particularly with health partners and patients.

To improve communications, local patients and residents have been asked to help shape the new organisation via the patient advisors group and in time they will be looking at stationary, standard letters and navigation to each of the hospital sites. A separate group have also been working with the programme team advising on the transitional website and they will also help design and build the website for the new organisation – a day one deliverable for the communications and engagement workstream.

The engagement throughout the merger project has seen an enhanced level of communications with senior staff talking and listening to hundreds of patients, stakeholders and members of the public. It is expected that this level of commitment will continue in the new organisation. As a result of this programme the merger team have already drawn together key stakeholders to develop the key priority areas for improvement within the new trust and a monthly meeting has been established between GP commissioners across each borough of the proposed new trust and representatives from each hospital site.

To date managers and clinicians have attended over 100 meetings in a 16 week period in addition to regular written communications. In response to queries and feedback, six dedicated borough based stakeholder events were held and four north east London wide events. For example on 3 November 2011 local people were asked to participate in a workshop with clinicians on key areas for care pathway improvement. Around 60 people attended this event.

Each service line via the CAGs has also been tasked with considering how best to enhance communications and engagement. This will become a core element in the gateway review process which is designed to ensure that all necessary elements of the transition process are in place before any changes are implemented.

8.2.6 Theme Six: Taking staff on the journey

The engagement has highlighted anxiety of further change amongst Trust staff (following recent restructuring), concerns about the feasibility of staff working across multiple sites which are geographically distinct, and concerns about how staff from different organisations with different cultures will integrate. Indeed, cultural differences across the three Trusts have been highlighted as a major barrier to the proposed merger succeeding, as has the unprecedented level of change in the NHS at the current time.
It is recognised that for the merger to be successful, it is clear that all staff must understand the necessity and opportunities of becoming one organisation in order to win their support for developing what could be the very best hospital trust in the country.

To aid this process a detailed staff engagement programme has begun to be implemented which includes local staff events, road-shows, surgeries, drop-in sessions, newsletters (where staff questions are answered) and opportunities to ask questions of the senior teams. These dedicated events are aimed at all levels within the three organisations. A series of three trust wide staff events have also been developed and senior leadership forums have taken place to learn from other experiences and ensure senior personnel have the information needed to lead local engagement.

The transitional website launched in November 2011 also provides an area dedicated to staff and regular updates, including a dedicated monthly newsletter developed following feedback from staff, are cascaded throughout the existing trust communication channels and are available on each organisations intranet.

A staff representatives briefing group was established following the formation of the merger programme team and provides an opportunity for both full time and local officers to interact with the merger integration director on a monthly basis.

Staff from each of the three Trusts have also volunteered to become merger advocates within their respective trusts. Their role is to provide information and receive questions and queries from staff members and reflect this back to the central programme team. Staff are also able to contact the programme team directly via phone or email.

Section 9 provides further details of the organisational development plans and how these will, amongst other things, support the integration of three different cultures.

8.3 Continuing the journey- a listening organisation

Through the merger engagement programme the new organisation has had a prime opportunity to build new and enhance existing relationships with internal and external stakeholders. This includes an opportunity to construct an innovative and assertive outreach approach to engaging with and involving the community, voluntary groups and other health and social care agencies in service design and decision making. As a result of this approach the Merged Trust will become an organisation that is responsive to the diverse needs of its communities which will ultimately help improve health outcomes and contribute to reducing health inequalities.

It is vitally important that the new organisation continues to listen, change and respond to feedback from local partners and the community. The organisation is here to serve local people and as such needs to focus on meeting local requirements. The involvement model for the new trust is being developed by local representatives and the merger provides a very real opportunity to make positive changes as the new organisation moves towards the FT model – changes which would be harder to achieve as individual trusts. The transitional executive team are clear that as an aspiring high-performing FT, that has the potential to be the best in the country, the journey does not end with authorisation to merge.

To achieve these ambitions the first step will be to standardise to best in class whilst looking to the future. This applies equally to the way that the Trust communicates and engages with local people and partners. The engagement undertaken in recent months has set the standard and it will be necessary to exceed expectations on the journey to FT status and beyond.
9. Integration

**Synopsis**

As outlined in Chapter 4, careful consideration has been given to designing the proposed integration journey, with Year 1 – integration, Year 2 – service improvement, and Year 3 onwards – transformation.

A significant amount of work to prepare for integration has already been achieved including; the design of the governance arrangements for the Merged Trust; an agreed suite of deliverables for Day 1 with associate implementation plans; identified vision and strategic objective for all clinical and corporate workstreams; design and costing of CAG and corporate management structures; and identification of significant clinical and financial benefits.

The programme team acknowledges however that there is still a good deal more to do, and it is recognised that a step up in pace is required now that commissioners have endorsed transition funding support in principle to the end of December 2011, and to the end of March 2012 pending FBC approval.

- Section 9.1 describes the key activities undertaken during the preparation phase
- Section 9.2 sets out the key activities to be undertaken during Year 1 – the integration phase
- Section 9.3 summarises the key activities to be undertaken during Year 2 – the service improvement phase
- Section 9.4 outlines the key activities to be undertaken during Years 3 to 5 – the service transformation phase
- Section 9.5 sets out the policy framework
- Section 9.6 summarises the organisational development strategy and approach which will underpin the integration
- Section 9.7 summarises arrangements for knowledge transfer
- Section 9.8 sets out the programme controls and risk management arrangements
- Section 9.9 summarises the assurance process prior to integration
- Section 9.10 summarises the ways of working prior to transition of controls.

Much time and effort has already been devoted to planning and preparing for integration. Work began while the OBC was being written and a number of key planning activities have already been completed by the time this FBC has been finalised. The three Trusts and the merger team are fully aware of the complexity and scale of the endeavour to merge to one new organisation on 1 April 2012, and are not underestimating the size of the challenge ahead. At the same time however, it is recognised that the risks of maintaining the status quo are also significant; there are considerable numbers of interim appointments at senior level at NUHT and WCUHT, as well as ongoing challenges to maintaining and delivering against the business as usual operational and financial agendas.

There is a significant programme of work ahead to integrate into one organisation and to deliver the vision and aims of the new trust. The merger team recognise that the integration plans will need to evolve as the focus shifts from approval of the FBC to delivery of the merged organisation. In addition the appropriate leadership capacity and capability to deliver, the scale of the integration becomes ever more critical. Over recent weeks a number of changes and additions to the programme leadership have been actioned. These have included;
A new Programme Integration Planning Director has been appointed to strengthen the focus on programme delivery

A new Informatics workstream lead has been appointed. This is now a dedicated full time role and will provide additional capacity to lead the delivery of the key informatics integration deliverables

A new appointment has been made to the Clinical workstream Chief Operating Officer role. This is also now a full time post and will provide additional capacity, working alongside the three trust’s existing Chief Operating Officers to deliver the clinical integration agenda. This post holder will also provide the lead for the estates workstream, ensuring that estates developments are directly linked with operational planning and delivery.

The rest of this section summarises the achievements to date and the planned integration work throughout the remaining phases of the merger.

9.1 Preparation phase

A set of integration parameters have been established to guide the programme through the preparation phase. These parameters are designed to make sure that the programme focuses on ensuring that patients will be no less safe on 1 April 2012 than they were on 31 March 2012. The overarching critical success factors required to achieve this are:

- Ensuring accountability and responsibility remains clear from Board to Ward throughout the integration and transition process to maintain safe, high quality care and operational and financial control
- Ensuring that operational performance, risk and financial reporting are effective and that there is no diminution in the information available to the Board, senior leaders and managers
- Maintaining control throughout the integration process via clarity of policies, processes and procedures
- Maintaining effective and efficient communication with staff and key external stakeholders and partner organisations across the health community throughout the change process.

To this end, in August 2011 the Transition Executive agreed the following high level transitional arrangements:

- Appointment of the Executive Board, CAG, Corporate Services Leadership positions and Hospital Management roles into designate positions prior to 1 April 2012
- Designation of appointments which are accountable for ensuring safe and robust integration alongside stable transfer from business-as-usual
- The corporate service will ‘act as one’, making aligned and collective decisions across the existing trusts, prior to merger to harmonise and position services to maximise benefits for operational services
- Workforce numbers to be reduced by using the ‘act as one’ principle through the adoption of a range of HR initiatives. This will minimise the requirement for compulsory redundancies
- Collective consultation with all other staff will commence post April 2012 and will run for 90 days
- Implementation of the new structures will only commence once CAGs have passed a formal readiness test to provide assurance that all the necessary elements are in place to
maintain safe and high quality services. (This is anticipated to be from 1 July at the earliest through to 1 October 2012).

Progress at the time of the FBC
Workstreams have already completed significant amounts of work to prepare for integration and key achievements to date include:

- Design of the governance arrangements for the new organisation including Board and Committee structures - that will provide assurance that quality and safety of care to patients, and operational and financial performance is maintained
- Agreement on the vision and strategic objectives for CAGs and corporate workstreams, as well as identification of the clinical and financial benefits resulting from the merger
- An agreed suite of Day 1 deliverables with associated project and integration plans
- Identification of critical success factors for the merger by workstream such that achievement of the vision, objectives and benefits can delivered
- Design and costing of CAG and Corporate management structures to provide a strong clinical leadership model, strength and excellence of corporate support to the CAGs and the business, as well as value for money
- Significant engagement with staff and key stakeholders and health partners locally to gain understanding of, and commitment, to the merger.

Focus of preparation until Day 1 (1 April 2012)
The completion of this work to date is a great achievement but the programme team acknowledges that there is still a good deal more to do before Day 1 to achieve the agreed Day 1 deliverables and ensure a safe and effective transition to the new organisation.

It has taken a significant amount of time, firstly to identify and agree the resource required to support the merger programme of integration, and secondly to secure support for this transition funding prior to the FBC approval, particularly the funding required this year. At the end of October 2011 funding agreement from the Commissioners was secured until such time as FBC approval is agreed, and this has enabled mobilisation of the integration to start. It is therefore recognised that a step up in terms of pace and focus is now required to achieve integration and the aspirations of the new organisation. This particularly applies to the HR and OD, finance and informatics workstreams where the Day 1 deliverables and first six months integration activities require more considerable additional resource.

Key areas of focus through to Day 1 will be:

- Appointing Non Executive and Executive Director positions from January 2012, so that the merged organisation has a new Board in place for 1 April 2012. In addition, appointments will also be made to the CAG Tier 1, Hospital Management roles, and Corporate Services leadership positions into designate positions prior to 1 April 2012
- Preparation for the transfer of staff that will occur as a result of the merger. This will include employee engagement and communications; leadership and employee development; staff side relations; and preparation for consultation with staff. Further work will be needed on the organisational design including development of job descriptions, roles and responsibilities and KPIs etc; as well as a focus on knowledge and change management. This is critical preparation for the first six months of integration
- The CAGs will flesh out the proposed organisational structures to a service line level, ensuring direct line of sight from Board to point of clinical service delivery. This will include a programme of leadership development underpinned by broader competencies and team building, embedding service improvement and patient experience at the heart of
all service transformation. A suite of priorities for early service improvements have been agreed (as set out in Section 6.2) and planning for these will take place. Examples include repatriation of outsourced elective activity and diabetes pathway co-design which will support patients to live life as normally as possible, reducing avoidable admissions, complications and premature mortality

- A unified Board Assurance Framework will be established for the new organisation, along with an integrated risk management system enabling a single view of risks across the Merged Trust. In addition, unified systems for reporting and managing incidents and patient safety and quality will be in place.

- Establishing a complete suite of harmonised policies, focusing first on critical ones that need to be in place for Day 1 to maintain safety, quality and control as well as to meet statutory, legal and regulatory responsibilities e.g. NHSLA and CQC. Examples include the Major Incident Policy, Fire, Health and Safety and Security policies, Standing Financial Instructions, Scheme of Delegation.

- Work will start to establish reporting arrangements for internal and external reporting on patient quality and safety, workforce, operational and financial performance. Reporting for the new organisation (whilst continuing reporting on the three individual trusts) will commence in January 2012. This will provide the opportunity to amend the reporting arrangements as required during the last quarter of 2011/12 to ensure that critical management information is in place and fit for purpose as soon as the new organisation comes into effect.

- A single finance ledger will be developed with common accounts receivable and accounts payable processes in place to enable financial reporting. Access to systems for all staff across all sites will also be in place, to ensure that no matter where front line staff are working they can access the information they require to inform decision making. The systems themselves will not be integrated until post Day 1, and in some cases, for example with the integrated CRS system this will not come into effect until 2014/15. A single Trust website and intranet or extranet will also be in place, along with a single Trust email address for staff.

In addition to the key activities outlined above, contracts with commissioners will also be established for the three original trusts. Due to the intricacies of the PBR mechanism there is a risk to both commissioners and the Trust of changes to current income levels. In order to fully understand the level of risk the income and contracting teams from each Trust are currently identifying the areas where fluctuations may be greatest - and calculating the potential monetary impact of this. This work is planned to be completed in December 2011 and once this has been undertaken, engagement with the commissioners is planned to de-risk the merger for both parties.

The contracts for Year 1 will be based on common planning principles and contracting terms. This will benefit the new organisation in the first year as there will be commonality in the assumptions that underpin the plans, making performance comparisons meaningful. The Trusts, will however maintain separate plans for the transition period.

From an estates & facilities perspective, all property titles and deeds from the three trusts will have transferred into the new organisation, and new signage will be in place on the main sites.

All of this will mean that in practice by Day 1 on 1 April 2012, a single organisation will be established with a unified Board supported by defined sub-committees. This structure is shown in Section 5.2 and will provide a stable and effective accountability. Key policies will be in place to ensure consistent, safe and effective practice. Finance, IT and other data systems will be integrated to ensure that the information required to run the Merged Trust is reliable and available to management and the Board, so that they can make the most informed decisions.
9.2 Year 1: integration phase

The integration phase of the merger represents a critical time during which there is an overriding need to maintain safe and high quality services at a time of significant change and upheaval – some of which is independent of the merger itself.

In the first year it is important that the planned move to the new Royal London site is completed successfully; the new A&E for WCUHT and the new urgent care centre for NUHT will open, the 2012 Olympic and Paralympic Games will also take place and require the new organisation to be a major receiving hospital. On top of this the new organisation will still be expected to deliver the objectives of Health for north east London, achieve CIP targets and maintain national standards and operational performance. This is particularly relevant given the individual Trusts face existing challenges with delivery of the 2011/12 financial efficiency targets, as well as with performance against A&E, 18 weeks and cancer access targets.

This is why in the first year an approach has been taken which seeks to minimise unnecessary full scale change from Day 1 which could de-stabilise the trust.

The planning assumptions for the new organisation and the Long Term Financial Model (as set out in Chapter 7) include maintaining a CIP target of just under 4% in year 1, as well as additional initial costs for integration. These costs include potential costs of redundancies, and project costs essential to the successful integration, particularly in the HR and OD, finance and informatics workstreams as well as some double running costs as the trust moves to the new structures. This recognises the need to maintain the financial efficiency target during Year 1 to a manageable level, as well as the requirement for additional resource and capacity to lead and deliver this scale of change.

9.2.1 Integration in the first six months

During the first six months, the organisation will concentrate on maintaining delivery of high quality services to patients, meeting operational and service performance targets and delivering the financial efficiency plans.

From an integration perspective the main focus will be changes to people’s roles and the organisational structure. It has deliberately been planned to focus on this quickly and early during the integration phase to ensure the effective transition from three individual organisations to the one Merged Trust, and that the clinical and financial benefits identified can be achieved. As referenced within the agreed transition arrangements outlined in Section 9.1, implementation of the new structures will only commence once CAGs have passed a formal readiness test to provide assurance that all the necessary elements are in place to maintain safe and high quality services.

During this time all other change will be kept to an absolute minimum such that distraction is minimised. There will be no big changes to IT systems or clinical processes, instead the focus will be on changes to corporate services that deliver efficiencies, the integration of CAG management structures, and operational stability during the mandatory 90 day consultation that will accompany the planned changes to people’s roles. During the first six months, work will also take place to plan for and embed cultural and organisational change.

By the end of the first quarter, the three month consultation process with staff for appointments below Tier 1 and corporate leadership roles will be completed, and implementation of the proposed changes to structures will then commence. Senior CAG and corporate leadership roles appointed prior to merger will be accountable for setting up the CAGs and corporate services. Corporate services will manage the transition to new organisational structures safely due to the act-as-one programme. To ensure accountability and safety, CAG leaders will be given a set of integration tests to ensure formal readiness for CAGs prior to transfer of controls from business-as-usual to the CAGs.

By month six the new organisational structures, with substantive appointments below Tier 1 and corporate leadership roles, will be in place following a full consultation with staff which
will commence from 1 April 2012. Integrated HR systems for the new merged organisations will be in place to enable the merged organisation to have seamless access to workforce and HR data and information.

Whilst all other changes during this time will be kept to a minimum, there are a suite of other discreet activities that will take place during this time:

- **Key governance milestones** will be reached e.g. the integration of reporting for risks, incidents, claims and litigation; a major incident command, control and communications exercise will have been held; and an informal NHSLA assessment completed

- **Standardised divisional reports across finance, workforce, quality and performance** will come into effect during the first six months of the new Trust to complement the standardised Board report which will have been in place from Day 1

- **From a finance perspective**, by the end of the first quarter the year-end accounts for the three Trusts will have been completed and signed off. Common accounts payable and accounts receivable processes will be embedded with any transitional issues resolved.

The first six months is also important in the Merged Trust's journey towards FT status in December 2014. While the assessment process will not start until the second year there is much preparation that can be done including carrying out a full market assessment to inform the service developments that the new organisation will pursue as a Foundation Trust. It is also a time when the new organisation needs to begin to write its Integrated Business Plan, and update its Long Term Financial model with downside scenarios and corresponding mitigations. A membership strategy is also required and the trust’s systems must be aligned with Monitor’s compliance framework.

### 9.2.2 Integration during the rest of year one

The focus for the remainder of the year will be embedding the new organisational structures, delivering the full value of cost improvement schemes implemented in 2011/12 and driving clinical and operational improvements for the benefit of patients and taxpayers.

The CAGs will focus on delivering the early priorities set out in Section 6.2 that were planned prior to merger. They will review progress to date across the three values of health improvement and health inequalities, patient experience, and equalities and human rights. This will help inform the development of their medium-term operational plans (within the context of commissioning intentions) and will drive the development of the clinical strategy.

A number of key milestones will be achieved for corporate functions including:

- **Integrated governance and safety**: the remaining organisational policies will be harmonised, consulted upon and implemented; fully integrated infection control and tissue viability teams will be in place; the capacity to publish integrated quality accounts will be established following systems integration; and a trust-wide governance audit will be conducted

- **HR and OD**: in addition to the organisational structure integration activity already outlined in the first six months an integrated ESR system will be established; work to integrate ESR feeder systems across the Trust sites will commence; and staff training in respect of newly created posts will be completed

- **Finance and procurement**: in addition to the finance reporting and process activities already outlined in the first half of the year, revised payroll procedures will be implemented to support integrated ESR systems; preparations will commence for the consolidation of outsourced payroll providers; and all high priority contracts will be novated

- **Informatics**: a new informatics strategy will be finalised and approved by the Trust Board; and a centralised IT help desk will become operational
• **Estate and facilities:** the capital programmes established under the predecessor Trusts will be implemented in line with agreed timescales such as maternity improvements and ward upgrades at WCUHT.

## 9.3 Year 2: Service improvement phase

With the completion of functional integration of corporate and clinical structures, in Year 2 the focus will shift to service improvement. A number of programmes will be implemented across the CAGs to deliver patient experience improvements and financial benefits including productivity initiatives driven by clinical standardisation and changes to clinical pathways identified by CAGs in their pre-merger planning work.

For example, within the Clinical Support Services CAG, pathology services will be re-designed across the three Trust sites to achieve the economies of scale cited by the Carter Review. This will involve core pathology services concentrated on the Royal London site whilst urgent and other essential services at WCUHT and NUHT will be maintained.

Such productivity initiatives will aim to move the new organisation to a position of ‘best in class’ across all specialties. Additional short-term improvements identified during the ongoing clinical strategy development process will be implemented whilst medium to long-term schemes are finalised.

At the start of the second year the new organisation will undertake Stage 1 of the Foundation Trust assessment process which will cover assessments of financial reporting procedures and key business plan assumptions, and shortly after this it will begin the statutory 12 week public consultation process concerning the application.

After implementing the recommendations from the Stage 1 assessment, Stage 2 of the assessment process begins in July 2013, which looks at historical due diligence and follows up on the financial reporting procedures review. Following this submission to the Department of Health, to gain Secretary of State approval, Monitor will conduct their review of the trust and a Board to Board meeting between Monitor and the trust will take place.

## 9.4 Years 3-5: Transformation phase

After successfully progressing through the first year of operation and remaining a safe and effective hospital, and focusing on improving existing services during the second year, April 2014 onwards will be time for the Trust to look at transformational change opportunities that will deliver significant improvements.

The Care Records Systems may be consolidated towards the end of Year 2 or during Year 3, dependent upon procurement options. From Year 3 there will subsequently be additional CRS functionality added to the system and from Year 4 the CRS and PACS systems will be re-procured for the Merged Trust. This will also be a time when the trust will be able to build upon a year’s worth of financial data to refine Service Line Reporting, which will underpin effective Service Line Management in the organisation.

During Year 2 a new estates strategy will be developed and will be implemented from year 3 onwards. This will be driven by the clinical strategy and will pursue a corporate landlord model to drive efficient and optimal space usage. The Trust will also have implemented a Carbon Reduction Commitment Energy Efficiency Scheme.

At this stage a review will also be carried out to look at the progress and impact of ICT and estates activities. This is because, at this stage it will be sufficiently late enough to see the results of ICT and estates work post-merger, but not too late to be able to review and amend the direction of this work if it is felt that changes in the environment require it.

It is anticipated that the Stage 3 assessment of working capital arrangements will take place in October 2014 with a target for authorisation from 1 December 2014.
9.5 **Policy framework**

Each workstream has identified the complete set of policies which need to be aligned for the new organisation (these are set out in Appendix G). A risk assessment of each policy has been undertaken to determine whether it will be required for Day 1.

The re-drafting of policies is taking place through a working group with cross-Trust representation. The policy style will be simple yet explicit to ensure there is clarity around expected practice, responsibilities and accountability. A degree of external scrutiny will take place to see if other Trusts can provide improvements to the drafted policies to ensure the final products are ‘best in class’.

Prior to Day 1, an internal process for approving new policies will be established reporting to the Integration Executive and Integration Board. Day 1 policies will be approved formally at the first Board meeting of the Merged Trust on the 2 April 2012.

Policies required for beyond Day 1, will be prepared and agreed through the processes outlined above. A policy approval group is part of the new organisation’s committee structure and this will begin its official work from the end of 2012/13 Quarter 1.

Pre merger the organisation is required to inform the NHS Litigation Authority of the merger detailing the business functions of each of the three trusts, the number of staff employed and the expected annual budget of the new organisation. The NHSLA will inform the organisation of the assessment level for both general risk management and maternity risk management. The existing Trusts can influence this process by ensuring that both WCUHT and NUHT achieve a Level 2 assessment for the general risk management standard pre merger.

This would likely result in an overall assessment level 2 for the new organisation (there is however a risk that NUHT may not achieve a Level 2 rating). Because BLT’s current risk rating is 3, even if NUHT achieves a Level 2 rating, the overall risk rating for the Merged Trust will still reduce to level 2. This will result in a cost pressure for the Merged Trust, and this has been built into the transition costs. For maternity risk management the Trust will be awarded level 1 status. Assessment levels will be made available on the NHSLA website post merger and will be accessible to the public and other regulatory bodies.

9.6 **Organisational development (OD) during transition**

The OD strategy will direct the creation of a new “one team” approach where all staff believe their job is to deliver world class patient care to the communities of north east London and where organisational values are visible from “Board to Ward”. With this in mind, the strategy will enable the transformation of the new organisation to a nationally and internationally highly regarded FT working in accordance with the ten pledges.

The Merged Trust aims to use the best in current practice to help build the new organisation thereby enabling staff from the three existing Trusts to identify with, and feel they belong to, the new organisation from the very outset.

In designing the OD Strategy, the learning from other mergers, both internal and external to the NHS has been considered. The new organisation has committed to:

- An OD strategy which is the first of a number of outputs and outcomes that will be delivered during the pre-merger phase
- A clear and intense focus on the need to work closely with the workforce. Given that 90 percent of staff work within clinical and operational areas, the CAGs are at the heart of the OD approach
- High levels of communication, engagement and feedback to ensure colleagues’ concerns, ideas and innovations can be understood and addressed
• A focus on clinical, financial and academic performance throughout the pre and post-merger activities, with clear lines of accountability and responsibility for CAGs across the three organisations.

The Merged Trust will ultimately be an organisation of over 15,000 employees and the transition will be highly complex from a people perspective. Indeed, research suggests that up to 65% of failed mergers and acquisitions are due to people issues, including cultural differences which cause communication breakdowns that result in poor productivity. With this in mind the organisational development strategy has been formulated around six outcomes which align with the competencies required of a FT. These outcomes are:

• One shared vision and values
• Strong clinical leadership and structures that deliver and lead world class patient care
• High performing workforce that achieves excellent clinical, operational and financial outcomes
• World Class Board Leadership and Organisation Design fit for Foundation Trust approval
• Set of integrated systems, processes and frameworks that enable a mobile and flexible workforce in a multi-site context
• Strong and clear mechanisms for engaging the workforce in the creation and sustainability of the new organisation.

Organisational development initiatives

The following programmes of work have been identified to support the delivery of the strategic outcomes set out above.

Organisation design - This initiative comprises OD activity which focuses on completing the design of the new organisation, its structure and roles, and developing and implementing a consultation document and transition arrangements. The Organisational Design will enable an effective business unit structure that supports Service Line Management (SLM) and compliance with Monitor’s Quality Governance Framework. Programmes of work will include an assessment of readiness for SLM; assessment of readiness for Monitor’s Quality Governance Standards; further development and fine tuning of future CAG and corporate structures and detailed planning for transition e.g. job analysis and job planning; and agreement of selection and pooling processes for staff affected by the merger.

Transition and integration – This programme is designed to ensure continuation of business as usual and to enable the early synergies to be realised, the following programmes of work are being taken forward: executive and senior managerial designated appointments will be made prior to 1 April 2012; corporate structures will be integrated to ‘act as one’ pre-merger; workforce numbers will be reduced using the ‘act as one’ principle and the adoption of HR initiatives to minimise the requirement for compulsory redundancies; collective consultation will take place with all other staff post April 2012.

One team - One of the key aims of the OD strategy is to achieve a unified culture that is informed by the needs of patients, GPs, other stakeholders and staff. This initiative therefore focuses on enabling staff in BLT, NUHT and WCUHT to act and feel as one team from Day 1. The following programmes of work will be undertaken: developing the vision and values; creating the organisational culture; building the cultural infrastructure; implementation of the ‘patient revolution’ initiative; implementation of the staff experience improvement programme.

Enabling leaders - Strong leadership and management at all levels in the organisation will be instrumental in ensuring the effective application and use of the organisational frameworks for developing a high performing workforce. A leadership framework will be implemented which describes the skills and behaviours the leadership of the Merged Trust will need.
Supporting leadership development programmes will be designed in line with the structural design of the organisation. Programmes of work will include the development of leadership and management competencies; Board development, for the Board as a whole and for individual executive and non-executive directors; developing processes and relationships between the Board and the top-team leadership; developing the CAG and corporate leadership teams; developing the clinical leadership.

**Empowering employees** – In order to achieve the goals of creating a workforce that is engaged, motivated and committed to the achievement of organisational objectives, the new organisation will need to ensure that individuals have meaningful work and are continuously learning and developing. Frameworks and processes will be required to cover appraisal, career development, talent management and succession planning. A number of development programmes will also be required, including an integrated corporate induction and generic soft skills training.

**Staff engagement** – A key outcome of the organisational development strategy is to create strong and clear mechanisms for engaging the workforce in the creation and sustainability of the new organisation. Alongside, and interwoven with this is work with the unions, operational communications within the CAGs and Trust wide programmes of staff engagement. Programmes of work include building the capacity of the senior leadership forum as a key lever for engagement; continuation of joint management and trade union meetings; and implementation of a highly visible communications and engagement programme targeting all staff groups and levels of seniority.

**Monitoring and tracking outcomes**

The outcomes of the organisational development strategy will be monitored and tracked to ensure that the desired benefits are realised. For example, through staff surveys evidence will be collected concerning how the organisations’ values have embedded in the new organisation. The extent to which staff engagement has improved will be monitored through the annual NHS staff survey; and improvements to patient safety, outcomes and satisfaction will be monitored through the annual Acute Quality Dashboard. In addition, the Trust will assess the extent to which the delivery of the clinical strategy and the yearly business plan has been supported by organisational development initiatives.

**9.7 Knowledge transfer**

A critical element in all of the workstream plans, throughout the preparation phase and the first six months of operation is knowledge transfer. It is essential to ensure that knowledge and organisational memory is not lost as staff in key leadership or management positions leave the organisation.

Research identifies that a number of factors have been found to influence the efficiency of knowledge transfers including:

1. Characteristics of the knowledge that is transferred e.g. is it tangible and explicit which is easier to capture/codify or intangible/tacit knowledge possibly embedded into routines/procedures or relies upon personal relationships which will not necessarily be present at the early stages of acquisition

2. Organisational characteristics – in particular the newly merged organisation has to be ready to receive and able to make use of the information. Differences in strategy, culture etc can also make it difficult to receive and make use of the information

3. Post-acquisition integration mechanisms that support knowledge transfer

4. Individuals’ willingness to share and make use of knowledge.

Experience from the private and public sectors suggest there needs to be a combination of formal process of “knowledge pull” and organisation developmental support to enable
informal socialisation activities that aim to build trust and foster close and open communication and develop collaboration before the merger.

The first step is for all workstreams to identify where the critical knowledge exists and who possesses it. For example, the three individual trusts each currently have an accountable officer for Infection Prevention and Control (IPC). The new Trust will have just one accountable officer for IPC which will be the Chief Nurse. It will be critical that the relevant knowledge about performance, systems and processes relating to infection prevention and control at each of the three trusts is provided to the Chief Nurse appointed to the new organisation. Once key positions and employees have been identified, a risk assessment of their criticality will be conducted by the HR and OD workstream to assist management in focusing on the most significant knowledge issues.

A knowledge transfer process will be put in place for each member of staff exiting the organisation and/or changing job. A standard format for this process will be agreed and managed through joint working between the HR and OD workstream and the Programme Management Office. This will comprise:

- Knowledge checklist and transfer forms which will need to be completed by the staff member before changing job or moving organisation. This will capture an understanding of the documents stored, location and content, location of audit or inspection files, personnel files etc, an issues and risks log, etc

- Pre-exit audit checks with staff to ensure for completion of the knowledge checklists.

- Pre-programmed handover discussions

- Exit interviews for staff leaving the organisation.

9.8 Programme controls and risk management

9.8.1 Programme management

Initial discussions to explore this proposed merger began in November 2010. Rapid progress was made and a decision to develop an OBC for this as the preferred merger option was agreed by the three Trust Boards in February 2011. This involved rapid mobilization of the programme team and resources to support the development of the OBC and FBC. A Supervisory Board had already been established and an Independent Chair appointed. In March 2011 Peter Morris was appointed as lead CEO and Lucy Moore as Integration Director. Ernst & Young were appointed to support the development of the OBC and FBC initially to the end of August 2011.

Workstream leads were appointed to lead seven corporate workstreams, drawing both from the three Trust executive teams and external support where it was felt to be necessary including a Chief Financial Officer who is dedicated to the programme. A programme team was mobilised to coordinate and develop project plans. Eight clinical workstreams were set up each with leadership provided from an executive director from the three Trusts to develop the clinical proposal. These eight executive sponsors include the three Trust Medical Directors.

Funding was committed from the three Trust Boards (total c£3m) and later secured from local commissioners (c£1.7m) bringing the total to c£5m to support the work programme. An agreed budget of £3.36m was agreed to the end of September 2011.

To date key deadlines set out and agreed in March have been met, with the OBC being approved by the three Trust Boards in July 2011 and NHSL in August 2011. At this point Stephen O’Brien, Chair of BLT assumed the chairmanship of the Supervisory Board with the full support of NHSL and the three Trust Boards. The Board was re-named the Integration Board – signalling the shift towards integration planning.
The work to develop the merger proposal has achieved a significant amount in a tight timeframe. The overriding principle adopted has been to keep the process, governance arrangements and structure simple whilst ensuring that there is a robust programme management framework and processes to first ensure that “business as usual” is not compromised during the planning and implementation stages, and second that the benefits of the merger are fully realised.

**Programme governance**

The Integration Board has overall responsibility for overseeing the work programme and ensuring the appropriate approvals for the proposed merger are secured and that the integration is delivered against a clear plan. It has delegated authority from the three Trust Boards, acting as a sub-committee of each. The Integration Board meets on a monthly basis and membership includes:

- Chairs and Chief Executive Officers from each of the three Trusts
- Medical Directors from each Trust
- The Chief Executive Officer and a non-executive Director from each of the Outer and Inner London Commissioners
- Representative from NHS London

Reporting to the Integration Board is the Integration Executive which meets every two weeks. It is chaired by Peter Morris and has a membership drawn from the CEOs, the corporate and clinical workstream leads and the programme office. Reporting into the Integration Executive is the Clinical Operating Board whose members are the sponsors of the clinical workstreams and the programme team (clinical integration lead – Sheila Adam and operational integration lead – Dawne Bloodworth. The Clinical Operating Board meets every two weeks, and is chaired by the Integration Director.

From a programme perspective activities are divided into two main groups containing a total of 15 workstreams:

<table>
<thead>
<tr>
<th>Corporate Workstreams</th>
<th>Clinical Academic Groups</th>
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</thead>
<tbody>
<tr>
<td>1. Education/R&amp;D</td>
<td>1. Cancer</td>
</tr>
<tr>
<td>2. Stakeholder Engagement &amp; Communications</td>
<td>2. Women's Health &amp; Maternity</td>
</tr>
<tr>
<td>3. Organisation Development &amp; Human Resources</td>
<td>3. Children's Health</td>
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<tr>
<td>4. Integrated Governance</td>
<td>4. Cardiovascular Services</td>
</tr>
<tr>
<td>5. Finance &amp; Procurement</td>
<td>5. Emergency Care &amp; Acute Medicine</td>
</tr>
<tr>
<td>7. Informatics</td>
<td>7. Ambulatory Services</td>
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</tbody>
</table>

Each workstream, in addition to a designated sponsor or lead accountable for delivery of the integration, is supported by one or more lead managers, driving activities within each workstream area including identifying workstream benefits, developing project plans and identifying risks and issues.

Workstream membership includes representation from all three Trusts which means that for example the three CFOs/Directors of Finance, HR Directors, Chief Nurses are meeting regularly with their senior leadership teams to support workstream leads. Within the CAGs, clinicians from the three Trusts are meeting regularly to plan next steps. The COOs will meet every two weeks from November 2011 to support the development of key elements of the integration plans and in particular the single reporting system, performance management and refinement of the operation structure for the new organisation.
The three CEO’s, the Integration Director and the CFO for the merger programme meet weekly to review and resolve key issues.

The central programme management office provides specific programme planning support.

**Moving from planning to integration – current status**

Following approval of the OBC, and in parallel with the development of the FBC, the aim has been to increase the focus on delivery of the integration both prior to Day 1 and ongoing with key milestones at Day 1, day 100, Year 1 etc. As such a number of changes have been made within the programme team to ensure the appropriate level of capacity and capability of the workstream leadership arrangements. A number of new appointments have been made to the programme as outlined at the start of this Chapter.

In order to deliver the agreed Day 1 milestones and activities beyond Day 1, each work stream was tasked with developing a forward resource plan to enable the expenditure budget from October 2011 to March 2012 to be agreed and transition funding required for 2012/13 to be quantified. These resource plans were agreed by the Integration Board at the end of October – with further funding support agreed in principle to the end of December and to be confirmed to the end of March – subject to FBC approval from NHS East London and the City £6.5m.

Significant mobilisation is now taking place to support those workstreams where additional resource is intensive – namely HR/OD, Informatics and Finance. Whist there is much to be done and rapid progress is now needed, workstream leads are confident that key milestones will be met.

In this context a fresh look is being undertaken of the programme, structure, reporting, project plans, risk reporting and resources required to deliver each workstream to ensure that the appropriate shift of focus is made towards delivery of Day 1 on 1 April 2012 and beyond.

**Project plans**

The overarching programme project plan is contained at Appendix H. The individual workstream project plans are available as supporting document to the FBC. Each are structured under the following themes:

- Project Governance
- Communications & stakeholder engagement
- Processes and procedures
- Policies
- Organisational
- Planning
- Technical systems including IT
- Management information
- Contracts & regulatory
- Facilities & support services
- Knowledge transfer
- Workstream specific tasks

Progress against activities and milestones is tracked and monitored by the Programme Management Office on a weekly basis and exceptions to the programme are reported for corrective action through the programme governance arrangements described above.

**9.8.2 Programme risk management approach**

Risk identification and assessment has been a key feature of the programme. All workstreams and key stakeholders within the programme have been required to identify the risks to successfully merging the three Trusts by 1 April 2012 and those risks that will face the new merged organisation. These risks have been through a consistent scoring process and
are logged within a central risk register system that allows them to be readily analysed, reviewed and escalated as necessary.

A pan-programme review has recently been undertaken to update the risks to achieving the merger by 1 April 2012 and to operating a safe and effective hospital service afterwards. High (red rated) strategic and work stream risks, together with their mitigation and risk level are available on request. The highest level risks are:

- Failure to agree transitional costs and funding
- Adequate leadership capacity
- External stakeholder challenge
- Delay in the CCP approval process
- Agreement on the terms of the merger between the three Trusts
- Management capacity including resulting from the Royal London PFI move
- Merger adversely impacts on performance at existing Trusts
- Threat of losing key talent
- Loss of support from clinicians including GPs
- Failure to meet 1 April 2012 integration timeline

9.9 Assurance prior to integration

In preparation for the merger, external due diligence has been undertaken in two parts. The first part consisted of a Due and Careful Enquiry of financial and commercial elements of the FBC and the transaction. Secondly, a clinical due diligence was undertaken in line with the requirements of the Department of Health Transaction Manual.

The Due and Careful Enquiry and due diligence has included a review of the assumptions and calculations used within the merger case but has also taken into account the views of senior clinicians, such as the Medical Directors at each of the three trusts.

The three Trust's Boards will consider both sets of due diligence.

9.9.1 Due and Careful enquiry

The Due and Careful enquiry is concluding on 2 December 2011, and the three Trust Boards will consider the findings and recommendations of this enquiry alongside the FBC prior to approval.

9.9.2 Clinical due diligence

The Trust Boards commissioned a report on Clinical Due Diligence (CDD), which is the clinical equivalent of the Financial Due and Careful Enquiry. The initial report focused on clinical performance, clinical governance and clinical risks within the three legacy Trusts and assessed whether there are any risks which are so significant that they might threaten the merger proposal.

A Steering Group was established jointly by the Clinical and Quality Governance Workstream Leads. Serco was commissioned to undertake the analysis, and Antony Sumara, an experienced NHS chief executive was appointed as external advisor. There was also participation by non executive directors and commissioners. The work was undertaken within a 4 week timescale, and the Trusts were extremely helpful in ensuring that both information and senior staff were available at short notice. The available data was analysed by Serco, and a ‘Confirm and Challenge’ session was then held with senior staff in each Trust.

The CDD exercise did not identify any clinical risk which is sufficiently significant to threaten the merger proposal. A number of aspects of good practice were identified. These included a clinically and cost-effective acute care pathway at NUHT, strong and embedded clinical governance systems and processes at BLT, and a proactive approach to patient experience at WCUHT.
However, a number of vulnerabilities were identified, including:

- Leadership capacity with a number of interim executive post holders at NUHT and WCUHT, and the major programme at the RLH to move clinical services into the new hospital building
- The risk of the Merger distracting attention from clinical service delivery, and their core responsibility to care for patients and keep them safe
- Some specific clinical risks, including a continuing delay in the replacement of a scanner at NUHT, and an area of low nurse staffing ratios also at NUHT
- An apparent lack of clarity about the respective responsibilities of the paediatric and anaesthetic teams in the initial care of a critically ill child at NUHT
- A concern about the provision of out of hours general surgical consultant cover, as surgery becomes increasingly specialised.

There were concerns about patient experience across all three Trusts, as evidenced in the most recent national inpatient survey. There was also a general impression that, whilst nursing and midwifery staff are engaged within the clinical governance framework, medical staff are much less so, although the commitment of the medical directors was noted.

A range of actions will be undertaken to mitigate these vulnerabilities:

- The Merger Team will be sufficiently resourced to ensure that the leadership teams within the three Trusts are able to maintain their focus on continuing to deliver safe patient care. A ward-based early warning/monitoring system, along the lines of ‘Safety Net’ (developed at BLT) will be rolled out across the three Trusts
- Whilst senior staff from across the three Trusts need to be properly engaged in merger planning, this will not distract them from their primary responsibilities to deliver safe care
- The clinical governance systems and processes at BLT will provide the basis for the clinical governance framework for the Merged Trust. The evidence reviewed through the CDD process indicated that, not only are both systems and processes sound, but that they are beginning to be well embedded throughout the clinical teams. In embedding clinical governance across the Merged Trust, priority will be given to ensuring that medical staff are properly engaged
- NUHT will urgently address specific concerns relating to a continuing delay in the replacement of a scanner, the initial care of critically ill children, and an area of low nurse staffing ratios which is already currently being reviewed
- An early review will take place of the present arrangements for out of hours consultant cover for general surgery; this will be led by the Surgery CAG with advice from NHS London
- There will be an early focus on patient experience and involvement, building on the Patient Revolution work at WCUHT, and good practice in the other two Trusts. This will involve actively seeking feedback from those who are critical of the services they have received.

Further work is planned to provide a more detailed clinical risk assessment, together with the mitigation in place, for the first meeting of the Merged Trust Board, and then to ensure that, when each CAG goes live, it has an overview with handover as necessary, of any outstanding clinical concerns within its remit. Equally, the financial impact of implementing these mitigating actions will need to be assessed in due course, but in the context of the LTFM, these are not envisaged at this stage to represent a material challenge.
In addition, there are aspects of the CDD which require further work, for example, further analysis of some specific risks such as serious incidents, incident reporting, complaints, the Department of Health’s Central Alerting System (CAS) alert system, clinical outcomes and CQUINS, as well as collating the views of relevant external organisations. This has not been possible in the timescale available, and will be encompassed in Phase 2 of merger planning and will culminate in the report to the first meeting of the Board of the Merged Trust.

9.10 Ways of working prior to transition of controls

9.10.1 Heads of terms

The heads of terms (the heads) set out an agreed basis for open and constructive cooperation and collaboration between the three parties prior to the merger. Their format is based on a template commissioned by NHS London for use in merger transactions. A draft version of the heads was included in the outline business case approved previously. The intention is for the final version to be signed off in conjunction with the approval of the FBC.

Although the heads are not legally binding, they are intended to create a moral obligation on the parties to abide by the terms contained in the agreement. The heads may be terminated if any one or more of the Trusts agree that the merger should not proceed.

Governance and implementation of the heads of terms

Issues arising at any of the Trusts that fall within the scope of the heads will, in the first instance, be tabled by the relevant chief executive at the Integration Executive. Where the issue cannot be resolved it will be escalated to three Trust Boards where a unanimous decision will be required in order to proceed.

The heads focus on ensuring there is transparency concerning matters at any one Trust that may affect post-merger integration and strategy, arising from:

- operational issues
- significant decisions on appointments, contracts and expenditure
- contractual breaches, material changes or litigation.

Reference is also made to supporting due diligence, and treating shared information in confidence.

The implementation of the heads will be supported by the ‘act as one’ concept introduced as part of the organisational development strategy of the merger. This establishes ways of working, in particular for the corporate service functions, prior to the merger.

9.10.2 Further tests prior to transition of controls - check

In addition, during the preparation phase prior to merger on 1 April 2012, and directly after the merger during the integration phase, there will be a series of gateway reviews of the clinical and corporate work streams. The aim of these reviews will be twofold:

- To formally assess workstream progress during the preparation phase, in order to identify remedial action and support where required - ensuring safe, effective and timely integration
- To assess readiness during the integration phase, prior to transition of controls from business-as-usual processes and governance structures to the new organisational structures.

The gateway reviews will be undertaken by executive and non executive Directors from the three Trust Boards prior to 1 April 2012, and from the new Board during integration post 1 April 2012.
10. Transition timetable

**Synopsis**

This Chapter explains the authorisations and approvals required as part of the transition timetable.

- Section 10.1 sets out the approval timeline for the FBC.
- Section 10.2 provides an overview of the key legal processes that will be required.
- Section 10.3 provides an overview of the Foundation Trust authorisation process.

10.1 Timetable for approval

Prior to final authorisation for the proposed merger from the Secretary of State, the FBC must be approved by the Integration Board, Trust Boards, Commissioning Boards and NHS London. The key dates for approval are set out in the table below.

<table>
<thead>
<tr>
<th>Approval required</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration Board</td>
<td>30 November 2011</td>
</tr>
<tr>
<td>WCUHT Board decision making</td>
<td>06 December 2011</td>
</tr>
<tr>
<td>NUHT Board decision making</td>
<td>07 December 2011</td>
</tr>
<tr>
<td>BLT Board sign decision making</td>
<td>07 December 2011</td>
</tr>
<tr>
<td>NHS ONEL board formal consideration</td>
<td>w/c 8 December 2011</td>
</tr>
<tr>
<td>NHS ELC board formal consideration</td>
<td>w/c 8 December 2011</td>
</tr>
<tr>
<td>Clinical Management Group approval</td>
<td>05 December 2011</td>
</tr>
<tr>
<td>NHS London Board decision making</td>
<td>13 December 2011</td>
</tr>
<tr>
<td>Department of Health Transaction Board and subsequent Secretary of State approval</td>
<td>w/c 23 January 2012</td>
</tr>
</tbody>
</table>

**Co-operation and Competition Panel**

The Co-operation and Competition Panel (CCP) was formally established in January 2009 and has four main remits:

- Considering and making recommendations on formal cases arising under the Principles and Rules

- Providing informal advice to commissioners, service providers and others on how the Principles and Rules might apply to them

- Educating NHS stakeholders on the role of the Principles and Rules

- Advising the Department of Health on policy issues related to co-operation and competition.

In relation to this merger, the CCP is advising the Department of Health on the potential benefits that this merger will bring for patients and taxpayers. Following a meeting with the trusts in early November 2011, the CCP suspended the deadline for completion of Phase II of its inquiry. The original deadline required that Phase II was completed by 17 November 2011.
The trusts have now been given until 30 November 2011 to allow submission of the FBC to the CCP and for further dialogue to occur. Subsequently the CCP will:

- consider the evidence on 5 December 2011
- publish a report and (probably) a remedies document in the week beginning 12 December 2011 for a period of consultation
- meet again on 9 January 2012 to agree its final report
- publish a final recommendation on remedies in the week beginning 16 January 2012.

This proposed timetable would allow submission of the report to the Department of Health in time for the Department of Health’s Transaction Board meeting in the week beginning 23 January 2012.

10.2 Legal process of transition

10.2.1 Transfer agreement

On the assumption that integration is agreed, and the three Trust Boards have agreed it is in the best interests of the Trusts to merge, legal advice will be sought to confirm the transfer agreement. This will include seeking a change of name for the new organisation through the Secretary of State as well as agreement on the transfer of assets.

10.2.2 Processes required to effect the transaction

The approval process and associated time line to approve the FBC is provided in Section 10.1, while Chapter 9 has described the activities planned to carry out the merger and establish an effective and safe organisation.

10.2.3 TUPE

This section outlines the legal staff consultation obligations both under the Transfer of Undertakings Regulations 2006 (TUPE) and Section 188 of Trade Unions and Labour Relations Act 1992 (TULRCA) and the indicative timetable for the new organisation to come into effect on 1 April 2012.

Since all staff currently employed by the three organisations will be affected, the existing Trusts are under a legal obligation under TUPE to inform staff of the impending transfer. As ‘good’ employers, plans are in place to provide a period of consultation in relation to the transfer for a maximum of 60 calendar days starting from January 2012. Within this period of consultation, employees will be invited to give comment, ideas and suggestions on the proposals to merge the three organisations.

10.2.4 Collective consultation

The requirement of the new organisation to collectively consult staff regarding changes to organisational structures, presents a significant financial, organisational and logistical challenge which has been identified early in the planning processes and is therefore receiving due care and attention to detail.

The collective staff consultation will be managed by Tier 1 senior managers who will be appointed to designate positions in advance of the 1 April 2012. A consultation process will also take place with these staff prior to the wider collective consultation process.

It is anticipated that the new organisation will need to consult with over 1,500 staff in establishing the new organisational structure. This will be followed by an agreed redundancy selection process. Both NUHT and BLT have recently collectively agreed with staff representatives processes for redundancy selection. These processes will provide a solid foundation for establishing the correct approach to the new organisation. Equality impact
assessments will be undertaken to assure the Boards that the proposals do not unfairly impact upon any group of employees.

In accordance with the NHS London framework in circumstances where current NHS staff are formally ‘at risk’ they will be given priority at each stage of the recruitment process. New or changed jobs or those not filled by slotting in or ring fencing will be filled by restricted recruitment initially at local level and then pan-London. The Trust will enable redeployment both internally and externally via the pan-London ‘at risk’ pool. The three Trusts will put in place interventions prior to merger to reduce the impact on affected staff such as vacancy management and cross-Trust support for service delivery.

Notice of redundancy will be given from July 2012 and financial reduction in pay commences not before September 2012.

Further details regarding the approach to collective consultation is set out in Appendix I.

10.3 Overview of Foundation Trust authorisation

The new organisation is expected to achieve FT authorisation by December 2014. This section provides an overview of the three stages of ‘Trust development’ – pre consultation, public consultation and post consultation. The timeline for this is shown in Error! Reference source not found.Appendix H together with key processes and milestones.

10.3.1 Pre-consultation

Trust review

NHS London will undertake a review of the Merged Trust from July 2013 to understand its state of readiness for Foundation Trust status in relation to seven domains of assurance. This review may take the form of a root cause analysis of constraints and challenges. An action plan for improvement will subsequently be developed between NHS London and the Merged Trust which will be subject to ongoing review and monitoring to ensure that actions are being addressed and to provide evidence to NHS London that tangible changes to the Merged Trust’s performance are being achieved.

Board review

As part of its review, NHS London will seek evidence of the capacity and capability of the Merged Trust’s Board to give assurance of fitness for purpose. Areas such as the experience and skill set of executive and non executive directors and their ability to demonstrate effective decision making will be tested. The assessment may take the form of trust board observations or a series of board-to-board events.

Draft business plan and long-term financial model

Work on the new organisation’s integrated business plan and refreshed long term financial model will commence in April 2012 and will continue through Year 1 and Year 2. NHS London (or their replacement/equivalent organisation) may agree a series of submission dates to review early drafts of the integrated business plan and long term financial model from July 2013 onwards. This will enable NHS London to take an early view on the quality and credibility of the Merged Trust’s application. Review meetings will be held to provide feedback and challenge on draft submissions.

10.3.2 Public consultation

12 week consultation

Monitor will not grant the Merged Trust an authorisation for FT status unless it is satisfied that the views of local communities and a diverse range of stakeholders have been sought. A 12 week public consultation will commence in July 2013 and will consider key elements of the
business plan including governance proposals, the vision and strategy, and the benefits and risks of FT status for the Merged Trust.

Membership recruitment

The Merged Trust must also be able to demonstrate that it has recruited a sufficiently large and diverse membership base to ensure the success of its proposed governance arrangements. The recruitment process will commence in April 2012 upon the commencement of the new organisation. A large membership base will provide the depth of need and diversity of opinion that will enable the Merged Trust to respond with more certainty to the health needs of its local communities. To optimise the benefits that the membership will bring the Merged Trust must articulate within its public consultation document and membership strategy, the role of the membership and how it will bring value.

10.3.3 Post consultation

Following the public consultation the Merged Trust will undertake a range of activities in relation to finalising its Foundation Trust application. This will include amending the constitution, where required, in light of feedback received from the public consultation; final iterations of the integrated business plan and long term financial model; historical due diligence exercises undertaken; and board-to-board practice. Additionally, NHS London will verify whether the Merged Trust has delivered the actions arising from pre-consultation activities.

The five year integrated business plan will incorporate aspects such as the vision and rationale for NHS Foundation Trust Status; service development plans; five year financial plans supported by activity, capital and workforce projections; proposals for governance arrangements; evidence that systems and processes are robust; HR issues and organisational development plans; and evidence of current service performance, including targets and standards to demonstrate compliance with national requirements. Additionally the integrated business plan will need to demonstrate support from the public (following the consultation), staff, and local stakeholders and in particular commissioners.

10.3.4 Historical due diligence

In October 2013 independent advisors will undertake an assessment of the Merged Trust’s historical financial position, financial reporting procedures and forward assumptions. This report will highlight any risks associated with the Merged Trust achieving a sustainable surplus in the future to meet Monitor’s assessment criteria. As part of the formal application to the Secretary of State, the historical due diligence report will be made available to the Applications Committee to inform decision making on the Merged Trust’s readiness to proceed to Monitor’s Foundation Trust assessment process.

10.3.5 NHS London (or new body) confirmation

Following these phases of development, NHS London will confirm whether the Merged Trust is ready to apply to the Secretary of State for support to apply to Monitor for FT status. Subject to support from NHS London, the Merged Trust’s submission to the Secretary of State is expected to take place in April 2014; the FT application would then be submitted to Monitor in May 2014; with the aim of full authorisation in December 2014.
Appendix A  Population Catchment

The local catchment for the existing trusts

The three trusts, BLT, WCUHT and NUHT, currently provide local acute services (Accident & Emergency, unscheduled care, scheduled care, maternity and elective surgery) to the three London Boroughs of Tower Hamlets, Newham and Waltham Forest and the surrounding boroughs. BLT also hosts the provision of community services in Tower Hamlets.

Figure 17: Area served by the existing trusts

BLT serves the Borough of Tower Hamlets. Flows for urgent care and A&E are mostly from Tower Hamlets and the immediate area (Newham, Hackney, Waltham Forest and the City of London) although its central location and designation means that it attracts Hyper Acute Stroke Unit (HASU) and major trauma patients from all north east London and Greater London. Flows for elective care include tertiary referrals so the spread of patients is much wider.

WCUHT’s catchment area extends to the east into the London Borough of Redbridge and to the north east to the borough of Epping Forest (part of West Essex PCT). Based on travel times, WCUHT is the nearest hospital to the east of the London Borough of Redbridge, and to the north east to the Borough of Epping Forest (part of West Essex PCT). Based on travel times, WCUHT is the nearest hospital to approximately 50% of the population of Redbridge and 19% of the population of Epping Forest.

NUHT serves the Borough of Newham, with only small inflows of patients from the surrounding area.
## Appendix B  Length of stay performance

Figure 18: NUHT, WCUHT and BLT compared against All London Trusts, data at April 2011

<table>
<thead>
<tr>
<th>Average Length of Stay (ALOS)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moorfields Eye Hospital NHS FT</td>
<td>0.6</td>
</tr>
<tr>
<td>Newham University Hospital NHS T</td>
<td>2.6</td>
</tr>
<tr>
<td>Chelsea And Westminster Hospital NHS FT</td>
<td>3.2</td>
</tr>
<tr>
<td>The Hillingdon Hospital NHS T</td>
<td>3.5</td>
</tr>
<tr>
<td>Kingston Hospital NHS T</td>
<td>3.89</td>
</tr>
<tr>
<td>The Whittington Hospital NHS T</td>
<td>4</td>
</tr>
<tr>
<td>West Middlesex University Hospital NHS T</td>
<td>4.09</td>
</tr>
<tr>
<td>Ealing Hospital NHS T</td>
<td>4.09</td>
</tr>
<tr>
<td>Bromley Hospitals NHS T</td>
<td>4.2</td>
</tr>
<tr>
<td>Barnet And Chase Farm Hospitals NHS T</td>
<td>4.29</td>
</tr>
<tr>
<td>Guy's And St Thomas' NHS FT</td>
<td>4.4</td>
</tr>
<tr>
<td>Benchmark Average</td>
<td>4.41</td>
</tr>
<tr>
<td>The Lewisham Hospital NHS T</td>
<td>4.5</td>
</tr>
<tr>
<td>Imperial College Healthcare NHS T</td>
<td>4.5</td>
</tr>
<tr>
<td>Homerton University Hospital NHS FT</td>
<td>4.5</td>
</tr>
<tr>
<td>Great Ormond Street Hospital For Children NHS T</td>
<td>4.59</td>
</tr>
<tr>
<td>North Middlesex University Hospital NHS T</td>
<td>4.59</td>
</tr>
<tr>
<td>Whips Cross University Hospital NHS T</td>
<td>4.59</td>
</tr>
<tr>
<td>Queen Mary’s Sidcup NHS T</td>
<td>4.59</td>
</tr>
<tr>
<td>Barts And The London NHS T</td>
<td>4.7</td>
</tr>
<tr>
<td>Epsom And St Heller University Hospitals NHS T</td>
<td>4.79</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital NHS T</td>
<td>4.79</td>
</tr>
<tr>
<td>Mayday Healthcare NHS T</td>
<td>4.79</td>
</tr>
<tr>
<td>St George’s Healthcare NHS T</td>
<td>4.9</td>
</tr>
<tr>
<td>King’s College Hospital NHS FT</td>
<td>4.9</td>
</tr>
<tr>
<td>Royal Free Hampstead NHS T</td>
<td>4.9</td>
</tr>
<tr>
<td>Barking, Havering And Redbridge University Hospitals NHS T</td>
<td>5</td>
</tr>
<tr>
<td>University College London Hospitals NHS FT</td>
<td>5.2</td>
</tr>
<tr>
<td>The Royal Marsden NHS FT</td>
<td>5.7</td>
</tr>
<tr>
<td>Royal Brompton And Harefield NHS FT</td>
<td>5.79</td>
</tr>
<tr>
<td>Royal National Orthopaedic Hospital NHS T</td>
<td>6.4</td>
</tr>
</tbody>
</table>

Source: NHS London
Appendix C  Health Inequalities

Examples of how health inequalities align with protected characteristics are set out below. These examples illustrate typical issues that the Merged Trust and local partners need to address in order to achieve reductions in health inequalities.

**Sex (male/female)** – Within the catchment there is a difference in life expectancy according to sex. On average, across the catchment women live longer than men by 5 years with a life expectancy of 81 years compared to a life expectancy for men of 76 years. (see 3.1.2)

**Gender re-assignment** – Little research has been carried out on how transgender people are affected by diseases such as cancer, but those who work on transgender health have noted that for transgender men, excessive testosterone can be converted into oestrogen by the body, which leads to increased cancer risk. With regards to transgender women, the risk of breast cancer increases following breast development and five or more years of hormone therapy.

**Race** – Numerous health inequalities relating to race and ethnicity exist, for example, the incidence of cardiovascular disease and associated strokes is disproportionately high amongst black and minority ethnic communities. Approaches to health inequalities must also recognise traditionally isolated ethnic groups such as travellers who consistently do not access health services.

**Sexual Orientation** – Lesbian, gay and bisexual people can experience significant disadvantage with regards to their physical and mental health. For example, rates of breast cancer and cervical cancer are disproportionately higher amongst lesbian women and rates of anal cancer amongst gay and bisexual men are higher if they are HIV positive than if they are not (Macmillan Cancer and Stonewall Research). With regards to mental health needs, over 40% of lesbian women, a third of gay men and a quarter of bisexual men have experienced negative or mixed reactions from mental health professionals when being open about their sexuality. (Morgan & Bell, 2003).

**Age** – As explained in Section 3.1 the catchment has a younger age profile compared to the London average which drives increased levels of demand for children’s and maternity services. Significant health inequalities exist with regards to rates of childhood obesity and tooth decay which can be linked to the fact that 52% of children across the catchment live in poverty and that 90% of children of primary school age come from families who do not have English as their first language. Levels of deprivation and language are recognised as key barriers to accessing healthcare.

**Religion and belief** – Alongside the ethnic diversity of the catchment is a broad diversity of religions and beliefs amongst the catchment population. Although specific figures are not available for health inequalities, it is generally known that religion and belief can impact upon access to healthcare and experiences of healthcare. For example, certain faiths dictate requirements of same sex clinicians. This may extend to specific arrangements required to maintain dignity, modesty and privacy during diagnostics and treatment. Such needs may prove a barrier to individuals accessing the care they need.

**Disability** – people with disabilities can suffer poorer health outcomes for a wide variety of reasons, for example because; they encounter difficulties in physically accessing services or communicating with service providers, or are deterred from doing so; their health is accorded less value and priority than other patients; people with long term disabilities are particularly likely to live in poverty; and because some disabilities, including mental health conditions are linked to higher incidence of particular health problems.
**Pregnancy and Maternity** – the demographic profile of the catchment will drive demand for pregnancy and maternity services. Particular issues are apparent in relation to infant deaths with an average of 5 per 1000 live births, a marginally higher rate than the England and London average as shown in Section 3.1. Failure to take into account the needs of black and minority ethnic children in service planning may be a key contributor to this statistic.

The examples, above, are not exhaustive of the needs and issues experienced by people with protected characteristics. However, they are illustrative of the work the new organisation must undertake to lower barriers to access and tailor services more keenly. This must be done in order to realise the objective of reducing health inequalities. The Merged Trust will therefore work to ensure compliance with equalities legislation across all protected characteristics in both service delivery and also employment.
Appendix D  Integrating Human Rights, equality and diversity: The role of the Clinical Academic Groups (18 October 2011)

The Merged Trust’s vision is to become a healthcare organisation that offers a portfolio of acute, specialist and community services tailored to meet the needs of a growing and demographically changing population. This is in the context of a catchment area which has some of the worst health outcomes and health inequalities in the country.

It is through a combined recognition of the unique needs of the community and by developing as an effective and financially resilient organisation that the Merged Trust will be better able to meet the needs of its diverse communities whilst simultaneously delivering on improved health outcomes and meeting its statutory equality duties.

Given the vision for the Merged Trust, the specific health inequalities identified in the catchment area and the requirements of the public sector equality duties, this document provides an outline of main areas for consideration by each Clinical Academic Group (CAG).

Clinical Academic Groups – Key considerations:

1. Developing leadership

Embedding and mainstreaming diversity and inclusion will require specific focused governance therefore; consideration should be given to strengthening the collective engagement and leadership by all members of the CAG. It is recommended that each CAG nominates an Equality Champion. Focussed leadership will also ensure that the process of equality analysis is embedded in policy development, workforce reconfiguration and any planned service reviews. Support and expertise can be drawn from designated equality leads.

2. Strategic planning, outcome focus and embedding into core business

All pathway development plans, service improvement plans, service or workforce reconfiguration plans should have a focus on each of the protected groups as defined by the Equality Act 2010 making sure that as part of the development, there is no negative impact on any of the groups but maximum positive outcomes with all strategic planning and operational changes giving due consideration to the baseline population figures for the catchment area. This applies to both service users and workforce.

3. Community Engagement

In order to support the development of a new organisation which promotes Healthcare, Wellbeing, Participation and Involvement - delivering a step-change in the health of local people within a generation, and as the Merged Trust moves to secure FT status – a central component in achieving this will be to ensure meaningful and on-going engagement with diverse communities. CAGs are asked to consider the following:

- Identify and engage with relevant community groups in catchment area, with the aim of achieving improved health outcomes for service users e.g. Local Involvement Network (LINK)
- Identify opportunities for partnership working in order to reduce health inequalities issues prevalent to particular community or protected characteristic groups
- Identify, publicise and make accessible a number of avenues for service user groups to communicate with and receive feedback from CAGs

Protected groups are: age, sex, race, disability, pregnancy and maternity, marriage and civil partnership, gender reassignment, religion or belief and sexual orientation.
4. Workforce and partners

The new Trust is proposed to be one of the largest employers in north east London and will be able to invest in local services bringing more jobs and prosperity to the local community. A key role which CAGs can play, in conjunction with Corporate Services, as employers and investors in the local economy, include:

- developing processes for the equitable recruitment of staff
- creating opportunities for clinical innovation
- supporting rotational opportunities for junior doctors
- ensuring the inclusion of staff at all levels in talent management activity;
- ensuring equitable approaches to succession planning
- working jointly with Public Health partners across the catchment area
- considering innovation in areas which may help to reduce health inequalities.

Human Resources and designated equality leads will provide support to CAGs to:

- Identify actions for fair recruitment.
- Provide relevant human rights, equality and diversity training for recruitment and selection panel members
- Developing recruitment plans which target communities showing high levels of deficit within the Trusts’ employment figures compared to their figures within the BELH catchment area.

5. Use of data and evidence

A key element to measuring success for achievement of the critical success factors will be the effective collation and monitoring of equality information. BELH must ensure consistency across data monitoring systems – the use of robust evidence in this process is vital. CAGs will be supported by human rights, equality and diversity specialists to consider the collation of equality data relevant to their objectives and to the health inequalities identified within their areas of expertise.

The use of robust evidence in this process is vital. Each CAG is encouraged to gather equality information relevant to their service user groups as this is an essential key to support each clinical work streams in the implementation of equality duties which also includes carrying out the equality analysis of its policies, procedures, decisions and any planned service reviews. Support in conducting equality analysis can be sought from designated equality leads.

6. Culture and values

An organisational culture which has the ethos and values of equity and diversity at its heart will be an organisation able to most effectively achieve the BELH vision. In line with the activities outlined for leadership development (Section 1. above) – will be an integrated approach to embed a culture that promotes inclusion and diversity for service users and workforce.

In order to achieve this, each CAG should ensure that its’ staff receives equality and diversity training. This will continue to be delivered by the designated equality leads and it is recommended that each CAG actively promotes and closely monitors the uptake of equality and diversity training amongst its workforce. Further support in this area can be sought from the HR service and OD service workstream.

The Trust

The Trust will enable and support this work programme through:

- Establishing a Human Rights, Equality & Diversity Committee which will report directly to the Trust Board
• Provide focus, leadership and coordination for the achievement of the corporate delivery of the equality agenda throughout the whole of the organisation via the Human Rights, Equality & Diversity Committee
• Appointing a Director (COO) whose role includes Executive Lead for Human Rights, Equality and Diversity
• Appointing a non executive director whose brief includes the non executive lead on Human Rights, Equalities and Diversity
• Establishing Equality and Diversity working groups which will report directly to the Human Rights, Equality and Diversity Committee
• Including Human Rights, Equality and Diversity in all induction programmes.

The Human Rights, Equality and Diversity team
Specialist equality leads will support the CAGs in:
• The equality analysis process for policies, procedures, service reviews and workforce reconfiguration
• Providing advice on giving due regard to the protected characteristic groups during their pathway development plans ensuring no negative consequence
• Providing corporate baseline population/catchment area data that will inform the development of care pathways and service improvement plans
• The development of equality objectives relevant to the priorities of their service user group(s)
• Ensuring that all CAG equality objectives are actioned and monitored
• Providing Human rights, Equality and Diversity training to staff.

Related Documents:
• Equality Impact Assessment – Completed Initial Screening Form, OBC, August 2011
• Embedding inclusion and diversity into the NHS at Board level, NLC 2010.
Appendix E  Design principles

The CAGs designed their structures through a series of clinically led workshops which used a suite of design principles and parameters as a starting point. These are set out below.

**CAG design principles**
- Patient care, service delivery and education and research will be embedded into management structures and processes
- Clinical leadership will be visible, multi-professional and aligned to the organisational vision
- Management will be structured to achieve a balanced span of control – with no more than four layers and ten direct reports
- Responsibilities will be devolved to local business units wherever possible
- Clear lines of accountability will exist between the Board and the Ward
- A clear set of behavioural standards will underpin the organisational values and form the basis of performance and talent management
- Services must support seamless patient pathways across sites and services – vertically and horizontally
- Each major site will have a senior responsible manager
- Single trust – wide policies, systems and processes will be aligned to the organisational vision
- Communications will be directed laterally across groups and sites, vertically through the hierarchy, and outwardly towards networks, commissioners and other stakeholders.

**COO design parameters**
- Reconcile service lines and management ‘units’. The current list of service lines varies between the very large and the very small. No department should span more than one CAG. This will require revision to the current CAG make up in several areas. As a principle doctors, nurses, income and expenditure should be on the same service line or, failing that, the same CAG
- Allocate staff to CAGs. Given a span of control of 10 wte and 4 layers this will dictate how many management bodies are required. CAG needs to demonstrate how the senior structure links effectively to the service delivery units
- Describe a service line management unit. This needs to be diagram that relates all frontline staff including junior doctors, consultants, secretaries and non-ward based nurses to accountable people
- Where the service line spans 6, 5, 4, 3 or 2 sites – identify either how a person with multiple locations will cover their week or how management will be undertaken of individuals in another way
- Design a CAG management structure that reflects affordable management of the new service lines. This will probably look similar to the present triumvirate proposals but will
Design principles

need to take account of the realistic span of control being required of the three post holders

- Deputy Chief Operating Officer will be managing a centralised Outpatients service

- It is expected that the CAG should target reduced management costs by between 20-30%.

Nursing design principles

- Lead nurse 8d managerially accountable to the Group Director. Professionally accountable to the Chief Nurse

- Career structure required as Matron 8a cannot currently achieve 8d Lead Nurse roles or ‘act ‘ into their roles as knowledge and skill gap – CAGs will require Head Nurse(s) 8c managed by Lead Nurse. Numbers will depend on size / complexity of CAG

- Matrons accountable to 8c / 8d Nurse / Midwife posts. Sisters accountable to Matrons

- Women’s Health – Associate Director of Midwifery at tier 1 as this title correlates with Nursing Directorate structure ADN

- All Matrons to be banded at 8a. To cover four clinical areas which could be across sites.

- Nurse/ midwife consultants to be accountable to Group Director

- To keep the ‘as is’ nurse/ midwife Consultant / CNS roles and when CAGs established to review their job plans.

- Community services will undergo a review of structures

- Governance structure – Head of Governance and sub structure required for each CAG with over view by Lead Nurse / Associate Director of Midwifery

- Ward sister title or sister title to be introduced and not ward / department manager.

Overarching philosophy

- Each CAG will be asked to design its own organisational structure using these design principles.

- These principles will initially be discussed in an OD-led workshop.

- The organisational structure will need to be fit-for-the-CAG purpose, but significant divergence will be challenged by the Clinical Operating Board.

- Clinical integration will be achieved through CAG leadership underpinned by:
  - Site management
  - A range of staff rotational programmes.
Design principles

CAG
- Each CAG will be led by a CAG Clinical Group Director (0.8 wte), CAG Director of Nursing and Governance (1.00 WTE) and a band 9 CAG Operations Director (1.00 WTE)

Service line group
- Each Service Line Group will have a budget of +/-£15m and will have a band 8c General Manager (1wte) and a Clinical Lead (0.2-0.4 wte).

Service Line
- Each service line will be managed at site level by a Matron and a Patient Pathway Team Leader
- Site issues will be addressed at this level with localised structures (to be determined).

Timescale
- Integration plans should be phased over day 1 (1 April 2012), Day 100 (July 2012) and 1 year (April 1 2013)
- In terms of implementation of the organisational structure changes post collective consultation, this will only commence once CAGs have passed the formal readiness test. This is likely to be from 1 July 2012 at the earliest post the 90 day consultation, through to 1 October 2012. It is possible that CAGs may proceed to implementation of the new structures in a phased or staged process where it is deemed some CAGs will be ready earlier than others.
Appendix F  KPIs

The formation of the new Trust will require the combination of three separate trusts each with differing performance management systems. The aim of the performance management system will be to focus on those areas of the business where improvements can be made or targets must be achieved.

A performance management framework has agreed based on a set of key principles and broken down into four quadrants - Quality, Workforce, Activity & Growth and Finance. KPIs relating to the Trust’s ambition to reduce health inequalities and to promote human rights, equality and diversity will be incorporated across these four quadrants.

The approach to identifying KPIs involved bringing together information from three sources:
- Details of the Performance Management Framework
- Best practice guidance regarding required KPIs from the Intelligent Board
- Details of current KPIs from the three trusts, sourced from the latest board reports.

KPIs for each of the latest board reports were listed out and compared with those suggested by the Intelligent Board. Where the Intelligent Board makes specific suggestions for measuring the KPI, these were added in as comments. In instances where a similar outcome was measured by the trusts but with differing levels of detail or methodology, these were still aligned with the equivalent of the Intelligent Board, and comments detailing this were added to understand the difference. Each trust will validate their listing of KPIs.

By highlighting KPIs covered by the Intelligent Board or at least two trusts the initial KPI listing can be assessed (Table 46). These will then be reviewed with the Medical Directors, Chief Nurses, Directors of Finance, and Directors of HR & OD to determine the final suite of KPIs. Shadow reporting will begin from January 2012 to allow smooth transition in April 2012.
## Table 48: KPIs by Performance Management Framework quadrant

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<th>Strategy</th>
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<tr>
<td>Referral rates to trust and competitors</td>
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<td>Projected activity growth</td>
<td><strong>Expenditure vs budget/forecast</strong></td>
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<th>Finance</th>
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<td>Inpatients and outpatients and Diagnostics</td>
<td><strong>Cash flow forecasts 6, 12 and 24 months</strong></td>
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<td><strong>Value of 30, 60, 90 day debtors</strong></td>
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<td><strong>Gross Margin at trading centre level</strong></td>
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<td>Cardiac and Cervical Cancer</td>
<td><strong>YTD Operating Performance</strong></td>
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<td>12+6</td>
<td><strong>Division/directorate Finance</strong></td>
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<td>Outpatient follow-up and administration</td>
<td><strong>Planned Outturn as a proportion of Turnover</strong></td>
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<th>Efficiency</th>
<th>Quality</th>
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<td>Day case rate</td>
<td>Patient Experience and complaints</td>
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<td>LoS, Pre op LoS and LoS of patients not discharged to the usual address</td>
<td>Patient opinion on outcomes</td>
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<td>Discharge</td>
<td>Cleanliness</td>
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<td>Theatre utilisation rates operations</td>
<td><strong>Mixed Sex accommodation monitoring</strong></td>
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<td>Diagnostic Services utilisation rate</td>
<td><strong>Discharge communications</strong></td>
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<td>Patient recall rate for inadequate/incomplete/incorrectly performed investigation/procedure.</td>
<td><strong>Maternity - birth choice and discharge documentation</strong></td>
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<td>Number of ICU high-dependency care episodes.</td>
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<td>Average occupancy in ICU.</td>
<td>Infection Control</td>
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<td>Total and mean for FCE cost of prescription by month.</td>
<td>Mortality measures</td>
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<td>Number of admissions</td>
<td>Serious untoward incidents</td>
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<td>% elective admission on day of surgery</td>
<td>Readmissions</td>
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<tr>
<td>DNA Rate</td>
<td><strong>Legislation and Claims</strong></td>
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<tr>
<td>Effective care record service</td>
<td>Maternity/Infant health and inequalities</td>
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<tr>
<td>Data quality</td>
<td>Reduce avoidable death, disability and chronic ill health from VTE</td>
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<td>Ethnic coding</td>
<td>Patient safety</td>
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<tr>
<th>Workforce</th>
<th>Patients experiences/outcomes and satisfaction</th>
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<td>Total headcount.</td>
<td>Patient Experience and complaints</td>
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<td>Total WTE.</td>
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<td>Gross Salary bill.</td>
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<td>£500 Spent Agency/Bank</td>
<td><strong>Mixed Sex accommodation monitoring</strong></td>
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<td>% of pay budget spent on agency staff (YTD)</td>
<td><strong>Discharge communications</strong></td>
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<tr>
<td>Time lost to sickness absence</td>
<td><strong>Maternity - birth choice and discharge documentation</strong></td>
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<td>Annualised Turnover</td>
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<td>No. Vacancies (FTE)</td>
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<td>Staff ethnic mix compared with population served.</td>
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<td>New Starters</td>
<td><strong>Legislation and Claims</strong></td>
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<td>Budgeted establishment (fte all staff)</td>
<td>Maternity/Infant health and inequalities</td>
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### Workforce: Additional KPIs
- EOL care
- Still births
- Postcode collection
- KPI ward dashboard
- Caesarian section rates

### Quality: Additional KPIs
- Patient safety
- Pressure ulcers
- Medication errors
- Reported Falls
- Deteriorating patients
- EOL care
- Enhanced recovery scheme
- Still births
- Postcode collection
- KPI ward dashboard
- Caesarian section rates
Appendix G  Policies required for Day 1

Each Workstream has identified the complete set of policies within their remits which will need to be aligned for the new organisation. A risk assessment has been undertaken against each policy to determine whether a harmonised policy must be in place for Day 1 of the Merged Trust.

‘Are significant Operational/ Financial/ Clinical Risks likely to occur if this policy were not in place for Day 1 of the new organisation?’

A YES/NO answer was required for each policy. For all policies where a ‘YES’ was detailed, these policies are required for DAY 1. For all policies where a ‘NO’ is detailed, a timescale for completing the policy has been indicated, by Quarter of 2012/13, as set out over the following pages.
### Merged Trust - Policies - FBC_Programme_Summary

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28/11/11
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### Merged Trust - Policies - FBC_Programme_Summary

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## Merged Trust - Policies - FBC_Programme_Summary

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Appendix H  Merger timeline and integration programme plan

Merger Timeline

- **PREPARE**
  - Apr’11
  - Jul’11
  - Oct’11
  - Jan’12
  - Apr’12
  - Jul’12
  - Oct’12
  - Jan’13
  - Apr’13
  - Jul’13
  - Oct’13
  - Jan’14
  - Apr’14
  - Jul’14
  - Oct’15

- **INTEGRATE**
  - Merger Timeline
  - Business Case
  - CTB/CCP/NHSL Sign-off
  - CCP Submission
  - CCP Assessment
  - OBC Completed
  - FBC Completed
  - NMSCC approved
  - New Trust Board (in shadow form) appointed
  - CFO, CRO & other support appointed
  - Staff Consultation
  - OD Strategy & Board Development Plan signed off
  - Plan for phased clinical and organisational change and early implementation of priority areas
  - Deliver OD Strategy

- **IMPROVE**
  - Secretory of State Approval
  - Submissions to Monitor
  - Submission to DH
  - Stage 1 Assessment
  - Stage 2 Assessment
  - Stage 3 Assessment
  - Working capital Review

- **TRANSFORM**
  - Target FT Authorisation
  - FT Public Consultation
  - OD Strategy & Board Development Plan signed off
  - Deliver OD Strategy
  - Implement clinical and organisational change

- **INDEPENDENT SRO APPOINTMENT**
  - Day 1
  - Apr’13
  - Apr’14
  - Apr’12

- **IBP/LTFM DEVELOPMENT**
  - Completion of integration phase
  - Completion of improvement phase

- **BOARD SIGN-OFF**
  - 12 month trading
### Trust Merger - Master Project - FBC_Programme_Summary

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<td>Apr</td>
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<tr>
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<td>Development of OBC and approval by all three boards</td>
<td>Apr</td>
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<td>Develop &amp; launch transitional merger site</td>
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<td>Former hospital websites and intranets no longer supported (to be removed subject to new information all being available on new media)</td>
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<td>Jul</td>
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<td>Care Quality Commission - complete Provider Compliance Assessments</td>
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## Trust Merger - Master Project - FBC_Programme_Summary

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<td></td>
</tr>
<tr>
<td>Task</td>
<td>Consolidate non-PFI contracts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Align Patient Transport contracts (where possible)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Task</td>
<td>Implement streamlined estates on-call process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Finalise and implement estates strategy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Complete Full suite of revised policies and procedures for quarter 4</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Project</td>
<td>BELH HR Function</td>
<td></td>
<td></td>
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</tr>
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<td>Section</td>
<td>ODHR - FBC Summary</td>
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<td>Activity 1</td>
<td>Summary tasks</td>
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<tr>
<td>Task</td>
<td>HR system goes live</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Harmonised Policies - approved, communicated and in place by Day 1</td>
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<tr>
<td>Project</td>
<td>BELH Research &amp; Development</td>
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<td>Section</td>
<td>Research &amp; Development - FBC Summary</td>
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<tr>
<td>Activity 1</td>
<td>Summary tasks</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Task</td>
<td>Research strategy for BELH Approved and in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>DAY 1 INDICATORS AGREED AND RECORDING AND REPORTING PROTOCOLS IN PLACE</td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>
Appendix I  Approach to collective consultation

Since June 2011 decisive action has been taken to secure the interests of the new Trust in advance of organisational change via the Clinical and Corporate workstream leadership teams. This workstream leadership team will consider key transitional decisions in relation to the workforce including:

- Methods of reducing future redundancy costs, e.g., vacancy management
- Recruitment planning
- Creating secondment and redeployment opportunities
- Structural change, e.g., does it meet the design principles of the new organisation.

The workstream leadership has since June taken a clear role in ‘signing off’ all tactical decisions in relation to workforce. This leadership model will include the individuals who are locally accountable, but will have the final clearance from the Integration Board to direct organisation to act in the interest of the new organisation. Each of the CAGs and corporate services workstream leadership team will be supported by a multi disciplinary team as outlined in the draft OD Strategy.

Currently, the exact number of proposed redundancy dismissals has not been finalised, and may be subject to such factors as attrition and vacancies remaining unfilled for a short time. However, it can be confirmed that a period of collective consultation would be required for all staff other than the Executive Board appointments (which is covered separately).

The Collective Consultation Regulations provide that consultation must commence no later than 30 or 90 days (dependent on number of proposed redundancy dismissals) before the first proposed dismissal takes effect. There is no requirement that consultation will continue throughout this period. Collective consultation will commence in April 2012.

In advance of April 2012 all feasible preparations are being made for the collective redundancy consultation process, so that it can commence immediately once the transfer has been completed. In particular, information will be collated which will need to be given to employee representatives under section 188(4) of TULRCA which includes the:

- Reasons for the employer’s proposals
- Numbers and descriptions of employees for whom it is proposed to dismiss as redundant
- Total number of employees of any such description employed by the employer at the establishment in question
- Proposed method of selecting the employees who may be dismissed
- Proposed method of carrying out the dismissals, with due regard to any agreed procedure, including the period over which the dismissals are to take effect
- Proposed method of calculating the amount of any redundancy payments to be made (otherwise than in compliance with an obligation imposed by or by virtue of any enactment) to employees who may be dismissed.
## Appendix J  Financial assumption tables

### Assumption overview – base LTFMs

<table>
<thead>
<tr>
<th>Assumption category</th>
<th>BLT Assumption</th>
<th>Additional notes</th>
<th>NUHT Assumption</th>
<th>Additional notes</th>
<th>WCWHT Assumption</th>
<th>Additional notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Basis of NHS income</td>
<td>Commissioner CSP</td>
<td>Also includes community health and growth of 1% in 2016 and 2017</td>
<td>Commissioner CSP</td>
<td></td>
<td>Commissioner CSP</td>
<td></td>
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<tr>
<td>Tariff deflator assumption</td>
<td>1.5% offset by 1% coding improvements as per Operating Framework and CSPs</td>
<td>1.5% offset by 1% coding improvements as per Operating Framework and CSPs</td>
<td>1.5% offset by 1% coding improvements as per Operating Framework and CSPs</td>
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<td></td>
<td></td>
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<tr>
<td>Education income</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Cost</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Quality care costs</td>
<td>SHA figures included in LTFM</td>
<td>1% year 1 to reflect pay freeze 2.5% thereafter</td>
<td>SHA figures included in LTFM</td>
<td>1% year 1 to reflect pay freeze 2.5% thereafter</td>
<td>SHA figures included in LTFM</td>
<td>1% year 1 to reflect pay freeze 2.5% thereafter</td>
</tr>
<tr>
<td>Pay inflation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Drug inflation</td>
<td>5.50%</td>
<td>5.50%</td>
<td>5.50%</td>
<td>5.50%</td>
<td></td>
<td></td>
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<tr>
<td>Other non-pay inflation</td>
<td>2.50%</td>
<td>2.50%</td>
<td>2.50%</td>
<td>2.50%</td>
<td></td>
<td></td>
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<tr>
<td>Marginal cost for new activity</td>
<td>50.00%</td>
<td>50.00%</td>
<td>50.00%</td>
<td>50.00%</td>
<td></td>
<td></td>
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<tr>
<td>Basis for future year CIPs included in model</td>
<td>CIP required to achieve financial metrics required (in line with NHS London’s scenario modelling analysis)</td>
<td>Based on actual savings identified for FY13 and FY14, 2.5% thereafter (realistic ask RE: NHS London scenario modelling analysis)</td>
<td>Based on actual savings identified in FY13 and FY14, between 2% and 3% thereafter in line with NHS London scenario modelling analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NHS London scenario modelling figures - £0.813m in 13/14 and a further £0.854m in 14/15 but will be reviewed.
Financial support

Cash support (non I&E) included

None

Included £10m working capital PDC in FY12 and £7.1m urgent care centre funding (£5.4m FY12, £1.7m FY13).

Not included is £8m of additional working capital funding expected in FY12. Payment of £10m long standing payables modelled in FY12.

Included in the model is a land sale of £18m and £6m of funding for A&E developments.

Not included are £18m advance on the land sale, £14m PDC for capital programme shortfall, tariff supplement for maternity development and 26.3m CTB funding.

Commissioner CSPs

INEL income by trust (£k)

<table>
<thead>
<tr>
<th></th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLT</td>
<td>259,117</td>
<td>257,028</td>
<td>258,738</td>
<td>264,741</td>
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<tr>
<td>NUHT</td>
<td>120,614</td>
<td>122,284</td>
<td>124,697</td>
<td>127,167</td>
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<tr>
<td>WCUHT</td>
<td>13,702</td>
<td>13,946</td>
<td>14,198</td>
<td>14,466</td>
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<td>Total</td>
<td>393,433</td>
<td>393,258</td>
<td>397,633</td>
<td>406,374</td>
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ONEL income by trust (£k)

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<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLT</td>
<td>98,600</td>
<td>98,751</td>
<td>99,483</td>
<td>100,727</td>
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<td>NUHT</td>
<td>6,768</td>
<td>6,901</td>
<td>7,032</td>
<td>7,166</td>
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<tr>
<td>WCUHT</td>
<td>165,365</td>
<td>164,640</td>
<td>163,908</td>
<td>163,187</td>
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<td>Total</td>
<td>270,733</td>
<td>270,292</td>
<td>270,423</td>
<td>271,080</td>
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Merger consolidation adjustments for intra group trading

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<th>Agreement of balances £m</th>
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<th>Forecast</th>
<th>Forecast</th>
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<tr>
<td></td>
<td>Mar - 13</td>
<td>Mar - 14</td>
<td>Mar - 15</td>
<td>Mar - 16</td>
<td>Mar - 17</td>
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<td>Group Payables</td>
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<td>Group income</td>
<td>7.8</td>
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<td>7.8</td>
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<tr>
<td>Group expenditure</td>
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<td>7.8</td>
<td>7.8</td>
<td>7.8</td>
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</tbody>
</table>
Appendix K  Cost reduction opportunities

The tables below summarise the new cost improvement schemes for 2012-15 and the clinical standardisation opportunities (which make up a total of £80.4m) by workstream and sub-workstream areas. The tables do not include the flow through or delayed schemes savings, these total an additional £17.5m. The tables also exclude savings related to corporate merger savings and CAG structure changes (totals £19.3m).

Cost Improvement Scheme Summary by workstream area

<table>
<thead>
<tr>
<th></th>
<th>FY 13 £000</th>
<th>FY 14 £000</th>
<th>FY 15 £000</th>
<th>TOTAL FYE £000</th>
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<tbody>
<tr>
<td>Clinical Productivity</td>
<td>5,044</td>
<td>14,728</td>
<td>1,630</td>
<td>21,403</td>
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<tr>
<td>Clinical Support Services</td>
<td>4,544</td>
<td>10,163</td>
<td>50</td>
<td>14,766</td>
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<tr>
<td>Corporate Services</td>
<td>7,740</td>
<td>16,470</td>
<td>1,500</td>
<td>25,710</td>
</tr>
<tr>
<td>Income</td>
<td>2,233</td>
<td>2,598</td>
<td>250</td>
<td>5,080</td>
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<tr>
<td>Workforce*</td>
<td>4,751</td>
<td>8,625</td>
<td>96</td>
<td>13,472</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>24,312</strong></td>
<td><strong>52,584</strong></td>
<td><strong>3,526</strong></td>
<td><strong>80,422</strong></td>
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Clinical productivity saving schemes by sub-workstream area

<table>
<thead>
<tr>
<th></th>
<th>FY 13 £000</th>
<th>FY 14 £000</th>
<th>FY 15 £000</th>
<th>TOTAL FYE £000</th>
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</thead>
<tbody>
<tr>
<td>Beds / LOS</td>
<td>375</td>
<td>3,520</td>
<td>1,074</td>
<td>4,969</td>
</tr>
<tr>
<td>Demand Management</td>
<td></td>
<td>1,375</td>
<td></td>
<td>1,375</td>
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<tr>
<td>Other</td>
<td>1,500</td>
<td>1,000</td>
<td>0</td>
<td>2,500</td>
</tr>
<tr>
<td>Outpatients</td>
<td>0</td>
<td>839</td>
<td>120</td>
<td>959</td>
</tr>
<tr>
<td>Pathways / Service Development</td>
<td>1,994</td>
<td>7,663</td>
<td>436</td>
<td>10,093</td>
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<tr>
<td>Theatres</td>
<td>1,175</td>
<td>331</td>
<td>0</td>
<td>1,506</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>5,044</strong></td>
<td><strong>14,728</strong></td>
<td><strong>1,630</strong></td>
<td><strong>21,403</strong></td>
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Cost reduction opportunities

### Workforce saving schemes by sub-workstream area

<table>
<thead>
<tr>
<th>Workstream Area</th>
<th>FY 13 £000</th>
<th>FY 14 £000</th>
<th>FY 15 £000</th>
<th>TOTAL FYE £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Review</td>
<td>600</td>
<td>550</td>
<td>0</td>
<td>1,150</td>
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<tr>
<td>Skill Mix / Structure</td>
<td>3,629</td>
<td>7,786</td>
<td>71</td>
<td>11,486</td>
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<tr>
<td>Temporary Staffing / Vacancies</td>
<td>335</td>
<td>201</td>
<td>0</td>
<td>536</td>
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<tr>
<td>Sickness Absence</td>
<td>188</td>
<td>88</td>
<td>25</td>
<td>300</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>4,751</strong></td>
<td><strong>8,625</strong></td>
<td><strong>96</strong></td>
<td><strong>13,472</strong></td>
</tr>
</tbody>
</table>

### Clinical Support Services saving schemes by sub-workstream area

<table>
<thead>
<tr>
<th>Workstream Area</th>
<th>FY 13 £000</th>
<th>FY 14 £000</th>
<th>FY 15 £000</th>
<th>TOTAL FYE £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Physics</td>
<td>39</td>
<td>0</td>
<td>0</td>
<td>39</td>
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<tr>
<td>Imaging</td>
<td>129</td>
<td>1,016</td>
<td>0</td>
<td>1,145</td>
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<tr>
<td>Pathology</td>
<td>439</td>
<td>5,115</td>
<td>0</td>
<td>5,555</td>
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<tr>
<td>Pathology &amp; Imaging</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Pharmacy</td>
<td>3,887</td>
<td>3,675</td>
<td>25</td>
<td>7,587</td>
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<tr>
<td>Therapies</td>
<td>61</td>
<td>370</td>
<td>0</td>
<td>431</td>
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<td><strong>Grand Total</strong></td>
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<td><strong>10,176</strong></td>
<td><strong>25</strong></td>
<td><strong>14,757</strong></td>
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### Corporate Services saving schemes by sub-workstream area

<table>
<thead>
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<th>Workstream Area</th>
<th>FY 13 £000</th>
<th>FY 14 £000</th>
<th>FY 15 £000</th>
<th>TOTAL FYE £000</th>
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</thead>
<tbody>
<tr>
<td>Corporate</td>
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<td>0</td>
<td>1,093</td>
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<td>Estates and Facilities</td>
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<td>4,375</td>
<td>1,500</td>
<td>7,401</td>
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<tr>
<td>Finance</td>
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<td>0</td>
<td>440</td>
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<td>HR</td>
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<td>3,850</td>
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<td>3,850</td>
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<td>Procurement</td>
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<td>7,805</td>
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<td>12,926</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>7,740</strong></td>
<td><strong>16,470</strong></td>
<td><strong>1,500</strong></td>
<td><strong>25,710</strong></td>
</tr>
</tbody>
</table>
Phasing and double count adjustments

All of the Cost Improvement Plans have been phased in line with;

- the merged organisations journey of integration in year 1, improvement in year 2 and transformation in year 3
- the flow-through, delayed and new schemes (excluding the standardisation opportunities) have also been RAG rated to reflect the confidence of delivery in line with the planned trajectory. The savings have all been adjusted to reflect the RAG rating allocated and to ensure a higher degree of confidence in the savings opportunities identified for FY13 – FY15. Schemes identified as having a red RAG rating have been rephased with 50% of the scheme being delivered in the following year to that originally identified, schemes identified as amber have been rephased with 25% of the scheme being delivered in the following year to that originally identified and schemes rated as green have not been adjusted and reflect their original timeline for delivery.

The RAG ratings and phasing assumptions have been developed with all three Trusts QIPP Programme Leads and the CAG Leads.

All schemes; flow-through schemes, delayed schemes, new schemes and standardisation opportunities have been reviewed to ensure that the savings identified are exclusive. Some areas of overlap were identified, in which case the saving has been adjusted to net off any potential double count.
Proposed merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust

Communications and Stakeholder engagement report
30 November 2011

This report describes the communications and engagement activities undertaken since the establishment of the programme management office in support of the proposed merger. The report outlines the discussions with a broad range of individuals, organisations and partners and summarises the responses received and key themes arising from the engagement programme.

The report is divided into the following sections:

1. Engagement and communications approach
2. Responses
3. Comments and concerns
4. Key themes and responses
5. Continuing the journey

Appendices

A. Selected response quotes
B. Roadshow engagement log
C. Report: clinical and corporate workstream stakeholder events, 3 November 2011 (draft)
D. Engagement log (detailed meeting logs and, where appropriate, copies of presentations used are also available on request)
E. Responses log
F. Report: stakeholder meeting, 15 September 2011
G. Report: financial stakeholder meeting, 20 October 2011
H. Formal letters

Appendices A and H are included at the end of this paper.
Appendices B – G are available on request from Adrienne Noon, Communications and Engagement Lead on 0207 092 5333.
1. Engagement and communications approach

A programme team for the merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whips Cross University Hospital NHS Trust was established in late March 2011. From the outset the programme team and trusts’ have acknowledged the importance of communication with and responding to local stakeholders, patients and clinicians regarding the merger proposals.

Prior to the publication of the Outline Business Case (OBC) in July 2011 the programme team and trusts ensured that key stakeholders were aware of the programme, the ambition and vision for the proposed new organisation, the integration planning requirements and the journey to become an authorised NHS trust. This was achieved through written briefings to key stakeholder groups, attending established meetings such as overview and scrutiny committees, clinical commissioning groups and local involvement network forums and specifically convened meetings on a borough basis.

The communications and engagement programme gathered significant momentum following the approval to proceed to a Full Business Case (FBC) by the NHS London Capital Investment Committee on 4 August 2011.

In order to reach as many stakeholders as possible, a detailed and robust 16 week programme of structured engagement has been implemented to capture and address stakeholder feedback for inclusion in our integration planning and the development of the FBC.

1.1. Overview of engagement activities following the publication of the OBC

- A summary OBC, “A vision of future healthcare for local people”, was published electronically on 29 July 2011 and in hardcopy on 5 August 2011. This prospectus gave details of the proposed merger and invited comment from the 26,000 recipients across all areas of the community. Recipients included:
  - Barts and The London (approx. 6000) and Newham membership lists (approx. 1000)
  - All GP practices in City and Hackney, Newham, Tower Hamlets and Waltham Forest. Smaller quantities were sent to practices in Redbridge, Havering and Barking and Dagenham and GP commissioners in inner and outer north east London
  - MPs, Local assembly and GLA members, community groups and libraries
  - Patients, patient forums and panels and Local Involvement Networks (LINks) in North East London (including West Essex LINk)
  - NHS Outer North East London and NHS East London and the City Boards and executive teams; NHS London executive team and DH executive team
  - Regulators and influencers including the Care Quality Commission
  - Local authorities – elected mayor’s, chief executive, chair of overview and scrutiny committee, cabinet member for health, social care directors and other key personnel

- The OBC prospectus has been made available to download from the merger project website in addition to trust and cluster websites and intranets. It is also available in large print, audio, Braille and in a variety of languages on request. An easy read version was produced with the support of LINks and published on 8 August 2011. Recipients were LINk organisations, patient
panels and others on request. Health and social care organisations, clusters and LINk partners have been requested to publish the prospectus on their websites.

- A video explaining the merger was launched on 15 September 2011 at an external stakeholder event and on the 21 September at a staff engagement event. The video has been made available on the trust and the merger project websites and has been shown at other key events such as the Medicine for Members event at Barts and The London NHS Trust, the Annual General Meetings of both Whipps Cross and Newham Hospitals and the Waltham Forest LINk members meeting on 12 October 2011.

- A range of posters and postcards for each trust has also been produced along with banners for common areas in the hospitals.

- The merger leadership team and trusts have also attended over 100 meetings with stakeholders including overview and scrutiny committees, LINks, health and wellbeing boards, clinical commissioning groups and patient representative panels in addition to one-to-one meetings with MPs and GP commissioners.

- A transitional website was launched on 15 November as a key information portal for staff, patients and the public to find out more about the proposed merger and to have access to key documentation and updates. The website content has been developed in conjunction with local patients. Each of the existing Trust’s websites provides navigation to this dedicated website.

- Letters and/or emails have been written to local community groups, GPs, the membership lists from Newham and Barts and The London, LINks and local authority colleagues inviting them to attend specially convened stakeholder events or expressing an interest for merger representatives to attend local established groups or forums.

- A clinical benefits prospectus, “The health and healthcare benefits of the proposed merger,” has been developed at the request of local stakeholders and is designed to provide key examples of the clinical benefits that the proposed merger would bring. Over 6,000 printed copies of this document have been sent to GPs, professional bodies, NHS, local authorities, MPs and LINk colleague’s.

- A series of 25 drop in information stalls were held at the three trusts between August and November 2011 for staff, patients, visitors and the public to find out more about the merger, ask questions and give us their feedback for consideration. Over 2,000 people (staff, volunteers, visitors and patients) have been engaged in these roadshows (appendix B). More dates are planned for early 2012.

- Six dedicated borough based events for stakeholders have been undertaken and four north east London wide events have taken place (including one dedicated event on finance), with over 300 people attending including GPs, councillors, LINk members, patient representatives and a local MP attending.

- Our staff have been kept up to date with monthly staff newsletters, email updates to senior colleagues and generic text has been supplied for internal bulletins and updating intranets. Both the corporate and clinical workstreams consist of staff from across the three trusts and as our focus changes to implementation there is a recognition that we need to do much more to ensure that our staff understand any changes proposed and what that means for them as individuals and teams. Further resource has recently been invested in this regard.
In addition to frequent Clinical Academic Group (CAG) workstream meetings there have also been nine clinical workshops which have brought together representatives from each trust and from each CAG.

A Patient Advisors Group has also been established consisting of LIInk members, patient panel representatives from the three trusts and the public. The role of this group is outlined later in section 1.6 of this report.

Staff representatives, including both local and full time officers, from across the three trusts have had the opportunity to meet with the Integration Director and merger team on a monthly basis since March 2011. In addition a series of workshops have taken place to determine a new fit for purpose partnership model from April 2012. We have also now agreed multiple working groups to take forward the development of policies which need to be in place prior to April 2012 and discussions are underway as to how both full time and local officers can be freed up to deliver the requirements for day one.

Staff from each of the three Trusts have also volunteered to become merger advocates within their respective trusts. Their role is to provide information and receive questions and queries from staff members and reflect this back to the central programme team. Staff are also able to contact the programme team directly via phone or email.

Work has also been undertaken with local and health media who have had access to clinicians from across the three trusts, met with chief executives and generally raised awareness of the proposed merger. Articles have signposted the merger roadshows and also focussed on the investment at each of the hospitals: the opening of the new Royal London hospital in December 2011; the A&E build at Whipps Cross hospital and the extension and upgrade of both the maternity and A&E services at Newham hospital. More work is planned in the coming weeks and months with a particular focus on local ethnic media.

Specifically, engagement activities with key stakeholder groups include:

1.2. GPs

All GP practices and commissioners in north east London received printed copies of the prospectus and a supporting letter inviting views on the merger and providing details of the 15 September engagement event.

GPs have been invited (through NHS clusters) to attend the recent finance specific and corporate and clinical workstream events. Both events were arranged to address local concerns and were scheduled for a Thursday afternoon / early evening to provide local GPs with a greater opportunity to attend. Although actual GP attendance was low, those that did attend the 3 November events were able to debate and identify (as requested) with clinicians key improvement areas for the proposed new trust. A commitment has been made by the merger team to continue working closely with GPs and other stakeholders on these areas and further follow up events will be arranged for 2012. A summary report is available (appendix C).

GP specific events have also been held in each borough and regular updates on the merger and promotion of engagement opportunities have been provided to the NHS Clusters and hospital trusts for inclusion in newsletters and e-bulletins.
The merger project team and colleagues from across the three trusts have also continued to regularly attend local Clinical Commissioning Groups and GP meetings across north east London, in addition to one-to-one meetings with GP commissioners and Cluster Clinical and Medical Directors and extraordinary borough based meetings have been convened as appropriate.

The membership of the Clinical Reference Group which provides a key link between Barts and The London NHS Trust and GP commissioners from all East London and The City boroughs has recently been extended to Newham University Hospital NHS Trust, Whipps Cross University Hospital NHS Trust and GP commissioners in Waltham Forest. This group meets on a monthly basis.

All GP practices and commissioners have received printed copies of the clinical benefits prospectus, “The health and healthcare benefits of the proposed merger,” which was available in draft form, in order for delegates to provide feedback on the contents, at the events on 3 November 2011.

1.3. Local involvement Networks (LINks)

Regular phone calls and email updates are sent to the LINks on the merger as are forthcoming engagement activities, including requests to attend and assist in promoting engagement opportunities and cascading materials. All LINks (including West Essex) received printed copies of the prospectus and a supporting letter inviting views on the merger and invitations to the 15 September, 20 October and 3 November stakeholder events. Hard copies of the OBC have also been sent upon request and an Easy Read version of the prospectus was produced in collaboration with LINKs.

The merger team have also attended LINk meetings and a specific event was held for LINk chairs and managers to meet with the three trust chairs and NHS East London and the City to explore the future partnership and involvement model. Further meetings are scheduled.

LINks have also been asked to assist the merger team by helping to design best practice models for patient experience and involvement and to develop the public facing website to ensure that it meets the needs of the local community.

The merger team continues to work with and support LINks in engaging with the local community by attending meetings and forums, providing briefings and producing materials as requested. LINks have also received printed copies of the clinical benefits prospectus to provide to local communities and their membership.

1.4. Local authorities

Regular updates are sent to north east London scrutiny, executive and cabinet colleagues (including Epping Forest) on the merger and forthcoming engagement activities. Council colleagues also received printed copies of the prospectus with an invitation to comment, and will shortly receive the clinical benefits case with supporting information. A request was made to health and social care partners to publish the prospectus on their websites: Tower Hamlets council took the opportunity to do so.

Key meetings in the last few months have included clinical and merger team attendance at each of the borough based Overview and Scrutiny Committees (including Hackney) - several of which included a focus on the financial aspects of the merger. This was in addition to attendance at the Joint Overview and Scrutiny Committee in Outer north east London in both March and July and the
inner north east London equivalent in July 2011. All colleagues received an invitation to attend the recent clinical, corporate and finance events, in which many colleagues attended and have subsequently commented on the unprecedented level of openness and transparency. The senior teams of each hospital trust continue to meet and correspond on a regular basis with local authority members.

**1.5. MPs and political**

All MPs and relevant GLA members received printed copies of the prospectus and an invitation to comment, and have been kept regularly informed of the merger process and invitations have been extended to recent engagement activities. The Rt Hon Stephen Timms MP attended the 15 September stakeholder event, following this he wrote an article for the Newham Recorder stating his broad support for the merger. All MPs will also receive the clinical prospectus and supporting information.

Senior colleagues from the hospital trusts and merger team continue to meet with local MPs in small groups and on a one-to-one basis.

**1.6. Patients and public**

A series of 25 roadshows took place throughout the hospital trusts between August and November 2011. Over 2,000 patients, visitors and the public took the opportunity to find out more, some documenting their formal views as indicated later in this report. Feedback received from the events has been considered when developing the FBC.

The merger team have written to local community groups with details of the proposed merger and expressing a desire to attend local meetings and forums. As a result the merger team have attended several local meetings including the Tower Hamlets LINk (THINk) locality event for networks five and six, a community event with 400 members of the public and attendance at LINk and trust membership forums.

Patients and members of the public are also engaged with the programme in two other fora:

- a group advising on the website design, content and usability of both the transitional merger project website which is on the following URL: [www.bartsandthelondon.nhs.uk/proposed-merger](http://www.bartsandthelondon.nhs.uk/proposed-merger) and the new public facing website for the proposed new trust which is a day one deliverable for the communications and engagement workstream; and

- a patient advisors group who are helping us design the new organisations patient experience and involvement strategies, branding, signage and other key issues.

Due to their success and popularity a further series of roadshows is being planned for early 2012 and we are working with local leaders regarding the best approach to further conversations with the community.

Local community groups, patients and public (via LINks) and trust members continue to receive regular updates and invitations to engagement activities.
1.7. Staff

A detailed staff engagement strategy has been developed to ensure our staff are fully informed and engaged around the process, next steps and their individual circumstances including the TUPE process and collaborative staff consultation.

Staff have been kept up to date with monthly staff newsletters, weekly updates to senior colleagues and generic text has been supplied for internal bulletins and updating intranets. A range of events have been arranged for staff including:

- three senior leadership forums (a fourth planned for December 2011) where guest speakers have discussed lessons learnt from the Heart of England NHS Foundation Trust and Boots Opticians mergers
- two ‘open invite’ events for staff from across the three trusts (a third planned for December 2011) – and a variety of events for staff in each trust to speak directly to members of the executive teams as well as discussions within service lines and team meetings
- Stakeholder events on the 15 September, 20 October and 3 November were also well attended by staff representatives
- The roadshow series has also been hosted throughout each local hospital site in areas and at times accessible for staff
- Nine clinical workshops have taken place since March 2011 for all clinicians across the three trusts to come together to further the integration plans for the proposed new trust. These are in addition to the frequent CAG and corporate workstream meetings.

Further detail on the engagement activities, including the feedback captured from the above meetings and discussions can be provided upon request.

2. Responses

The following is a summary of the views (see appendix E) that have to date been expressed at meetings and events (105 responses), roadshows (72 responses), in letters and other communications (43 responses).

It is not always possible to be clear about the overall strength of feeling of the respondent (e.g. letters often highlight a particular point or points but the level of support is unclear). Nevertheless, each response has been placed in one of five categories by a communications manager and double checked at director level.

There have been 220 responses so far:

- 75 responses support the merger;
- 54 responses support the merger but had concerns or required reassurance;
- 39 responses had concerns;
- 8 responses don’t support the merger.

It was unclear whether the remaining 44 responses supported or opposed the merger. Some were simply asking questions on how the merger would be delivered and what this might mean for them. The next section sets out the comments and concerns that have been received. These also take into account the comments made at the many stakeholder events that have been arranged (appendix B).
3. Comments and concerns

Some respondents stated their views on what needs to improve, irrespective of the merger, including:

- Better communication between hospitals, GPs and patients
- Shorter waiting lists
- Improved patient care
- Concern over the quality and cleanliness of wards
- Administration – particularly with patient and GP letters

A number of respondents also made the point that they wanted the new trust to include ‘The Royal’ or ‘The Royal London’ in the proposed trust name.

Of those that did express an opinion on the merger:

**Over a third (75) supported the proposal** and highlighted what they felt were positive aspects of the merger including:

- It will safeguard and improve care for people widely over east London, including the provision of local and highly specialised services
- There would be more stability and support for Newham and Whipps Cross
- Great way to provide a more seamless services
- The quality of patient care would be improved by sharing expertise
- Merger will lead to better health outcomes; better career pathways and improved research outcomes
- Economies of scale by becoming a larger trust
- Financial projections make the merger vital
- No other obvious options

**93 respondents (over a third) either supported the proposal but wanted some reassurance (54); or didn’t express support or objections but did have some concerns (39) including:**

- Care needs to be kept local – especially for older people and those with disabilities
- Existing links to hospitals outside the area (often for more specialist treatment) need to be maintained
- Quality of service could be at risk if cost savings are pushed too far
- The effect this will have on other hospitals (such as Homerton University Hospital NHS Foundation Trust and Barking, Havering and Redbridge University Hospitals NHS Trust)
- Need more detail about the finances and how they could be solved / improved
- The large size of the trust and whether this could be properly managed
- How local implementation by borough will be maintained
- Staff jobs and future working arrangements across three sites
- More assurances about how we will be improving patient experience
- Further information is required on the cost improvement programmes (CIPs)
- Clarity on the market forces factor is a requirement from GP commissioners as is involvement in the appointment process for the chair, non-executives (where possible as this process is led by the Appointments Commission) and executive positions
Stakeholders at meetings wanted to know how they could be involved – both in clinical considerations and to comment upon and scrutinise proposals and further detail on the finance workstreams. Two stakeholder events on finance (20 October) and Corporate and Clinical workstreams (3 November) were held to address this feedback. The reports and feedback from these events are available as appendices C and G.

Stakeholders stressed the need for local management and implementation of services as each hospital serves different communities. Political stakeholders have, on the whole, been positive about the merger and can see the benefits however they would like to see more clarity regarding the overall vision for each site.

Eight respondents didn’t support the merger and highlighted what they felt were negative aspects of the proposal:

- This is as a consequence of Government cuts
- The merger would restrict choice and could undermine the financial viability of Homerton Hospital
- There wouldn’t be enough beds and more people would die
- The overall structure of the merger is to big and individuals will get lost in the system
- Not secure

The feedback from stakeholder meetings indicates that similar concerns were raised in each of the boroughs regarding the affordability of the Barts and The London PFI and whether the services at Whipps Cross and Newham would be sustained or drawn into Barts and The London. Similar concerns were expressed in City and Hackney regarding the future provision of services from Homerton University Hospital NHS Foundation Trust as they are not part of the proposed merger.

Some stakeholders, whilst accepting the need for change, questioned whether this was just about finances and whether the management team was capable of delivering a successful merger of this size at the same time as maintaining existing services.

4. Key themes arising to date

4.1. Theme one: Financial sustainability for future generations

There has been a frequently raised view and desire to understand the financial environment and pressures under which the three trusts currently operate; what alternatives to the merger would be possible for each of the organisations and how the private finance initiative (PFI) at Barts and the London NHS Trust in particular would impact on the proposed new hospital trust.

Stakeholders have been quick to recognise that the NHS is not immune to the financial difficulties that the current economic climate has highlighted and understand that the NHS must become more efficient, whilst continuing to provide patient centred and value for money services. There is a clear wish within the health and social care economy to agree an approach for local hospital services which will secure the future of locally accessible services and a financially stable system for future generations.
**Action taken in response:**
Throughout the development of the FBC, the three existing Trusts have been open and transparent regarding their current financial uncertainties, the impact of PFI arrangements and the potential sources of funding to close the financial gap which will remain for the new merged trust. Reviews have been undertaken by several borough-based overview and scrutiny committees and a financial due diligence process has been led by an external company. The senior leadership and financial teams from the Trusts have attended meetings with local partners and a dedicated stakeholder event has been hosted solely on finance.

The merger team has been and continues to be actively engaged with the Department of Health and NHS London to find a financial solution which meets the needs of the local health economy and will ensure the resilience of local services for future generations. A stable financial health economy within five years is outlined within the financial planning for the merged trust following discussions with regulators to smooth the costs of transition and the efficiency savings that all NHS trusts are being asked to make year on year. The trusts believe that the greater risk to the health economy is if the merger does not proceed as outlined at the financial stakeholder event hosted on 20 October 2011.

GP commissioners and local authority partners have stressed the need for the new trust to be financially independent. The model described in the long term financial planning meets these expectations and reflects the ongoing dialogue with regulators.

Engagement on the long-term financial model following the publication of the FBC is planned.

4.2. **Theme two: Providing choice and delivering care closer to home**
Commissioners have been clear in their guidance that the existing and/or new organisation must respect commissioning intentions. Central to these commissioning intentions is the premise that more care should be provided closer to home and that hospital is not always the answer.

Further to this, and linked to the financial theme (and the cost of the Barts and The London PFI) is a concern by numerous stakeholder groups that the financial case for change will lead to a reconfiguration of services in the future and in particular the centralisation of services to the new Royal London hospital.

**Action taken in response:**
The OBC and FBC have each been informed by the latest information available in the commissioning strategic plans for north east London. The new Merged Trust integration plans demonstrate this and the commitment to moving care into the community by the year on year reduction in forecast income.

The published commitments from the Merged Trust to local people have been outlined as follows:

- to ensure long term continuity of excellent and comprehensive local access; and
- improved access to specialist services throughout north east London
The Merged Trust is clear that services need to be provided locally where possible and there is a drive to devolve specialist services closer to home where it is clinically appropriate to do so; for example providing chemotherapy at Whipps Cross for patients who currently travel to The Royal London hospital (something specifically required in securing support for the merger by Waltham Forest Federated GP Commissioning Group).

To make a range of services available closer to home each service will need to be evaluated on its own merits on the basis of patient safety and value for money among other prioritisation criteria. The new trust has committed to doing so in partnership with key stakeholders in the local health and social care economy as demonstrated by the 3 November stakeholder event where the key areas for improvement within the new Trust were discussed with a view to prioritisation and action.

The integration of Tower Hamlets Community Health Services to Barts and The London NHS Trust in July 2011 also provides a valuable rich source of information on how best to integrate services in a more community based setting and efforts to engage with primary care colleagues to develop services have been enhanced in recent months.

4.3. Theme three: Partnership working

The proposal to bring together the three hospital trusts would see the creation of one of the largest hospital trusts in the country. There are a large number of benefits which this can bring due to the size and scale of the new organisation in terms of patient care, outcomes and opportunities to staff. Acknowledging this, stakeholders have asked how the new Trust will work with local partners including neighbouring hospital trusts such as Homerton University Hospital NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust. Stakeholders have also wanted to understand how local decisions will be taken and how local commissioners, patients and local authority partners will be able to influence local decision making.

Additionally feedback received from patients has highlighted that there is much more to be done to improve the experience of hospital services.

**Action taken in response:**

The transitional management team understands that improving the health of local people cannot be done in isolation and requires the collaboration of local health and social care partners and the involvement of the local community.

The Merged Trust is committed to working with and involving local partners in all that it does, for instance in designing new care pathways with the priorities for change identified in partnership with primary and community care colleagues and local people – the first opportunity to do so being the stakeholder event on 3 November 2011.

The new organisation is looking to strengthen relationships with current and future commissioners, local authorities and local involvement networks. To aid this, an inclusive structure has been developed where local GPs will have a formal role in the organisation working alongside the Medical Director and a monthly meeting of GP commissioners and the medical directors of each of the three trusts has been initiated. The medical director and strategy directorates in the new
organisation will also focus on the health of the local community and work with local partners on the public health agenda; an example being the recent ‘small c’ campaign.

A patient-centred approach to transition planning and service design has also been adopted with the engagement of a patient advisors group to work as part of the integration planning team. The knowledge and insight of the patient advisors has helped shape the new organisation’s commitment to deliver on the health bill commitment of ‘no decision about me without me’, the patient involvement programme and ensuring that front line teams have patients’ needs and interests at the heart of all that they do. Patient experience metrics will be incorporated into how the Trust evaluates workforce performance. The patient advisors will continue to guide the new organisation throughout the transition process and are ensuring that the new Trust has a robust involvement model in order to make a seamless transition to foundation trust arrangements following authorisation.

Partnership working also encompasses the new Trust approach to staff representation and a new way of working has been developed with full time and local union officers through a workshop approach in recent months. A further aspect of partnership working is ensuring that the new Trust communicates and engages effectively - as a result of positive feedback the number of roadshows held in recent weeks has been doubled and more are planned for 2012.

The new organisation is also looking to work with Homerton University Hospital NHS Foundation Trust to co-operate where it is in the best interests of patients and taxpayers. This approach is also being extended to Barking, Havering and Redbridge University Hospitals NHS Trust, local mental health trusts and other local healthcare providers. Working together to share best practice, and to develop and build on existing clinical networks, can only be of benefit to local people.

As expressed above, access to services closer to home is a guiding principle for the new organisation, as is the ability for local people to influence local hospital decisions. As a direct response of feedback throughout the engagement process there will now be very senior local personnel based at each hospital site. Not only will these key individuals have local intimate knowledge of their hospital but they will also be tasked with enhancing local relationships with health and social care colleagues.

4.4. Theme four: Realising the benefits

A range of stakeholders have expressed a desire to work with the merger team to be involved in the development of metrics which measure benefits realisation. Other stakeholders would simply like to know the methodology and metrics that will be applied to ensure standards and timescales are met.

Another strong recurring theme throughout the engagement concerns the potential name of the new organisation with a strong preference to reflect local ownership of services and to capture existing goodwill and practices from each of the hospital sites.

**Action taken in response:**

It is critical for any organisation to be clear about its objectives, its performance and to ensure constant evaluation in order to maintain and enhance its reputation and level of services. The new organisation is developing a performance framework and benefits realisation programme that will
complement local stakeholder requirements and ensure that it delivers on all of its potential - on time and to the highest possible standards.

The performance metrics will also be published accordingly in order to enhance transparency and enhanced communications will enable partners to review, understand and provide feedback to the new trust.

The name Barts and East London Healthcare merger project was adopted by the programme on an interim basis whilst the approvals process and necessary integration plans were developed. During the integration journey we have heard very strong preferences for the new Trust name and as such a commitment has been made by the three trust boards that the individual hospital names will remain as they currently are with the only change being the parental, overarching Trust name.

An engagement programme specifically on the new Trust name has been undertaken with staff representatives, merger advocates, senior managers and some external partners, including the patient advisors group. The outcome of this engagement and the selection of a new name will take place by the three trust boards alongside their consideration of the FBC.

4.5. Theme five: a need to improve our communication

A wish for more opportunities to raise anxieties, seek reassurances and suggest solutions across the trust service lines was a frequent request. A number of stakeholders also acknowledged improvements made in this area recently by some services.

Action taken in response:

Communication is central to the success of a new organisation. The engagement undertaken to date has highlighted that each of the legacy Trusts could significantly improve communication, particularly with health partners and patients.

To improve communications, local patients and residents have been asked to help shape the new organisation via the patient advisors group and in time they will be looking at items such as stationery, standard letters and navigation to each of the hospital sites. A separate group have also been working with the programme team advising on the transitional website and they will also help design and build the website for the new organisation – a day one deliverable for the communications and engagement workstream.

The engagement throughout the merger project has seen an enhanced level of communications with senior staff talking and listening to hundreds of patients, stakeholders and members of the public. It is expected that this level of commitment will continue in the new organisation. As a result of this programme we have already drawn together key stakeholders to develop the key priority areas for improvement within the new trust and a monthly meeting has been established between GP commissioners across each borough of the proposed new trust and representatives from each hospital site.

To date managers and clinicians have attended over 100 meetings in a 16 week period in addition to regular written communications. In response to queries and feedback, six dedicated borough based stakeholder events were held and four north east London wide events. For example on 3
November 2011 local people were asked to participate in a workshop with clinicians on key areas for care pathway improvement.

Each service line via the CAGs and each corporate workstream have also been tasked with considering how best to enhance communications and engagement. This will become a core element in the gateway review process which is designed to ensure that all necessary elements of the transition process are in place before any changes are implemented.

4.6. Theme six: taking our staff on the journey

The engagement has highlighted anxiety of further change amongst Trust staff (following recent restructuring), concerns about the feasibility of staff working across multiple sites which are geographically distinct, and concerns about how staff from different organisations with different cultures will integrate. Indeed, cultural differences across the three Trusts have been highlighted as a major barrier to the proposed merger succeeding, as has the unprecedented level of change in the NHS at the current time.

**Action taken in response:**

It is recognised that for the merger to be successful, it is clear that all staff must understand the necessity and opportunities of becoming one organisation in order to win their support for developing what could be the very best hospital trust in the country.

To aid this process a detailed staff engagement programme has begun to be implemented which includes local staff events, roadshows, surgeries, drop-in sessions, newsletters (where staff questions are answered) and opportunities to ask questions of the senior teams. These dedicated events are aimed at all levels within the three organisations. A series of three trust wide staff events have also been developed and senior leadership forums have taken place to learn from other experiences and ensure senior personnel have the information needed to lead local engagement.

The transitional website launched in November 2011 also provides an area dedicated to staff and regular updates, including a dedicated monthly newsletter (developed following feedback from staff) are cascaded throughout the existing trust communication channels and are available on each organisations intranet.

A staff representatives briefing group was established following the formation of the merger programme team and provides an opportunity for both full time and local officers to interact with the merger integration director on a monthly basis.

Staff from each of the three trusts have also volunteered to become merger advocates within their respective trusts. Their role is to provide information and receive questions and queries from staff members and reflect this back to the central programme team. Staff are also able to contact the programme team directly via phone or email.
5. Continuing the journey

Through the merger engagement programme the new organisation has had a prime opportunity to develop existing and build new relationships with internal and external stakeholders. This includes an opportunity to construct an innovative outreach approach to engaging with and involving the community, voluntary groups and other health and social care agencies in service design and decision making. As a result of this approach the Merged Trust will become an organisation that is responsive to the diverse needs of its communities, which will ultimately help improve health outcomes and contribute to reducing health inequalities.

It is vitally important that the new organisation continues to listen, change and respond to feedback from local partners and the community. The organisation is here to serve local people and as such needs to focus on meeting local requirements. The involvement model for the new trust is being developed by local representatives and the merger provides a very real opportunity to make positive changes as the new organisation moves towards the Foundation Trust model – changes which would be harder to achieve as individual trusts. The transitional executive team are clear that as an aspiring high-performing foundation trust, that has the potential to be the best in the country, the journey does not end with authorisation to merge.

To achieve these ambitions the first step will be to standardise to best in trust whilst looking to the future. This applies equally to the way that the Trust communicates and engages with local people and partners and will be reflected in the communications and engagement strategy for the new organisation. The engagement undertaken in recent months has set the standard and it will be necessary to exceed expectations on the journey to Foundation Trust status.
Appendix A: Selected quotes

Examples of supportive comments:

“This Merger will allow Barts and The London Hospitals, Newham University Hospital, and Whipps Cross to do exactly what they have been designed to do, which is; to provide the best possible healthcare for their service users and community”

“We are pleased to note that ‘listening to patients’ and ‘improving patient experience’ is at the heart of the discussions for the merger”

“The Royal College of Midwives (RCM) supports the boards’ overall intentions and objectives for the merger. We are very pleased to see that the focus for the changes is to improve the quality of healthcare in the area, and applaud the commitment to provide maternity services locally unless women are better served by centralisation…

We believe that the merger could open up new ways of working between the three maternity units in the area, and encourage Barts and East London Healthcare to facilitate the sharing of good-practice among them. To do this, we recommend that clear channels of communication are established between senior trust managers and the heads of midwifery and staff in each unit.

The RCM supports the proposed merger, and we look forward to seeing how it progresses”

“Good thing for East London. To pool resources and knowledge together is a good idea.”

“I think that the merger is a good idea that could deliver high quality care for Newham residents”

“This will bring benefits to both patients and staff if the resources are managed and used wisely and far from politics of the day.”

“In my view, the proposed merger between Whipps X, Newham, and Barts and the London Trusts, is sorely needed as:

It will safeguard and improve care for people widely over East London, including the provision of local and highly specialised services. People in East London deserve care at a uniformly high level wherever they live.

it will strengthen the catchment patient base of the teaching hospitals within the City and in Whitechapel/Bethnal Green, thus safeguarding their future, allowing them to develop further, and aiding their teaching and research efforts.

It will have positive beneficial effects on Barts and the London and its staff

It will reinforce the role of the academic alliance that is being constructed between UCL and Queen Mary - providing a secure ground for the medical aspects of this alliance………”

“I personally feel that the proposed merger will be very beneficial for the majority of staff. I think that we are all more than aware of the problems NUHT have had over the past few years which has resulted in a number of staff being made redundant etc. Three joint trusts would be such a powerful way of providing an excellent standard of patient care. We could have different sites for different specialities etc.”

“Need to be honest that the financial projections make the merger VITAL for healthcare in north east London or we will be seeing 1 - 2 hospitals go bust.”
“I understand the necessity of the merger and can see how it can benefit my small area of service provision. I am beginning to understand some of the methods for how it is going to work. I feel more information regarding the work realities needs to be provided to all clinicians and ensure that the right clinicians are included early in CAGs and other discussions.”

“I feel that it is inevitable so all that remains is to commit ourselves to making sure that what results is actually better for local people – patients and staff – than our present situation”

“I think we would benefit from this merger, working together and improving the patient care in east London.”

“POSITIVE - this should lead to better health outcomes for east London; better career pathways and good practice for staff; should improve research outcome through larger subject groups and concentration of resources; and attract expert staff. Economies of scale.”

“A change is always difficult but based on the information given I am able to motivate and support others to see it happen.”

“It is a good opportunity for growth, change and a new way of working. It will allow for the diverse talent in the organisation to flourish.”

“Think it will benefit. Challenges and positive for the local economy we need to be able to deliver sensitive messages and relay.”

“Very proud and positive to be part of the merger which one day will be the hospital of the future for both patients and staff.”

“Of course there are worries and the future will be difficult, but I am convinced that in the long term it must be better for our patients and that is the most important thing of all”

**Examples of respondents with supportive comments requiring assurance or having concerns:**

“We are eager to see Barts and East London Healthcare initially focusing on improving the capacity and quality of services in each of the existing maternity units, and to do this it is imperative that each unit retains its own Head of Midwifery…

The RCM would also like to urge that the utmost care is exercised in the merger to ensure that the high debt levels at Whipps Cross do not lead to financial difficulties for the new trust”

“The Waltham Forest GP Clinical commissioning Consortia are pleased that our concerns are being taken on board. We look forward to working with you in the future”.

“Want the merged trust to radically review its estate and develop an estates rationalisation plan on the back of its service strategy…

“We need a clear commitment to retaining a full range of local services at Newham…”

“We would like to further understand how the coming together of back office functions would address the often reported issue of cancelled appointments and lost notes, particularly at the Royal London will be improved rather than made worse”

Our GPs noted with some scepticism the "commitments" proposed by the Trust outlining the improvements which would be achieved by the merger. It was felt that a significant change of attitude and managerial focus would be required to deliver and achieve these. We remain very concerned that the merger will remove the Trusts focus on this work which is fundamental to good
clinical care. We are worried that an even larger organisation will be worse and less responsive and will not put the concentration onto the delivery of these given the other priorities.

We would want joint work across INEL on the best disposition of specialist and generalist clinical services and no assumption of centralising services at BLT / the newly merged Trust. We also do not anticipate a shift in patient flows to the new Trust at the expense of Homerton unless related to specific agreed service shifts” (City and Hackney Pathfinder CCG)

“I can see the benefits of a merger when there seems no other choices i.e. financial pressures and lack of services at the hospitals. As with all mergers / changes of structure there will be challenge.”

“I wonder if the determination and courage is there to transfer three institutions which have never been really well managed - endless issues of systems, data, estate, finance, standardisation, professional compliance, customer care, etc. - and create one which genuinely is well run on a consistent basis over the long term? The impression of commitment is there; it would be interesting to see some more evidence than some PowerPoint and a video.”

“I fear we will be too big. How do you ensure appropriate team of the budget. I want guarantees that patients from City and Hackney will not be compelled to access certain services at Whipps Cross and Newham.”

“A little concerned that it will be too big and could end up with the problems that are happening at BHRUT”

“There are fears that the merged trust will take services, resources and staff away from Neighbouring trusts such as BHRUT.”

“I feel the merger does create good opportunities for the future of the health service in East London. However I feel that it is important that each hospital doesn't lose its identity.”

“It’s not going to solve the problems we have. It’s going to make the task of GP commissioning much harder because it will be a virtually secondary care monopoly

“It isn't good for staff morale. We are understaffed and if we can provide more jobs for the people on the wards than it will have benefit – otherwise it’s useless.”

“Still concerned how merger will happen and what the real impact on (change) staff will be. Concern that all staff are not fully aware of what this merger is and how / when it will affect them. Concern extent of financial savings and staff cuts that will be needed.”

“We can have these high level aspirations but my fear is that we need to balance the books will become the overwhelming force”

“Good in theory, but fear how it will work - how will it be quality assured? Budget projections. How will this impact on primary care? Doctors and HP spread too thinly? This will affect continuity of care. Training - will there we adequate opportunities if consultants lead 24 / day. Fears of money and resources being pulled from WX and Newham to fund BLT PFI. Great looking new buildings don't mean great care, how are we going to recruit world-class staff?”

“Good from perspective of hospital trusts but amalgamation poses threats to competition for GPs and Commissioners.”

“Overwhelming for community health services faced with the 3 acute trusts.”
“Necessary and offers great benefits. Lots of work still to do and anxiety amongst front line staff.”

“I believe that this merger will result in me losing my job. However in terms of standardisation and best practice this could result in better care for patients.”

“My only concern is timing, whether all these lovely ideas would be met by April. My suggestion is that is should be carefully thought through and constantly engage staff in the process.”

“…The aim of the merger is meant to be promoting best practice for patients therefore it does not make sense to reduce specialist posts – it should be spread by skill around a bigger area and mimic good practice. We are struggling to influence the decision even with a good idea of how this could work for patients and not cost more.”

Examples of comments from respondents’ who do not support the merger:

“Accordingly, it is our considered view that the current plans will not lead to a financially stable trust as the lack of any usable reserves means that the proposed trust can only fund capital expenditure from loans. Further its current financial position is such that even without further borrowing the risk of financial failure is too great for us to support this merger”

“Due to personal experiences in hospital, am strongly against. The merger three trusts have problems and need to be corrected separately, as together the patients will be the losers. This is all about Government savings at our loss. No.1 on your letter is your duty why are we getting a new Hospital and refurbished Barts and need to merger. If you treat more patients and as you do from wider areas the Government should allow for this pay for it and not cutback.”

“The position outlined in the submission from Hackney LINk to the CCP is unchanged.”

“I think it would be a disaster. More patients would not get the correct treatment and more patients would die. There would not be enough beds for everybody needing them.”

“It will be very expensive. A shame people are not being consulted, just engaged. The overall structure of the merger is too big and individuals will get lost in the system. Many details not addressed”

“I do not think it is good. Too many boroughs to deal with and too much wasting time. Not secure”

“I am sad that any hospital has to merger with another to survive or share their funds… its not beneficial to the hard working care providers …no good to share so little we have here with others.”

Appendix H: Formal letters

Copies of the formal letters received from stakeholders including Clinical Commissioning Groups and Royal Colleges are attached below.
Further appendices available

Appendices B – G are available on request from Adrienne Noon, Communications and Engagement Lead on 0207 092 5333.

Appendix B: Roadshow log

A record of each of the roadshows, including venues, dates, times and numbers engaged

Appendix C: Report of the corporate and clinical workstream events 3 November 2011

This draft event report is a summary of the meeting and a record of the detailed questions and answers. An attendance log and the presentation pack accompany the event report.

Appendix D: Engagement log

The engagement log is a record of the opportunities at which stakeholders have been provided to share their views including meetings, events, emails and formal views.

Appendix E: Responses log

Each formal response has been collated into a consistent matrix to inform our key themes and to ensure we provide appropriate action or remedies for issues raised.

Appendix F: Report of stakeholder meeting 15 September 2011

This event report is a summary of the meeting, a record of the detailed questions and answers. An attendance log and the presentation pack accompany the event report.

Appendix G: Report of the finance meeting 20 October 2011

This event report is a summary of the meeting and a record of the detailed finance questions and answers. An attendance log and the presentation pack accompany the event report.
Appendix H:

Formal letters
Dear Dr. Moore

I am writing to you following NHS East London and the City’s Clinical Commissioning Committee meeting which took place on Friday 18 November 2011. At the meeting we considered the evaluation of the business case for the Barts and East London hospitals merger project. Newham Commissioning Group was not present at the meeting and their views have been represented outside the meeting and do comprise part of the overall reflections as outlined in this letter.

Lucy Moore, Project Director, Stuart Saw ELC Director of Finance, and Dr Steve Ryan, BLT Medical Director attended our monthly clinical commissioning committee meeting to present recommendations following an evaluation of the merger business case. It was acknowledged that clinical commissioning groups in ELC had been engaged throughout development of the business case. The CCGs present acknowledge that sustainability of both Newham and Whipps Cross Hospitals is a key driver to the proposed merger.

I can confirm that the committee gives broad support to the merger but is seeking further assurances in a number of areas, these can be summarised as:

- The development of plans to control the activity and improve productivity in each hospital trust, with particular focus on performance in Barts and The London Trust,

- The development of plans which show a commitment to cultural change in the new organisation – the organisation should focus on relationships between primary and secondary care clinicians in order to embed a collaborative approach focused on delivery and in improving the patient experience,

- Transition costs not to be passed on to clinical commissioning groups,
The business case needs to articulate how patients will still be free to choose service providers and helps build resilience at local sites including enhancing local services.

I hope that this letter helpfully sets out the ELC clinical commissioning committee’s support for the merger project and provides the BELH merger team with the necessary steer around the areas that ELC CCGs are seeking further assurances on.

I would be happy discuss these matters further if helpful.

Best wishes

May Cahill
ELC Clinical Director
Chair ELC Clinical Commissioning Committee
18th November 2011

Peter Morris
Chief Executive
Barts and The London NHS Trust
The Royal London Hospital
Whitechapel
London E1 1BB

Dear Peter

The proposed merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust

Tower Hamlets Clinical Commissioning Group would like to provide a formal view to Barts and The London NHS Trust on your proposal to merge with both Whipps Cross and Newham Hospitals. We would like to thank you and your team for the time that you have taken to discuss the proposals with us over the course of the last six months.

The views of the commissioning group have been shared with you on numerous occasions and we are pleased that you have amended your integration plans accordingly to reflect our feedback. These include the inclusion of senior hospital site managers for each locality, that you must use local commissioner assumptions in your long term financial planning model and that you make a commitment to continued improvements at a local borough level.

The commissioning group is therefore willing to support the merger provided that the following are implemented and progressed in the new organisation:

- Tower Hamlets Community Health Services is to remain a priority within the new trust and we do not wish to see any changes to local service provision without the appropriate discussion and consultation with GP commissioners.
- The improvements in clinical outcomes that you have indicated are realised as part of the merger process and that the agreed plans within the long term financial model are adhered too.
- Suitable measures of performance will also need to be put in place from the outset of the new trust and that this data is made available to commissioners in a timely manner, broken down to site specific information.
The committee would also like to reiterate that we do expect to be involved in any care pathway redesign or key areas for improvement and that we do expect to see action in the agreed areas in the first year of operations.

We would not wish to see any reduction in service levels that we currently receive and would not support any frontline service reconfiguration without appropriate consultation with health partners and the public.

Communication and engagement by each of the services needs to be significantly enhanced.

The CCG would like to be involved in the recruitment of the Chair, CEO and other key board positions.

We would also not be prepared to directly fund the merger or subsidise any underlying deficits which arise as a result of the merger, be they related to PFI costs or any other deficit.

We would also like to reiterate that now we have established regular meetings through our joint Clinical Reference Group, chaired by our commissioning group vice-chair Isobel Hogkinson and attended by our colleagues in Newham and Hackney, that we do see this group as pivotal to moving forward with better healthcare services in east London. The importance of this relationship is further enhanced now that the membership has been extended to both Newham and Whipps Cross Hospitals and to GP commissioners in Waltham Forest.

Yours sincerely

Dr Sam Everington
Chair
Tower Hamlets Clinical Commissioning Group

cc: John Wardell, TH CCG Chief Operating Officer
    Jane Milligan, TH Borough Director
    Alwen Williams, Chief Executive, NHS ELC
Dear Stuart,

PROPOSED MERGER OF BARTS AND THE LONDON, NEWHAM AND WHIPPS CROSS TRUSTS

Our Board discussed the above at our last meeting and I am writing to you to outline the conditions on which City & Hackney CCG would be prepared to support the proposed merger. As you know, City & Hackney CCG has taken delegated responsibility for NHS commissioning and therefore this response is made in that context.

We have 3 conditions:

• Finance and Productivity;
• Systems Improvements;
• Consideration for viability of clinical services at the Homerton.

Finance and productivity

Our commissioning strategy as a CCG is to find ways to safely reduce hospital activity, and over the past 5 years we have been successful in working with the Homerton to achieve this.

We expect to do the same at the new merged Trust through a combination of demand management initiatives and productivity gains which the CCG will lead. We believe our focus on clinical pathways has improved the quality of care, supported clinical morale and enabled both the Homerton and our CCG to be in financial balance.

We know that the tariff deflator is proposed at minus 1.5% per annum for the next four years, which includes an assumption of 4% efficiency on the part of Providers. Further, as Commissioners we have built detailed additional Productivity savings into our current CSP (and other INEL commissioners have done the same) which is being refreshed and the refreshed CSP Plans must reconcile back to the Long Term Financial Model (LTFM) in the merger Business Case. As Commissioners we will want to see, therefore, that agreed plans within the LTFM are adhered to. Additionally we are aware from the SaFE overview that
there are significant opportunities for increases in productivity (which should be possible at BLT and should therefore be realised through the proposed merger) and our support for the merger is conditional on the delivery of these productivity gains by the Trust to us as a commissioner. It will not be acceptable to us as Commissioners, for example, for the merged Trust to over-trade against the agreed plan values whilst failing to deliver its Productivity Plans.

We believe that there is now an important piece of work which needs to be taken forward to look at the proposed service lines in the merged Trust and benchmark these against upper quartile performance. As a commissioner we would be looking for both contractual levers and a contractual commitment to deliver these improvements and would, if possible want to tie our funding of the trust’s activity to the achievement of the action plans and the year on year productivity gains. We think that this work needs to be clinically led by a clinician external to BLT who has already achieved gains in clinical and organisational productivity and this piece of work needs to be owned by at least the 3 INEL CCGs.

Beyond these productivity expectations we would:

- Not be prepared to put any direct funding into the merger team or project management of workstreams falling out of the merger;
- Want the merged trust to radically review its estate and develop an estates rationalisation plan on the back of its service strategy;
- Urge NHS London - perhaps via UCL partners - to review again the disposition of, and pathways for cancer and cardiac work to ensure we aren’t commissioning duplication of services and that best practice/cost effectiveness is being delivered;
- Not be prepared to subsidise any underlying deficits arising from the merger, be they related to PFI costs or any other deficit;
- Ask the Cluster to develop plans around capping financial risk over the next four years, using the LTFM to hold Providers to agreed plans.

**Systems Improvements**

We have flagged on numerous occasions to BLT that we are seeking a stepped improvement in the managerial and administrative systems in the merged Trust. Too often our patients care is compromised by poor admin systems - notes not being available at clinic, duplicate investigations, poor communications about appointments leading to DNAs etc (and all of these poor systems also have an adverse financial impact for us as commissioners, so we are rewarding administrative inefficiency). Communication with GPs remains poor which also compromises clinical care.

Our GPs noted with some scepticism the "commitments" proposed by the Trust outlining the improvements which would be achieved by the merger. It was felt that a significant change of attitude and managerial focus would be required to deliver and achieve these. We remain very concerned that the merger will remove the Trusts focus on this work which is fundamental to good clinical care. We are worried that an even larger organisation will be worse and less responsive and will not put the concentration onto the delivery of these given the other priorities.

We would therefore like to work with NHS ELC as our commissioning partner to find a way to contract for improvements in these service areas and link some kind of financial penalty to non delivery - we would be happy to receive some proposals from you on how we might best achieve this.
Viability of the Homerton

Our current favourable financial position is due to the willingness of the Homerton to work with us to safely reduce activity. We do not want to compromise their viability and want a guarantee of consideration of their integrity as a very efficient DGH. We would want joint work across INEL on the best disposition of specialist and generalist clinical services and no assumption of centralising services at BLT / the newly merged Trust. We also do not anticipate a shift in patient flows to the new Trust at the expense of Homerton unless related to specific agreed service shifts

Best Wishes,

Clare Highton
Chair
Newham Health Partnership
Stratford Village Surgery
50c Romford Road
London   E15 4BZ

30/11/2011

For the attention of:
   Lucy Moore, Programme Director, BELH Merger

Copy to:
   Alwen Williams, CEO, East London and the City Alliance
   May Cahill, Clinical Director, East London and the City Alliance

Newham Health Partnership response to the initial consultation on the proposed merger of the Royal London Hospital with Newham University Hospital and Whipps Cross Hospital

Newham Health Partnership (NHP) is a first wave pathfinder Clinical Commissioning Group that represents 53 practices, providing health care to approximately 292,000 patients in Newham.

Our guiding principal is to plan services that will provide the best possible health care within the available resources, maintaining and increasing patient choice in Newham. We aim to provide at least 30% of local patients with the choice of receiving enhanced care in a primary care setting.

NHP members have discussed the proposed merger at length in a series of meetings, and we welcome this opportunity clarify NHP’s initial views on the proposal.
NHP does wish to support the proposed merger; and we expect to be in a position to provide a fuller endorsement once we have had an opportunity to review the full business case that supports the merger proposal.

We trust that the business case will demonstrate how the merger will support the local commissioners to deliver the out of hospital and care closer to home agendas, and will therefore specifically address:

1. Extending patient choice in Newham by supporting the provision of local AQP services so that increasing numbers of patients in the borough can choose to receive enhanced care in a primary care setting.

2. Enabling other providers to run local outpatient clinics so that the Royal London does not have a monopoly of outpatient provision in Newham.

3. Demonstrating a clear rationale of how the merger will deploy clinical models to maximize the benefits of a comprehensive local acute service in Newham that will ensure the continuation of 24 hour emergency and urgent care provision underpinned by the comprehensive range of local hospital services, including SCBU, as defined in healthcare for London.

4. Creating a robust process by which local Newham GPs and clinicians at the Royal London and NUHT will jointly develop and implement new care pathways and clinical services that enhance the quality and range of services available locally.

5. Demonstrating how planned savings will be shared with local commissioners.

6. Support local GPs to maximize the range and quality of local services available to our community through the innovative utilization of freed up resources in Newham.

NHP recognizes that the current difficult financial situation within the NHS and the requirement to achieve Foundation Trust status have necessitated the proposed merger. We have sympathy for the organizations involved and support the need to adopt a pragmatic approach to overcoming the challenges that confront them.
Yours sincerely

Dr Ashwin Shah, MBE
Chair, Newham Health Partnership Clinical Commissioning Group

Dr James Lawrie
FRCGP MBBS MA (oxon) MBE
Vice chairman of Newham Health Partnership Clinical Commissioning Group
On behalf of Newham Health Partnership.
25 November 2011

Dear Lucy

The proposed merger of Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust

Waltham Forest Federated GP Clinical Commissioning Group would like to provide a formal view to Barts and the London NHS Trust on your proposal to merge with both Whipps Cross and Newham Hospitals. We would like to thank you and your team for the time that you have taken to discuss the proposals with us over the course of the last six months.

The views of the commissioning group have been shared with you on a number of occasions. These include the need to keep a strong locality focus, that you must use local commissioner assumptions in your long-term financial planning model and that you make a commitment to continued improvements at a local borough level.

The commissioning group is therefore willing to support the merger provided that the following are implemented and progressed in the new organisation:

- Localisation remains a priority and can be evidenced ie increased Chemotherapy provision delivered in Waltham Forest.
- The improvements in clinical outcomes that you have indicated are realised as part of the merger process and that the agreed plans within the long-term financial model are adhered to.
- Suitable measures of performance will also need to be put in place from the outset of the new trust and that this data is made available to commissioners in a timely manner, broken down to site specific information.
- There is recognition of local CCG requirements and models of service are fixed accordingly; ie “community specialist services” delivered in Waltham Forest.
- We would expect pricing to be clearly demarcated between tertiary and “DGH” type functions, particularly in non-pbr.
The committee would also like to reiterate that we do expect to be involved in any care pathway redesign or key areas for improvement and that we do expect to see action in the agreed areas in the first year of operations. Any concentration of specialist provision should go through the same consultative process that the successful vascular move underwent.

- We would not support any frontline service reconfiguration without appropriate consultation with health partners and the public.
- Communication needs to be maintained at the very high level currently in place with primary and secondary care clinicians working on integration projects.
- The CCG would like to be involved in the recruitment of the Chair, CEO and other key board positions.

We would also not be prepared to directly fund the merger or subsidise any underlying deficits which arise as a result of the merger, be they related to PFI costs or any other deficit.

We look forward to collaborating with you and our fellow CCGs in the forthcoming months in seeing this project go forward to the benefit of patients in Waltham Forest and East London.

Yours sincerely

Dr Gabby Ivbijaro
Chair Waltham Forest Federated GP Clinical Commissioning Consortia

cc. Conor Burke – Director of Commissioning Support
    Alwen Williams – Chief Executive
30th November 2011

Lucy Moore
Integration Director
Merger Project
Aneurin Bevan House
81 Commercial Road
London E1 1RD

The proposed merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust

Thank you to you and your team for attending the Barking and Dagenham Clinical Commissioning Committee on three occasions over the last few months.

The views of the committee have been shared with your team directly and below I have outlined the discussions and areas of challenge that we have raised in these discussions. As such our support for the merger is contingent on the following:

- The merger has the support of the clinical body. Our experience of mergers has not been favourable in the past and many of us recall the process that led to the formation of Barking, Havering and Redbridge University Hospitals NHS Trust which was, and continues to be, a very difficult integration of the clinical community.

- The clinical commissioning committee would not be prepared to fund the merger or proposed trust in any capacity now nor in the future should difficulties arise. Our expectation is that you have completed all necessary checks of the financial modelling and you have undertaken external validation of the process, methodology and outcomes.

- The improvements in clinical outcomes that you have indicated are realised as part of the merger process to benefit the residents of Barking and Dagenham. Suitable measures of performance will also need to be put in place from the outset of the new trust.

- The committee will also need assurance that as commissioners we would not be subject to any changes in the market forces factor / tariffs that are currently applicable for our providers.
The committee would also like to reiterate that we do wish to be involved in any care pathway redesign and would like further local services to be developed which are in line with local commissioning intentions to bring services closer to home.

The committee would not wish to see any changes in local services other than implementation of the recently approved Health for north east London proposals. Any future changes would require consultation and detailed analysis to ensure that this meets the requirements of our increasing population.

It is also very important that the new trust works closely with Barking, Havering and Redbridge University Hospitals NHS Trust. We are all aware of the difficulties facing this provider and it is essential that the standard of service is significantly enhanced. We would want to see the proposed new trust working with and sharing best practice with colleagues throughout north east of London.

Yours sincerely

Dr Arun Sharma
Chair Barking and Dagenham Clinical Commissioning Committee
25 November 2011

Cathy Geddes  
Acting Chief Executive  
Whipps Cross University Hospital NHS Trust  
Leytonstone  
London E11 1NR

The proposed merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust

Thank you for attending the Redbridge Clinical Commissioning Committee in September and for joining Louise Mitchell, Redbridge Borough Director, myself and Lucy Moore at an earlier discussion regarding the proposed merger.

The views of the committee were shared with you at the meeting in September and our support for the merger is contingent on the following:

- The merger has the support of the clinical body at Whipps Cross Hospital. Our experience of mergers has not been favourable in the past and many of us recall the process that led to the formation of Barking, Havering and Redbridge University Hospitals NHS Trust which was, and continues to be, a very difficult integration of the clinical community.

- The improvements in clinical outcomes that you have indicated are realised as part of the merger process. Suitable measures of performance will need to be put in place from the outset of the new trust and that this data is made available to commissioners in a timely manner.

- Whipps Cross Hospital is to remain a viable hospital site with full A&E and maternity services and the supporting infrastructure for these services. This is in line with the recent approval of the Health for north east London proposals and the analysis that has been done with respect to population growth and the patient flows expected to Whipps Cross Hospital.

- The committee will also need assurance that as commissioners we would not be subject to any changes in the market forces factor / tariffs that are currently applicable for Whipps Cross Hospital.
The committee would also like to reiterate that we do wish to be involved in any care pathway redesign and would like further local services to be developed such as the chemotherapy example that you provided.

Finally it is very important that the new trust works closely with Barking, Havering and Redbridge University Hospitals NHS Trust. The quality of services currently run from this trust is not of a high standard and the financial challenge is immense. We would want to see the proposed new trust working with and sharing best practice with colleagues throughout north east of London.

Yours sincerely

Dr Hector Spiteri
Clinical Director
Redbridge Clinical Commissioning Board
Newham LINk
‘Paving the road to equity in health and social care’

25th November 2011

FAO:
Ms Jo Lobban
Communications and Stakeholder Manager, Merger Project

Dear Ms Lobban,

**Newham LINk’s Formal Submission:**

**RE: Merger proposal of Barts and The London NHS Trust, Whipps Cross University Hospital NHS Trust and Newham University Hospital NHS Trust**

Thank you for inviting us to submit our views on the proposed merger of Barts and the Royal London NHS Trust, Newham University Hospital Trust and Whipps Cross University Hospital Trust. We do believe that we have been effectively informed to date and that this has enabled us to understand the financial reasons for the merger.

We are aware that there is a growing debt burden which is a driving force of the proposed merger. Some Trusts are not in a position to repay their debts so are seeking merger as a means of subsuming these into the larger merged organisation. Trusts are seeing the ‘no other option’ as the driving force for the merger option. The option to ‘do nothing’ is presented as not an option that can be taken. Financial arguments led by the three Financial Directors have been made well and have made sense. It is also believed that the merger will pool resources and therefore enable Newham, as others, to be better equipped as a Foundation Trust.

As Foundation Trust status is not yet achieved for Newham, and as it is unlikely that the Trust will achieve this status within the required deadlines they will automatically be going into operating within the termed ‘Failure Regime’ until or unless such status is later achieved leaving them open to ‘external take over’. There is a timescale for this achievement (2014/15) prior to any expressions of external interest. NHS Development Authority will be the body responsible for Trusts not yet Foundation Trusts, in the transition period, to support the organisation’s future. LINk are concerned if we do not get Foundation status in Newham, this will mean a loss of local control of solutions with the DoH in charge.
Newham LINk would wish to see a better expression of the clinical benefits of the merger within the full business case and also considers that there needs to be a wider consultation looking at such clinical benefits and that Patient and Public Involvement should be central in this. The facts about the implications of ‘no merger’ being submitted or agreed, needs to be put to the public.

Newham LINk need to be consulted once we have a better understanding of the outcome of the current ‘clinical due diligence’ assessment process being undertaken by Serco Consultancy into the clinical performance and any potential risks or issues regarding current services and future service developments in the Trusts’ clinical performance, so that the overall performance and actual and potential risks are properly considered.

Newham LINk look forward to receiving the full business case so that we can comment further. It is our hope that this full case will address our key concerns.

Therefore, we would like to see within the business case:
- A fuller explanation of how service improvement will be delivered for Newham residents. This includes addressing ongoing concerns of patients regarding respect and dignity and a substantial improvement in patient experience across the three hospitals.
- Evidenced based assurance that there will be no reduction in the full range and quality of choice for Newham patients.
- We need a clear commitment to retaining a full range of local hospital services at Newham, including maternity and A&E. Indeed we would like renewed assurance that there will be no reductions to services in Newham as a result of the merger.
- Newham residents should not be asked to travel further for services, which currently are provided in borough, unless there are robust clinical reasons. Our transport concern is about the cost of travel for some of the poorest people in the country, particularly in moving from zone 3 to Zone 2, the lack of physical accessibility of public transport links and the need to improve current hospital transport arrangements.
- We would wish for this commitment and assurances to clearly state that there would not be reduced access to locally provided services for Newham residents in the future, unless supported by residents and other key stakeholders locally.
- We would like to further understand how the coming together of back office functions would address the often reported issue of cancelled appointments and lost notes, particularly at the Royal London will be improved rather than made worse.
- We would wish to see that the mergers would not lead to difficulties in Newham retaining and attracting good quality staff.
- How the merger would work with our local Clinical Commissioning Group and other health and care Providers to deliver integrated care within Newham.
- We would like to see within the business case a full addressing of the concerns being raised by the Co-operation and Competition Panel, East London Clinical Commissioning Groups and our fellow LINks.
- We also look forward to seeing the full Equality Impact Assessment that has been requested and how its outcomes will be effectively addressed.
We wish to reiterate that Newham LINk understand the financial reasons for this merger, but that we need to ensure that patient’s needs and patient choice remain central to the decision making process.

The redesign of the services and the enhancement of clinical quality and patient experience and outcomes from services commissioned at the newly merged hospital Trust will ensure that high quality accessible services are provided for local communities and that services are also based on patient needs rather than on short term financial constraints imposed on the local NHS.

We in Newham LINk remain committed to working with the Merger Team and other stakeholders to achieve the best possible acute services for our residents.

Yours Sincerely,

Mavis Wenham
Interim Head of Newham LINk
SUBMISSION ON THE PROPOSED MERGER OF BARTS AND THE LONDON NHS TRUST NEWHAM UNIVERSITY HOSPITAL NHS TRUST AND WHIPPS CROSS NHS TRUST
These submissions provide the view of Hackney Local Involvement Network (the LINk) and should be read with the submissions from the LINk to the Competition and Cooperation Panel in relation to this proposed merger. The purpose of these submissions are to assist NHS East London and the City in deciding whether to approve the Full Business Case for the proposed merger.

Providing safe services across multiply sites is a difficult task and, therefore, in view of the examples of Barking Havering and Redbridge University Hospitals NHS Trust and South London Healthcare at the stakeholder event on 15 September 2011 the Integration Director was asked 'Q. Can you give an example of a two/three Trust merger that has been both clinically and financially stable?’ The answer that was given was 'We have a clear understanding of the challenges we face, and our ambition is significant. We understand and take the lessons from previous mergers very seriously and will take these forward in our detailed planning. We have also recently visited the team who led the successful merger of Heart of England (Birmingham) so we can learn from what worked and what didn’t to further develop our thinking. We have also looked closely at the experiences in London and we are aware of the risks involved, but the greater risk to local services is staying as we are.'

On checking the CQC website it is noted that this trust was registered with three conditions imposed on it after it declared itself non compliant in those areas. The last condition relating to staff training was lifted in February of this year. Also it is noted that at three of the Hospitals run by Heart of England that were inspected in October of this year they were found to be non compliant on one of the standards. While recognising that there are risks in not doing anything we also note that maintaining clinical quality in large trusts is difficult and every trust that has tried so far has had problems so we must question whether a three trust merger in these circumstances is too risky.

We note that while the merger team has mentioned and quite rightly recognised the risks no explanation has been given about how the risks are to be managed or mitigated.

One of the stated benefits of the proposed merger is that it would produce a financially stable trust. On the 20 October 2011 the merger team held a Finance event to show the financial underpinning of this merger. From information given at this event it would appear that of the £237m in CIP savings required over the next five years. Of this £26m will be found by reducing duplication and sharing back office functions and a further £31.5m - £116m is to be found if the services in each of the

References:
1. See the CQC website at www.cqc.org.uk
2. See Slide 9 from the Finance Event presentation on 20 October 2011
trusts were as efficient as the best to be found in the three. This would leave a minimum gap of £95m in CIP savings to be found over five years which equates to an average of £19m. This would be a challenge as savings resulting from the three trusts operating as efficiently as the best of the three currently does has already been taken into account.

It is noted that this £95m is based on the maximum £116m from services in each of the trusts being as efficient as the best to be found in the three. If the minimum of £31.5m is made then the amount needed to be found from CIP savings or additional income will be £179.5m over five years this equates to £35.9m a year savings at this level cannot avoid impacting on patient care. The mean five year CIP savings target is £137.25m which gives a mean annual CIP target of £27.45m. It is difficult to see how such sums can be found from savings alone.

It would seem therefore that to meet the CIP savings target the merged trust would have to either increase its income or institute significant service and/or estate rationalisation to reduce its cost base. Any such programme would take some time to implement as it would require public consultation and engagement. It is therefore not certain that all or any of the service and/or estate rationalisation plans could be implemented with the five year period to assist in meeting the CIP target.

In reaching this conclusion it is noted that the proposed trust has a £80m cash shortfall in its merger plan as at the 20 October. £27.5m of this is met by a loan from the Challenged Trust Board. This still leaves a gap of some £52.5m to be found. It is not clear where this will come from. We would also observe that Whipps Cross has a current in year deficit as at 20 October of £6m and has had to take radical steps in an attempt to eliminate this in year deficit. There is also a suggestion that Whipps Cross might miss its CIP target for this year. Newham is also having difficulties with its CIP target for the year.

This view that there will have to be some degree of service reconfiguration is reinforced by the comment of Geoffrey Rivett in his submission to the Competition and Cooperation Panel when he said: ‘Sadly I have to say that I found the Vision of the future healthcare for local people either naive or duplicitous. The covering letter says that the proposal is to merge the three hospital trusts and not to reconfigure services. Were this so it would be a first. Since the 1890s the King’s Fund, and subsequently the NHS, have used organisational and managerial merger as a pre-condition to

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3 See Slide 20 from the Finance presentation on 20 October 2011
4 See Slide 21
facilitate service reconfiguration

Any service rationalisation would have to be seen in light of the proposals under Health for North East London. Under these proposals North East London will lose one A & E and Maternity unit this would increase the pressure on the remaining units. Accordingly, any reduction in the number of these units by any plan to rationalise the services provided by the proposed trust would have a significant impact on patient choice and overall service provisions. It is accepted that there are no current plans for any such rationalisations. However, we have doubts that the proposed trust would have the financial resources to sustain services on all sites.

In this regard we would concur with the view of the Klear Clinical Commissioning Group in its submission to the Competition and Cooperation Panel where they observed Equally our neighbours in Newham may come under similar threat if the large merged, organisation began to find it not commercially of interest to continue to deliver services in each local area in favour of centralisation. Such an outcome would create inequity for patients in Hackney and Newham who would experience loss of choice and increased travel time and costs. We note that these concerns of Klear seem to be echoed in concerns from the Competition and Cooperation Panel who have raised the same concerns about reduction in patient choice and increased travel.

We would observe that the Competition and Cooperation Panel have currently suspended their inquiry at the request of the parties to the merger to allow them to provide further material in relation to the potential costs and potential benefits of the merger.

The alternative to service reconfiguration is to increase income. The Commissioning Intentions from the City and Hackney Clinical Commissioning Consortia is based among other things on savings from Barts and the London. This is because it is recognised that the Homerton University Hospital Foundation Trust cannot be squeezed to far to make savings and other hospitals will have to make savings as well. It is also noted that the Finance Director for Barts and The London at the finance event on 20 October indicated that due to a change in the funding of post graduate research this income source will be reduced. Accordingly, it is hard to see where any significant additional income will come from.

The recent history of trusts that have merged in similar situations is not encouraging. In the most

5 See the minutes of the Newham Borough Committee at page 422 of the Board Papers for the NHS ELC Cluster Board meeting on 23 November 2011.
6 See CCP Notice of 14 November 2011
recent case of South London Healthcare they managed this year to come top of the list of trusts with a deficit. Since it started in 2009 it has never managed to break even. It was allowed to set a deficit budget and exceeded the amount of the deficit quite substantially. It is important to note that this was also a three trust merger. Against this background the assurance given by Dr Lucy Moore during questions at the Health in Hackney Scrutiny Commission meeting on 10 October 2011 that ‘If the project team was going to get approval to merge they will need to demonstrate that the trust will be successful.’

It is of concern that in view of the history of NHS mergers there does not appear to be any consideration of what to do if there is any financial failure. This concern is heightened by the consequences. It has to be borne in mind that Barts and The London Trust also includes the community health services for Tower Hamlets. It follows that any financial failure may affect a larger number of people than if a hospital trust which did not also provide community health services.

We note that one of the primary drivers for this merger is the need to achieve foundation trust status. We must express some doubt as to whether the proposed merged trust would be able to do this in its current financial position. If we are right then the proposed trust will end up having to be merged with another trust or broken up and further mergers done to provide a trust or trusts capable of becoming a foundation trust. We would suggest consideration is given to a much slower timetable to ensure financial stability in the constituent trusts before merging as this would give a better foundation for a viable trust. It should be noted that the 2014 deadline is no longer a fixed position so a more leisurely pace to get it right should be used.

Accordingly, it is our considered view that the current plans will not lead to a financially stable trust as the lack of any usable reserves means that the proposed trust can only fund capital expenditure from loans. Further its current financial position is such that even without further borrowing the risk of financial failure is too great for us to support this merger.

7 Minutes of the meeting of the Health in Hackney Scrutiny Commission at page 13 question iii.
Adrienne Noon  
Communications and Engagement Lead  
Barts and East London Healthcare Merger Project  
Aneurin Beven House  
81 Commercial Road  
London  
E1 1RD

28 November 2011

Dear Adrienne,

The Steering Group of the City of London LINk responds as follows to the request for comments regarding the proposed merger of the three East London hospital trusts:

When discussing the proposed merger, members of the Steering Group have raised concerns in the following areas:

- The value of the merger for Barts Hospital.
- The value of the merger for City residents.
- Whether IT systems could support an integrated body.
- Whether there might be expectations on sick patients to travel long distances (eg. across London to Whipps Cross).
- Accessibility issues.
- The impact of a large merged body on neighbouring trusts and the impact on commissioners.
- Loss of clinical staff and the impact of sharing staff across areas.
- The value of the merger for the City workforce
- The lack of planning for integrated ‘polyclinic’ type provision within the proposals.
It was the conclusion of the Steering Group that:

- The needs of City residents had not been considered;
- The proposals were primarily financially, as opposed to clinically driven;
- Although other areas may benefit, medical services for the City would be diluted;
- Not enough information was available to convince the Group the business case was viable.
- The concern that services must not be further distanced from the City needs to be reiterated.

Yours sincerely,

Nicholas Kennedy – Chairman of the City of London LINk Steering Group
Tower Hamlets Local Involvement Network (THINk)
Submission on the proposed merger of Barts and the London NHS Trust,
Newham University Hospital NHS Trust and Whipps Cross NHS Trust

THINk accepts that under current government policy the three hospital Trusts have
been forced into a financial situation where a merger is the best option available in
order to protect local NHS services and avoid fragmentation and possible private
sector takeovers. This is not ideal. There should have been more time for proper
public consultation and alternative options should have been available.

THINk accepts that there are benefits to the planned merger and that working
together better will probably save money and improve access to specialist services.
However we are concerned that there has not been adequate time or thought given
to the impact for patients and local communities. We do not believe the proposed
merger is just a “back-office process” but see this as the beginning of a major
restructuring of hospital services that requires full public consultation.

Although we are always keen to see improvement in the quality of services and
outcomes for patients we are concerned that the merger will:

- limit patient choice particularly with BLT now also delivering community
  services in Tower Hamlets
- provide a mono-cultural approach that is focused on a clinical rather than
  holistic approach to care
- inhibit the capacity for some of the poorest and most ethnically diverse
  communities in the country to engage with and help in the commissioning and
design of services to meet their needs, as Tower Hamlets residents are such
a small segment of the new Royal London’s patient base
- lead to a huge clinically led merger structure that will result in a jostling for
  supremacy with the specialist clinical services coming out on top and
community health services and care closer to home losing out
- lead to a rationalising of property with fewer staff but with larger numbers of
  patients as populations grow
- not resolve the financial problems, therefore leaving the new Trust still
  vulnerable to takeover
- lead to increased travel for vulnerable people and their carers.

It is a fact that patients and the public prefer local services. They feel that they are
more accountable, easier to navigate and that they connect better with other
community health, social care and voluntary sector services. If the merger is based
on the principle of making things bigger in order to keep them local, we would be
supportive.

We want to see a demonstrable commitment to putting patients and the community
at the centre of the new organisation through representation from the highest
governance levels right down to individual consultants or nurses ensuring that
patients are involved in decisions about their treatment and care. This is not just
about gathering patient experience; it is about patients being involved in
appointments, service redesign and rationalisation, setting annual plans, ensuring
patient focused outcomes in contracts and performance monitoring. Patients may
also have good ideas about how to save money and more importantly where money
is currently being wasted. Service changes shouldn’t happen unless patients have
been engaged and the likely impact has been considered.
The takeover of Tower Hamlets Community Health Services by BLT does not give us confidence that an approach that engages patients in change is accepted within current management.

We look forward to working with the new Trust should it go ahead to ensure that patient engagement is at the heart of all that they do.

Amjad Rahi and Christine Sheppard
Joint Chairs

Tower Hamlets Involvement Network
WF LINk supports the broad principle of the merger both as a mechanism to drive up service quality which can be realized through increased pooling of current skills set among existing staff and the greater deployment of best practice in order that minimum standards within each existing Trust are raised and comparable across the Trust as a whole. WF LINk broadly backs the principle of efficiency savings and the realization of funds from current assets / estates to help offset part historical debts with the clear proviso that these funds are directly deployed back into local services for the prime benefit of the local populations/ communities served by the proposed Trust. WF LINk believes this is essential in order that commitments made for services to be enhanced and importantly remain local and accessible (minimizing additional burdens associated with greater travel) at all times.

WF LINk feels that clear strategy must be put in place which allows for maximizing transparency and has at its core the full involvement and engagement of patients and public. This is critical due to the timeframes involved. The LINk views greater synergy is essential between current Trust – wide developments such as the Equality Delivery System, for example, which would allow for patient and public involvement/ human rights to be embedded and strived for as part of the (internal) core standards.

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Dr Lucy Moore  
Integration Director  
Merger Project  
Aneurin Bevan House  
81 Commercial Road  
London E1 1RD  

25 November 2011

Dear Dr Moore

Proposed merger of three NHS Trusts: Whipps Cross University Hospital, Newham University Hospital and Barts and The London

I am writing in response to your letter of 16 November, inviting Tower Hamlets Health Scrutiny Panel to submit formally its views on the merger, to be included in your submission. Thank you for this invitation. Below are the points that the Panel would like to make with regard to the proposed merger.

- The Panel remains concerned that the merger, which will mean significant change for the organisations involved, comes at the same time as The Royal London Hospital is moving into its new building and other ongoing major changes in NHS structures, locally and nationally, both of which bring upheaval and uncertainty. We are worried that NHS management will be overstretched and all staff will have to manage amidst more instability and change.

- The initial information presented to stakeholders, including the Panel, did not provide any information as to the financial drivers of the merger. Later discussions did recognise these drivers, as did the additional stakeholder meeting, and this openness was welcomed by those present. We would encourage the Trusts to maintain this openness and include the financial information in their communication with the wider public.

- It will be an enormous challenge for such a large organisation to be genuinely focussed on the needs of local people, given the diversity of the population across the three boroughs, and the Panel urges the Trusts to take this challenge seriously.

- We recognise that there are no plans as yet for changes to services, and that any such changes will be consulted on, but we would like to reiterate our concern about the poor transport links from Tower Hamlets to Whipps
Cross Hospital in particular. If Tower Hamlets patients are to be required to attend Whipps Cross we ask that additional transport provision is considered.

- Finally, many residents are very concerned about the impact that the merger will have on the services they receive now and in the future. The Panel is in turn concerned about the limited consultation the three Trusts have done with local residents. I know the Mayor of Tower Hamlets, Lutfur Rahman, has written to you to voice similar concerns. The Panel would therefore urge the Trusts to increase the public consultation and engagement being undertaken to ensure local residents are fully aware of the proposals and are able to voice their views.

Thank you again for inviting the Panel to submit our views formally. We shall await publication of the Full Business Case and hope to discuss these issues with you again at a future meeting of the Panel.

Yours sincerely

Cllr Rachael Saunders
Chair of Health Scrutiny Panel

Contact: Sarah Barr
E: sarah.barr@towerhamlets.gov.uk
T: 020 7364 5954
Dear Dr Moore,

I am writing in response to your letter and prospectus about the proposed merger of Barts and The London, Newham University Hospital and Whipps Cross University Hospital NHS trusts.

The Royal College of Midwives (RCM) supports the boards’ overall intentions and objectives for the merger. We are very pleased to see that the focus for the changes is to improve the quality of healthcare in the area, and applaud the commitment to provide maternity services locally unless women are better served by centralisation.

The RCM does have some early concerns about the prospect of consolidation of maternity services in the area. We are eager to see Barts and East London Healthcare initially focusing on improving the capacity and quality of services in each of the existing maternity units, and to do this it is imperative that each unit retains its own Head of Midwifery.
There is also a risk that the relative sizes of the three units could lead to a consolidation based on convenience for the new trust rather than for the explicit benefit of women. The RCM recommends that any impact of the merger on the structure of maternity services should be consistent with the proposed reconfigurations outlined in the Health for North East London programme. We strongly believe that local access to services and the need to retain established specialisation, for example the capacity of maternity units to serve their distinct local migrant populations, provide strong grounds for retaining the current three maternity units. However, we do recognise and appreciate the commitment to further consult on any consolidation of maternity services, and encourage Barts and East London Healthcare to engage with staff and the RCM at the earliest opportunity.

The RCM would also like to urge that the utmost care is exercised in the merger to ensure that the high debt levels at Whipps Cross do not lead to financial difficulties for the new Barts and East London Healthcare.

We believe that the merger could open up new ways of working between the three maternity units in the area, and encourage Barts and East London Healthcare to facilitate the sharing of good-practice among them. To do this, we recommend that clear channels of communication are established between senior trust managers and the heads of midwifery and staff in each unit.

The RCM supports the proposed merger, and we look forward to seeing how it progresses.

Yours sincerely,

Sean O'Sullivan
Head of Policy

General Secretary: Professor Cathy Warwick, CBE, DSc (Hon) MSC, PGCEA, ADM, RM, RN
President: Ms Liz Stephens RM, RGN, BSc (Hons), MA, MSc
Patron: HRH The Princess Royal

The Royal College of Midwives. A Company limited by guarantee. Registered No 30157 at the above address
Dr Lucy Moore  
Integration Director  
Merger Project  
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81 Commercial Road  
London E1 1RD

Dear Lucy

I would like to thank you and your wider team for the time that is being dedicated to work with staff representatives, to develop partnership working arrangements, since the establishment of the merger programme team in early 2011.

The Royal College of Nursing welcomes the opportunity to work with your team to design a new staff representative partnership model. We look forward to being involved in the design and implementation should the proposed trust receive the necessary approvals.

We would also like to share with you a formal view on the proposed merger on behalf of our members. We believe that the principles of the merger are sound in that you are proposing a clinical care pathway model.

While the aspirations of being initially 'best in trust’ and then 'best in class' are commendable, we need more detail on how this is demonstrated and how this will be achieved. We expect to see this detailed in the Full Business Case (FBC) to be published later this month.

Specifically the formation of the new trust by developing Clinical Academic Groups (CAGs) looks to be a very exciting opportunity for nurses, nursing and the RCN. We would however like to ensure the following are addressed in the final implementation plans:

- That an appropriately banded senior nursing lead is an equal partner in each of the senior leadership teams for the clinical academic groups.
- That each group has significant nurse and health-worker, representation and presence.
- We want a clear process on how clinical vacancies for the new trust will be recruited to.
- We need to identify and agree a policy for staff members who may have difficulty rotating between sites, should they be required to do so as part of their future role.
- We seek a policy which ensures that training opportunities will be equally and fairly applied to all staff members.
- We want to see a robust policy to support access to and funding for opportunities around education and research and development for professional / occupational groups.
• We expect to contribute to and be part of the Equalities Impact Assessment process for policy and consultation planning.
• We expect to contribute to the development and implementation of the newly formed organisations Equality Delivery Scheme. Given the significant demographics of the local populations across three boroughs we were surprised at the lack of detail relating to equalities and diversity.

Further to these points the Outline Business Case (OBC) makes reference to several areas were we would require further clarification in the coming weeks.

• **Outcome three** of the Organisational Development and Workforce Strategy refers to key areas which need to be delivered:
  - create meaningful jobs based on robust job analysis;
  - skills and competencies framework; and
  - establishing a culture in which staff enjoy the work.

The RCN and wider trade union group, would wish to be involved in the skills and competencies framework and also any performance management framework which is developed for the new organisation. We would also like to see more detail on how you propose to integrate three different cultures and link this to the equalities agenda.

• **Outcome six** of the same strategy in the OBC refers to a potential change around agenda for change terms and conditions for some staff members. We would expect to see the full retention of Agenda for Change terms and conditions for all staff. This is an important piece of work that will require further investigation by all trade union colleagues. We request more information about the comments you have received relating to this section, and with regard to the harmonisation of on-call rates.

On the basis outlined above the Royal College of Nursing supports the proposed merger of the three trusts. We welcome the clinically led approach to the plans, and fully support the principle driver behind the merger to achieve best clinical practice and patient experience across the three trusts.

The test for us all will be to achieve this in the current economic climate.

Yours sincerely

Sue Tarr
Operational Manager
Dr Lucy Moore
Integration Director
BELH Merger

Via email

Dear Dr Moore,

I am writing to you to confirm network support for the Barts and East London proposed merger. In particular the network recognises the need for the change within North east London and is keen to work with an organisation that is committed to preventing illness in addition to providing excellent clinical care which complies with network standards. We endorse the requirement to provide locally accessible and high quality services to the population especially as we are working with primary care teams to support delivery of care closer to home initiatives. We welcome the expansion of the academic health sciences role within this trust as this will drive up quality and service improvement across the patient pathway.

As you are aware the network has been established for sometime in North East London with already well developed clinical leadership and support to improve outcomes and access to high quality cardiovascular and stroke pathway so we see the merged organisation building on this existing platform working with all partners across the network.

We would very much welcome the opportunity to provide input into the design process and roll out of the CAGs.

I look forward to working with you,

Janet Lailey
Network Director
NEL Cardiovascular and Stroke Network
25 November 2011

Dear Trust Boards,

I have been using Trust services for many years and more recently have been acting as a Patient Representative and Trust Ambassador. I think that the merger is a good idea that could deliver high quality care for Newham residents. As long as the proposed organisation can deliver on the financial challenges and ensure that services remain local, so that patients do not have to travel to receive their care, I am fully supportive of the merger.

Clare Mehmet

NUHT Patient Representative
25 November 2011

Dear Trust Boards,

As a Patient Representative, Trust Member, Trust Ambassador and service user I believe that if improving care and services is the prime objective of the merger and it will bring about better quality in the outcome of patients wellbeing, then I’m supportive of change that will improve local health services.

Although change and mergers always bring fear and worries for people as they lose their comfort zone. In the real world, care and support should be first class in every aspect and if the merger can improve healthcare then it should be considered with an open mind.

Jayanti Solanki
NUHT Patient Representative
25 November 2011

Dear Trust Boards,

As a service user, a Trust Ambassador, and the Young Persons Patient Representative for Newham University Hospital NHS Trust (NUHT), I am very excited about the proposed merger between Newham University Hospital NHS Trust, Whipps Cross, and the internationally renowned Barts and the London Hospitals.

From seeing first-hand the effort, passion and care put into this merger proposal, as well as the wealth of information provided, I feel very assured that these three NHS organisations are pursuing the best possible option in order to take NHS healthcare provision for us (their service users) one step further in the right direction. The merger focuses upon amalgamating services, values and protocol throughout, which together, should raise the standard of healthcare provision and accessibility to better healthcare services and options for us all.

Working as one Trust would mean that the great values from each Trust would be echoed across the board at all three sites, so the Trusts will work together to ensure suitability, accessibility and provision of great service for all those who use the services provided at the three sites.

For example; having the merger will allow transition and referral for treatments and clinics to run a lot more smoothly, by allowing for services which would normally be located away from one’s local hospital to be provided at one’s local site on particular days. There is also the benefit of allowing access to specialist treatment which may have regularly been restricted to the availability within one’s local hospital, or were often subject to lengthy waiting lists, all in which could no longer be an issue if all three Trusts were merged as one.

With this, patients are able to take advantage of the three Trusts merger and will find they have access to the best care possible. This eases the stress of travelling to receive treatment; especially for patients who would regularly undergo chemotherapy/ radiotherapy treatments etc.

This Merger will allow Barts and The London Hospitals, Newham University Hospital, and Whipps Cross to do exactly what they have been designed to do, which is; to provide the best possible healthcare for their service users and community, and this is a prospect that I as a service user, Trust Ambassador, and Patient Rep am excited to hear has been proposed, and it is a change in which I eagerly await to see come to pass.

Jemma Greenaway
NUHT Patient Representative
25 November 2011

Dear Trust Boards,

I am involved with Newham as a Patient Representative, service user and Trust Ambassador and sit on many of the internal working groups. I feel that the merger will be good for the local public. It will bring lots of benefits to the local populations as well as staff. It will help Trusts to learn from each other and overcome any weaknesses. If the merger can bring all three trusts to a really high standard I think it is a positive change for future healthcare.

Stella Oloyede

NUHT Patient Representative
Merger – Patients' Panel Response

I write on behalf of the Patients' Panel at Whipps Cross University Hospital NHS Trust to give our support to the proposed merger between Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust.

As a patient group, many of our members have attended the various Stakeholder events that have been held to learn of these proposals. We are pleased to note that 'listening to patients' and 'improving the patient experience' is at the heart of the discussions for the merger. We also understand that by merging you will be able to bring together the vast experience of a world renowned teaching hospital such as The Royal London and other specialist services, providing high quality treatment closer to home.

We feel that it is important that each hospital retains its identity within its local community and that where possible patients are treated locally closer to their home so as to minimise the travelling difficulties experienced by certain patients especially those with disabilities and those families with young children.

No doubt by merging there will be significant efficiencies and savings throughout the three hospitals, which must be put to good use to ensure future financial viability. However, we trust there will be no reduction in services and no job losses particularly for front line staff within these proposals. It is important for all staff to be kept informed of these developments to alleviate any job anxieties over the coming months.

We are aware that considerable work is taking place to develop the Governance process together with the Clinical Academic Service Groups. We feel that it is very important therefore to take the best quality standards and practices from each hospital and develop them through the merger process, this should hugely improve patient care and the patient experience. The merger should also provide an excellent opportunity for staff to gain experience and help to retain them in the future when seeking promotion or looking for career development.

Signed on behalf of the Patients' Panel

Colin Anderson BEM
Chair Patients’ Panel, Whipps Cross University Hospital NHS Trust

Interim Chair: Anne Whitaker
Acting Chief Executive: Cathy Geddes
Proposed merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust

Deciding the name of the new organisation
1 December 2011

1. Overview

The name Barts and East London Healthcare merger project was adopted as an interim name following the formation of the merger programme team in early 2011. As part of the approvals process for the merger it is essential that we have agreement on the new trust name in order to make the necessary submissions to NHS London and the Department of Health.

Each of the trusts therefore undertook an internal engagement exercise with their executive and senior managers asking for views on four options, which were:

- Barts and East London Healthcare
- Barts and East London Health
- Barts Healthcare
- Barts Health

Some external views were also sought from local health partners including commissioners and other acute providers in east London.

2. Feedback on the proposed name

The comments received can be reflected in the following key themes:

2.1. Mixed views on the retention of East London

Generally Whipps Cross and Newham staff stated a preference for East London to be retained in the name as it was representative of the diverse community that all three trusts serve. There was also a strong view that the use of East London reduces the anxiety that the merger is a takeover by Barts and The London.

Barts and The London responses preferred to remove the East London reference, but this was in order to support the new business moving forward and the world class aspirations outlined by the clinical teams. These respondents went on to say that the local hospital names must remain as they reflect the community that the new trust will serve.

References were also made that East London seemed to be an ‘add-on’ to the name.

2.2. Length of the name

There was a clear view that the length of the new trust name was an important consideration, particularly when noting that when the new trust attains foundation trust status the name will increase in length.
Those that preferred the shorter names did so as it would be easier to say, easier to spell and clear for all stakeholders.

Many that supported the longer name options indicated that perhaps the ‘healthcare’ or ‘health’ could be dropped when used with NHS Trust. It should be noted that this would not be possible in the legal name of the trust and it was also noted that the use of an ampersand is not appropriate in a trust name.

There was a view shared that the word ‘health’ was too vague and could lead to misinterpretation of the services offered by the new trust. Equally, other views indicated that this was favourable as the approach was to have a more holistic view of the health and wellbeing of local people.

A single view was shared from Newham that Barts and East London Healthcare was simply too long and suggested that we are trying too hard to be inclusive of smaller partners in the trust name when there is a clear direction that the hospital names will be retained.

In total there were 62 eligible responses received from across the three trusts; Barts and The London (14), Newham (20) and Whipps Cross (28). The feedback on each option is reflected below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Staff preferences</th>
<th>Percentage of total who expressed a view</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barts and East London Healthcare</td>
<td>33</td>
<td>53%</td>
</tr>
<tr>
<td>Barts and East London Health</td>
<td>6</td>
<td>10%</td>
</tr>
<tr>
<td>Barts Healthcare</td>
<td>10</td>
<td>16%</td>
</tr>
<tr>
<td>Barts Health</td>
<td>13</td>
<td>21%</td>
</tr>
</tbody>
</table>

2.3. Views of NHS partners in East London

Views were also sought from other acute providers and commissioners in east London: NHS East London and the City, East London NHS Foundation Trust and Homerton University Hospital NHS Foundation Trust. Queen Mary University London, patient representatives and Local Involvement Networks (LINks) have also been asked for a view during the informal engagement process. Where a preference has been expressed there was a view that a shorter name, without East London would be preferred to avoid any confusion in the local health economy with current providers.

2.4. Alternative names

Some respondents took the opportunity to provide alternative names, although this was not a question raised during the engagement process.

Suggestions from Whipps Cross University Hospital NHS Trust
- Barts Hospitals
- Barts NHS Trust
- Barts NHS Foundation Trust
- Whipps Cross, Barts and East London Healthcare
• The London Olympic Trust
• The Olympic Trust, East London
• East London and Barts Trust
• Barts and East London NHS Trust

Suggestions from Newham University Hospital NHS Trust
• Barts and East London Hospitals

Suggestions from Barts and The London NHS Trust
• Barts East London and Community Healthcare (BELCH)
• Barts and The London
• Barts

3. Other considerations to take into account

It is very difficult from the process undertaken to draw parallels in terms of those that have taken the time to respond, their roles in the various hospital trusts and to balance the views of those who have not had an opportunity to input into the discussion. It is also important to note that the process was not a ‘vote’ to determine the name but rather to inform the decision making of the Integration Board.

Another important consideration is that ‘East London’ is owned within the NHS (in terms of registration with the appropriate authorities/regulators) by the East London NHS Foundation Trust which could cause some difficulty in the registration process. We have attempted to get clarity on this, however, differing views have been expressed as the DH branding authority is essentially not agreeing any new names, URLs or email domain names for use until the Health Bill has successfully completed its passage through Parliament (as evidenced by the delay in launching the merger transition website where permission was originally granted and then retracted).

4. Example views from staff

Quotes supporting ‘Barts and East London’ options:

“Barts is important as the recognisable brand name but I feel on its own it fails to convey the message of the reach of the new organisation and its vital focus on the population of East London.”

“Barts and East London Health. Difficult to leave out Barts and if there is no reference to East London, we will make ourselves unpopular.”

“… ‘healthcare’ represents a wide range of services spanning local acute, tertiary and community and there is something more compassionate about having the care on the end of heath to my mind.”

“I prefer Barts and East London Healthcare as it incorporates the identity of the other three organisations more i.e. the Royal London, Newham and Whipps and I agree that on notices and headed paper etc that the site name should be retained.”
“This way it seems less of a takeover from Barts and more inclusive, recognising the other former trusts by their location.”

“I feel very strongly that we need to keep the East London element in the name.”

Quotes supporting ‘Barts’ options:

“Barts Healthcare is my preferred option. I think having just one name might help in breaking psychological barriers and give the sense of belonging to one name/brand rather than Barts and East London Health which may lead to some current held views about staff working at Barts and those working elsewhere.”

“Barts Health - Short, easy to say, easy to spell, clear what it is, people will know where I work if I say this. Not if I say something longer. No doubt about my views!”

“Barts Health or Healthcare - I think that either can withstand further changes in the future. Especially, as you can retain 'Royal London Hospital' 'Whipps Cross' within it. So you have the best of both, and a 'group' ID which is very strong.”

“If we want to rival Mayo clinic etc we need a name which is not geographically tied (while brand tied). As an FT I suspect our ambitions might grow... Guys & Tommys and Kings both have foreign arms now, and the Christie is planning a national cancer provider network...”

“Barts Healthcare - short, simple and recognisable brand but importantly the ‘East London’ is not an add on for the new organisation it is a fundamental part of it hence my dislike of ‘and East London.”

“It is the only option that achieves all the principles set out in the presentation, including becoming an iconic healthcare brand. ‘Barts and East London’ is too long, and the tendency to shorten it to BELH loses the reference to Barts. In London only large DGHs have the population they serve in their names. Barts and East London is equivalent to ‘Guys and South East London’ or ‘Imperial and West London’. These would never happen.”

5. Conclusion

There is a clear consensus that the existing hospital names must be retained. This has already been agreed by the Integration Board and now needs to be communicated clearly to staff and stakeholders.

The Integration Board at their meeting on 30 November 2011 considered the contents of this paper and approved the name of the new organisation as Barts Health NHS Trust.

6. Recommendation

The board is asked:

TO NOTE the contents of the paper