Revised Clinical Strategy for King George Hospital

04 July 2017 (v6)

Strategic Narrative Paper

Key messages

The decision to close the A&E at King George Hospital (KGH) was made in 2011. It is apparent that the factors influencing this decision have changed significantly since the original Health for North East London (HfNEL) decision was made. These factors include both the national policy context as well as the local context, such as changing north east London (NEL) demographics and emerging new models of care.

Therefore a binary approach to decision making, that concludes either to “close” or “not close” the KGH A&E is unlikely to be satisfactory for patients, commissioners and other stakeholders, as it will not reflect these changes. It is also unlikely to meet the Value for Money (VfM) requirement of a business case, per HM Treasury’s Green Book guidance.

In addition, the recent work undertaken in May and June 2017 provides compelling evidence that a new model of emergency care across NEL is evolving with significant emergency care demands. This requires a new clinical model to be developed across Queen’s Hospital and KGH, which will include the determination of the UCC specification. There will be a gateway review and agreement with both Barts Health NHS Trust (Barts Health) and the Barking and Dagenham, Havering and Redbridge CCGs (BHR CCGs) on the clinical model. Once this is developed the implicatio n for key stakeholders, including Barts Health (which run Newham and Whipps Cross hospitals) will be understood.

It is proposed that the key stakeholders remain engaged with BHRUT during the development of the Trust’s updated clinical model.

1. Introduction

The HfNEL review conducted in 2010/11 considered the provision of clinical services across North East London and made a series of recommendations intended to improve clinical care across the region, building clinical and financial sustainability and addressing workforce challenges. Amongst other recommendations, was the proposal that KGH in Ilford, should not continue as a full District General Hospital site and should be transformed into a less acute site providing elective services for BHRUT and local hospital services including an urgent care centre. Neighbouring Queen’s Hospital would be expanded to cater for the activity shift and Whipps Cross Hospital would also be redeveloped.

Accordingly changes were made to the KGH site including the closure of the maternity unit in 2013 with blue light ambulances conveying children being diverted elsewhere. Changing emergency services from a full A&E or ED were consulted upon and received Secretary of State’s approval in 2011, subject to a number of Independent Review Panel (IRP) recommendations being met. Difficulties at BHRUT and in the wider health community meant that it was not until 2015 that this position was reached, at which time a North East London Acute Reconfiguration (NELAR) Board had been established.

The NELAR project determined a need for an enhanced UCC on the KGH site, additional ED capacity at Queen’s Hospital, additional A&E capacity and beds at Whipps Cross and additional beds at Newham. There would also be a need to relocate the current satellite dialysis unit at Queen’s (managed by Barts Health) to facilitate the expansion of Queen’s ED. The project required significant capital funding to allow this building work to take place and it was anticipated that this money would be sought from the Trust Development Authority (now NHS Improvement or NHSI). The NELAR project had a number of sub groups, such as

assurance and workforce, led by key managers within partner organisations, supported by BHRUT.

In October 2016, BHRUT submitted a SOC, on behalf of BHRUT, Barts Health and BHR CCGs, to NHSI for proposed changes to acute services in NEL in October 2016. The regulator recognises that the proposed service change is a priority focus for the local system leadership under the recently submitted NEL Sustainability and Transformation Plan (STP). As part of their final assurance process, NHSI requested the STP to provide further detail on a number of key assurance areas, including initial assessments of activity shifts, capacity, and revenue impact by provider consequent to the KGH reconfiguration and a high-level assessment of the associated net capital investment. Since the original review, BHRUT has experienced improvements in a number of areas. In March 2017 it formally had its special measures status lifted in recognition of the progress and improvements that have been made in t he provision of care. The workforce has been strengthened, with appointments in a number of key clinical areas, including A&E. that have provided stability and improved performance. The Trust has also worked closely with Queen Mary's University London to develop a physician associate's syllabus and has a rolling programme of placements at the trust to support its delivery of care. The Trust is also one of only five trusts nationally to have been selected for the Virginia Mason Institute programme of improvement and has also been selected as a pilot site for a national 'vanguard' project to transform urgent and emergency care

2. Work undertaken in May and June 2017

In May 2017, the STP commissioned further work to complete the SOC that was submitted to NHSI in October 2016, with a focus on providing additional assurance in six areas identified by NHSI (See Appendix A). Led by the STP Programme Director, engagement and weekly progress meetings were held with representatives from East London Health and Care Partnership (ELHCP, which comprises 20 organisations in East London who are working together to develop the ELHCP STP, previously known as the NEL STP), BHRUT, Barts Health, BHR CCGs and NHSI. The STP has recognised the imperative around implementing change at KGH as both a long standing commitment and also the dependencies around change at KGH potentially unlocking strategic planning across the sector as the impact on surrounding organisations is understood.

Based on a detailed urgent and emergency care patient flow analysis specification document, governing the assumptions, approach and data to be used, that was agreed by all parties – an independent analysis of patient flows and impact for the KGH acute reconfiguration was undertaken.

This served to help us understand the shift of A&E attendances and emergency admissions to other nearby sites, what the impact would be on the A&E and bed capacities of nearby sites and providers, and hence the impact on revenues and costs - if the A&E at KGH were to close and be replaced with an enhanced UCC. BHR CCGs are currently preparing a tender for the UCC on the KGH site (which is currently provided by Partnership of East London Cooperative (PELC) until the end March 2018). The UCC specification was finalised (June 2017) and was based on the national UCC specification. However, the findings of the work undertaken in May and June, which underpin this Strategic Narrative Paper, will require the development of a new clinical model for KGH and Queen's Hospital.

Focus was also placed on the remaining areas of additional assurance sought by NHSI, while a high level schedule of accommodation and associated capital costs was undertaken by Essentia Trading Ltd (part of Guys and St Thomas NHS Foundation Trust).

This process was also designed to review the original proposal and decision to close the A&E at KGH, in order to determine how the STP should progress.

3. Key findings

> Please note all details included in this section, pertaining to anticipated activity and capacity changes, financial impact and capex estimates, are based on the 2011 decision to close A&E at KGH.
>
> However, these findings and analysis do support the recommendation in this paper, that a new clinical model is needed. Therefore the activity, financial and other information is provided largely for context and should not to be relied upon for any other purposes.

3.1 Activity

In the event of an A&E closure at KGH – anticipated activity shifting to Newham Hospital is significantly higher than projected in original HfNEL planning and in the 2016 SOC. Activity to Whipps Cross Hospital is lower and marginally decreased for Queen's. Please refer to Appendix A for further details.

Distribution of A&E attendances shifted away from KGH

The model estimates that potentially 25% to 44% of forecast A&E attendances will be retained by KGH and captured by the UCC. The majority of the remaining A&E attendances will shift to Queen's, Newham and Whipps Cross hospitals.

Distribution of non-elective admissions shifted away from KGH

It is assumed that all non-elective admissions will shift to other sites under the reconfiguration. In line with the A&E shift, the majority of patients are likely to go to Queen's Hospital, with the remainder going largely to Newham and Whipps Cross. Using the same methodology as for the A&E attendances to calculate where patients are likely to go, it is estimated that 47 -61% of admissions would shift to Queen's Hospital, 20-25% to Newham and 18-26% to Whipps Cross.

3.2 Capacity

A capacity analysis of additional beds that would be required to accommodate the activity shifts was also undertaken:

Change in non-elective beds

It is assumed that all non-elective admissions will shift to other sites under the reconfiguration. In line with the shift of non-elective admissions, 47-61% of beds shift to Queen's, 15-24% to Newham and 19-31% to Whipps Cross.

As with the shift of non-elective admissions, the key sensitivity determining how much activity goes to each of the three main sites is whether patients go to the nearest site by drive time or by public transport. The wider range than for non-elective admissions is due to the extra sensitivity around length of stay at Newham and Whipps Cross.

Change in critical care beds

It is assumed that all non-elective critical care beds shift to the alternative sites in proportion to non-elective beds. Only non-elective critical care is considered.

3.3 Capital costs (capex)

An initial high level assessment of the associated net capital investment was carried out and a Schedule of Accommodation was developed. The capital costs of providing the additional beds that would be required, is provisionally estimated at c. £120 -125m, substantially higher than earlier estimates based on changing activity numbers, updated approaches and current Health Building Notes (HBNs). HBNs provide best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.

These costs are driven by current pricing (excluding inflation and VAT) but includes a planning contingency and a substantial residual optimism bias.

3.4 Financial impact

Net provider financial impact is marginally negative at £1.6m in 'year 5' (2021/22) (pre-capital cost impact) due to decreased revenues as a result of differing KGH UCC and A&E tariffs and stepped cost increases linked to additional activity and capacity.

3.5 Affordability

A full affordability review will be required at the next stage to review the impact of the capital cost alongside the changes in expenditure required to support this investment.

4. Conclusion and recommendations

Conclusion	Recommendation
A binary approach to decision making, that concludes either to "close" or "not close" the KGH A&E is unlikely to be satisfactory for patients, commissioners and other stakeholders, as it will not reflect these changes. It is also unlikely to meet the Value for Money (VfM) requirement of a business case, per HM Treasury's Green Book guidance. However, it should be noted that this review has not undertaken any further scrutiny of the clinical risk profile or the workforce and thus presents no further evidence on these areas which continue to be managed by the trusts.	Agree that the original decision now needs a changed approach based on a redesigned clinical model, maximising opportunity from existing estate and allowing for the greatest workforce flexibilities.
The recent work undertaken in May and June 2017 provides compelling evidence that a new model of emergency care across NEL is evolving with significant emergency care demands. This requires a new clinical model to be developed by BHRUT, incorporating an integrated UCC specification. Subsequent to the model being developed, there will then be a gateway review and agreement with Barts Health on the revised model and the updated potential impact on Whipps Cross and Newham hospitals. A new staffing model could be developed as part of the new model of care. A significant amount of strategic work has been done to date. The earlier production of an OBC by BHRUT was halted. Should this work be restarted, it will need to have a new clinical model as its strategic position, with the 5 case model built around this for approval.	A new clinical model of emergency care is developed across NEL which builds on the roles of BHRUT, Barts Health in partnership with the CCGs and the potential for the system to offer a comprehensive and efficient urgent and emergency care model. These developments should be taken to OBC level with the clinical model as the driver of strategic change. BHRUT will initiate and lead this work, with support from the sector to understand the impact and other associated developments. Acknowledgement that the development and agreement of the new clinical model represents the initial first phase of the OBC work, while the second phase would involve more detailed implementation planning. It is recommended that a 'gateway' be implemented at the conclusion of the first phase to determine the extent to which other parties would be required to be actively engaged in implementation. This extent would be dependent on the new clinical model itself and the resultant implications on patient flows. Propose that the procurement for the UCC on the KGH site is paused in order that this can take into account the development of the new clinical model.

Conclusion	Recommendation
The decision to close the Accident and Emergency Department at KGH was made in 2011. It is apparent that the factors influencing this decision have changed significantly since the original HfNEL decision was made. These factors include the national policy context (for example the introduction of STPs, changing A&E classifications, the introduction and increased prominence of ACOs and the release of the Naylor Report)) as well as the local context, such as changing north east London demographics and emerging new models of care.	Agreement of output from review and activity estimates as indicative of changes since original decision. .
The likely change in activity resulting from only maintaining an UCC at the KGH site and associated costs suggests that the development of a new model for emergency care is required. Currently KGH UCC is based on the national UCC spec, resulting in a significant activity shift, if these changes are pursued.	Propose that the procurement for the UCC on the KGH site is paused in order that this can take into account the development of the new clinical model. STP to consider emergency care model and impact on surrounding services.
Throughout the development of the change process at KGH and Queen's, substantial capital numbers have been identified. Recent work for the development of this Paper further increases these numbers, including on-costs, non-works and optimism bias to c. £120-125m. These costs are available by organisation; however in light of the above discussion points, judgement will need to be reserved as to reviewing final capital totals with the expectation that a greater concentration of activity at the UCC may result in a requirement for less new capacity across the system. Further NHSI and Treasury approval would be required for any spend above £50m.	Further capital review required through business case development.
There is a programme cost to developing further OBCs which individual organisations with the support of the STP will need to bear the cost of. This is usually in the range of 2-3% of construction costs over the life of OBC and FBC and will include PMO, healthcare planners and costs consultants, commercial advisors and other professional support.	Programme costs considered by the STP based on existing OBC work underway in the system.
Communications are critical as the key messages are complex and require a consistent cross-organisational approach. Support from key stakeholders is essential.	Communications support is an integral part of the PMO that would manage the implementation of acute reconfiguration.

5. Next steps

- The Boards of BHRUT and Barts Health and the Governing Bodies of BHR CCGs, Waltham Forest CCG and Newham CCG are asked to approve the recommendations and conclusions outlined in this Paper.

- The STP to seek clarification with NHS England of the impact of this new approach on the parameters and legality of the original Secretary of State decision with regards to KGH.

- The status of the revised SOC, with additional assurance provided in specific areas sought by NHSI, is to be confirmed at a meeting between BHRUT, NHSI and the STP. This meeting is expected to occur in July.

- BHRUT will develop an integrated clinical model for emergency care including the urgent care component, across its two sites and with community and primary care. Defining patient flow is the core strategic element of the OBC. This model should be built within STP governance structures understanding the impact if any on neighbouring organisations. This will include workforce redesign and an understanding of the best use of available estate. Any commissioning changes and investment will be considered as part of this OBC. Both Barts Health and BHR CCGs will need to consider how the changes may impact on them and should input into the process.

- BHRUT will evaluate a range of options including a status quo "do nothing" option, the development of an updated model of care and the associated capital requirements.

- The STP process would continue to provide overview and support to ensure cohesion across the system.

Appendix A

Please note all details included in parts i) and ii) of this appendix, pertaining to anticipated activity and capacity changes, financial impact and capex estimates, are based on the 2011 decision to close A&E at KGH.

However, these findings and analysis do support the recommendation in this paper, that a new clinical model is needed. Therefore the activity, financial and other information is provided largely for context and should not to be relied upon for any other purposes.

Areas of additional assurance sought by NHSI, upon review of the SOC submitted in October 2016

i) *An initial assessment of activity shifts, capacity, and revenue impact by provider consequent to the KGH reconfiguration. For the SOC stage this should include an initial high-level analysis for each provider impacted - with detail to be built upon later in the business case process.*

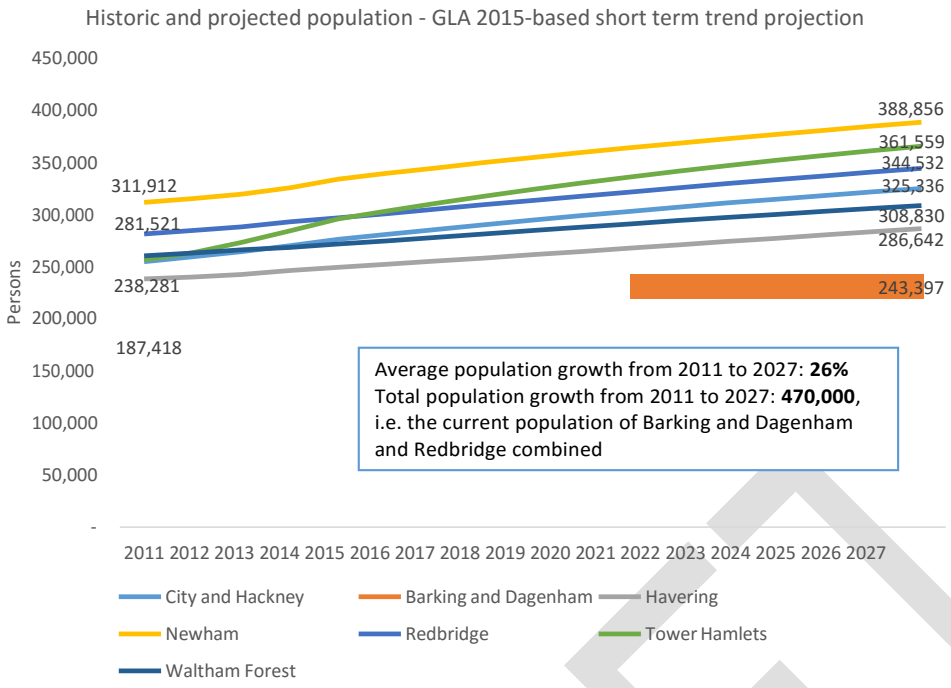
Please see Section 1.3 above.

Population growth

Since 2011, the population in North East London has grown by an average of 1.8% per year, faster than the average population growth of 1.4% per year across Greater London. Tower Hamlets has grown the fastest, at 3.2% per year, while Waltham Forest has shown the slowest growth, at 1.1% per year, and the population in Barking, Havering and Redbridge has grown by an average of 1.4% per year, with the fastest growth of 1.9% per year in Barking and Dagenham, and the slowest growth of 1.2% in Havering.

Over the next 10 years, the population in North East London is projected to grow at an average of 1.3% per year, faster than the average population growth of 1.1% per year across Greater London. The population of Barking, Havering and Redbridge is projected to grow by an average of 1.3% per year, with the fastest growth of 1.5% per year in Barking and Dagenham, and the slowest growth of 1.2% in Havering.

The graph below projects the estimated population growth in the respective boroughs:



Distribution of A&E attendances shifted away from KGH

	2010 analysis		2016 analysis*		Refreshed analysis, projected to 2020/21 (central projection)*		Refreshed analysis, projected to 2020/21 (range)*	
	Change in number of attendances	% of KGH activity	Change in number of attendances	% of KGH activity	Change in number of attendances	% of KGH activity	Change in number of attendances	% of KGH activity
Queen's	33,604	82.0%	42,369	59.8%	35,532	56.2%	20,661-35,875	44.1-58.2%
Whipps Cross	4,099	10.0%	18,519	26.1%	12,205	19.3%	8,674-16,899	18.5-26.7%
Newham	3,279	8.0%	9,971	14.1%	14,245	22.5%	10,001-17,442	21.3-27.3%
Other	5	0.0%			1,288	2.0%	895-1,338	1.9-2.1%

The analysis uses five sensitivities (demographic growth rates, number of KGH A&E attendances shifting to the UCC, patient mode of transport, length of stay, and amount of diversion from KGH) around a central projection, to give a range of potential outcomes.

The central projection used in the analysis assumes that 45% of forecast minor A&E attendances (25% of total A&E attendances) will be retained by KGH. For attendances which are not retained by KGH, the central projection assumes that walk-in attendances go to the next nearest site by public transport from their approximate home location, whilst ambulance attendances go to the next nearest site by drive time.

Under these assumptions, it is estimated that 56% of shifted A&E activity would go to Queen's Hospital, 19% to Whipps Cross and 23% to Newham. However, results are highly sensitive to these assumptions. For example, the model estimates that assuming walk in patients use private vehicles instead of public transport would decrease the A&E attendances at Queen's by approximately 18%, in conjunction with an increase in attendances at Newham and Whipps Cross by 17% and 32% respectively.

This analysis was carried out using approximation of patient's home location by GP, or postcode district if GP data is not available, to map out the catchment population across the providers.

The relevant proximity of facilities may also contribute to a specific patient flow dynamic resulting from A&E referrals.

Distribution of non-elective admissions shifted away from KGH

	2010 analysis		2016 analysis*		Refreshed analysis, projected to 2020/21 (central projection)		Refreshed analysis, projected to 2020/21 (range)	
	Change in number of admissions	% of KGH activity	Change in number of admissions	% of KGH activity	Change in number of admissions	% of KGH activity	Change in number of admissions	% of KGH activity
Queen's	17,298	68.0%	9,805	60.8%	9,000	58.6%	7,243-9,391	47.1-60.6%
Whipps Cross	4,419	17.4%	4,491	27.9%	2,884	18.8%	2,745-4,037	17.9-26.0%
Newham	2,961	11.6%	1,825	11.3%	3,180	20.7%	3,027-3,856	19.7-24.9%
Other	758	3.0%			290	2%	275-301	1.8-2.0%

Similar to the analysis on the shift of A&E attendances described above, the key sensitivity impacting the shift in activity for the three main sites is whether patients drive or use public transport. Assuming patients will go to the next nearest site by public transport, rather than by drive time, increases the shift of patients to Queen's rather than to Newham and Whipps Cross. There may also be a further shift of patients to Queen's, due to patients arriving at KGH who are not suitable for the UCC and are diverted to Queen's as the next nearest A&E from KGH and subsequently admitted.

Separate conversion rate assumptions for walk in and ambulance arrivals have not been included, so the impact of using public transport rather than driving may be overstated.

Change in non-elective beds

	2016 analysis	Refreshed analysis, projected to 2020/21 (central projection)	Refreshed analysis, projected to 2020/21 (range)
Queen's	139-143*	134	107-140
Whipps Cross	73	46	44-72
Newham	24	45	34-55
Other		4	4
(KGH non-elective beds)		(229)	(231)-(225)

Change in critical care beds

	2016 analysis	Refreshed analysis, projected to 2020/21 (central projection)	Refreshed analysis, projected to 2020/21 (range)
Queen's	3	5	4-5
Whipps Cross	1	2	2-3
Newham	1	2	1-2
Other		0	0
(KGH critical care beds)		(8)	(8) – (8)

Financial impact

Revenue includes non-elective admission revenue from spell tariff, best practice tariff and excess bed days; additional critical care revenue for non-elective admissions is not included, and critical care costs are also excluded.

Only variable costs move with the patient, so there is a net positive financial impact on the alternative A&E sites. Stranded short-term, variable long-term costs have been treated as variable in this analysis.

Potential impact on revenue and costs in year 5 (2021/22) – central projection

		KGH A&E	KGH UCC	Queen's	Newham	Whipps Cross	Other sites	Total
Revenue impact								
A&E revenue	£m	(12.4)	1.4	5.6	2.2	1.9	0.3	**(1.1)**
Non-elective revenue	£m	(34.2)	-	20.2	6.8	6.6	0.6	-
Total	**£m**	**(46.6)**	**1.4**	**25.7**	**9.1**	**8.5**	**0.8**	**(1.1)**
A&E cost impact								
Pay	£m	7.5	(0.9)	(3.7)	(1.5)	(1.3)	(0.0)	-
Drugs	£m	0.3	(0.0)	(0.1)	(0.1)	(0.0)	(0.0)	-
Diagnostic support	£m	1.1	(0.1)	(0.6)	(0.2)	(0.2)	(0.0)	-
Other non-pay	£m	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	-
Overheads	£m	0.3	(0.0)	(0.1)	(0.1)	(0.0)	(0.0)	-
A&E subtotal	**£m**	**9.2**	**(1.1)**	**(4.6)**	**(1.8)**	**(1.6)**	**(0.1)**	-
Non-elective cost impact								
Pay	£m	18.7	-	(11.1)	(3.9)	(3.7)	(0.3)	**(0.4)**
Drugs	£m	1.2	-	(0.7)	(0.3)	(0.2)	(0.0)	**(0.0)**
Diagnostic support	£m	1.2	-	(0.7)	(0.2)	(0.2)	(0.0)	**(0.0)**
Other non-pay	£m	4.7	-	(2.8)	(1.0)	(0.9)	(0.0)	**(0.1)**
Overheads	£m	-	-	-	-	-	-	-
Non-elective subtotal	**£m**	**25.8**	**-**	**(15.4)**	**(5.4)**	**(5.0)**	**(0.5)**	**(0.5)**
Net impact	**£m**	**(11.6)**	**0.3**	**5.8**	**1.9**	**1.9**	**(0.2)**	**(1.6)**

ii) Initial high-level assessment of the associated net capital investment supported by appropriate analysis and advice. Review that proposed capex requirements are essential and not excessive.

Please see Section 1.3 above.

Capital costs (capex)

	Queens		Newham		Whipps Cross		Total	
	Option 2A: ED New Build	Option 2B: ED Refurb	Option 2A: ED New Build	Option 2B: ED Refurb	Option 2A: ED New Build	Option 2B: ED Refurb	Option 2A: ED New Build	Option 2B: ED Refurb
Cost excluding VAT and inflation (£m)	73.8	71.5	25.3	24.5	25.4	24.7	**124.5**	**120.7**

The Schedule of Accommodation sets out two Options for each of the sites. Option 1 provides 100% single inpatient beds and Option 2 50%.

It has been understood and assumed that the Inpatient beds will be New Build, Critical Care will be reconfigured existing accommodation and that the Emergency Department can either be New Build or Refurbishment.

Only the Capex Requirements for Option 2 (50% Singles) was reviewed and then provided the two sub-options for ED either being provided in New Build (Option 2A) or Refurbished (Option 2B) space.

For Option 2B the departmental costs for the refurbished ED - the baseline position is taken at a benchmark abated rate of 0.60. This assumes a significant element of reconfiguration will be required rather than simply refurbishment.

The health planners have also sensitised the comparative Scheme Costs should the abatement rate be changed to a lower rate of 0.4 (assuming refurbishment only) and a higher rate of 0.7 (with more extensive reconfiguration). However given the ED only represents 10% of the overall area requirement these changes do not significantly impact the bottom line.

iii) the latest risk assessment and NEL STP system mitigation plan for non-elective care services delivered at the KGH site;

The STP needs to highlight the importance of a robust risk management process to ensure that all key risks are identified and proper mitigation plans are in place for the reconfiguration programme. This is particularly crucial as BHRUT are expected to experience an activity loss, while requiring significant investment at Queen's.

Both BHRUT and Barts Health (particularly at Whipps Cross also continue to experience recruitment challenges – due in part to the national imbalance between emergency medical workforce planning and provider requirements across England.

The STP recognises that the acute service reconfiguration programme requires careful monitoring of delivery to ensure that proper controls are in place to mitigate associated risks. As with other system-wide programmes, a robust proactive risk management process should be established under the NEL STP, with the register of key risks reviewed on a monthly basis by the Programme Board to ensure ownership of Programme risks and to provide assurance that risks are being effectively mitigated.

The table below provides a preliminary risk assessment for key risks associated with KGH acute reconfiguration programme of the non-elective care services, and the relevant risk controls.

Objective	Risk	Mitigation plan and controls
Provide positive patient experience	• Delayed patient access to acute care • Inability to meet targets for delivering quality, sustainable and safe services to the patient • Ineffective governance arrangements which would impact service delivery for the Programme or do not effectively transform service delivery	Establish the STP clinical governance framework and system wide strategy to: • Identify and manage potential significant incidents or adverse events as a result of reconfiguration of acute services in the local community • Support the local evaluation of non-elective care service standards including the enabling of clinical audit programmes at the organisational level • Support the implementation of quality and safety urgent care service programmes • Support overall clinical effectiveness of emergency care services in NE London through supervision and monitoring • Enable waiting time policies and other efficiency programmes and continuously monitor performance of services in support of mitigating any disruptions resulting from service unavailability and displaced activity.
Achieve financial sustainability	Failure to deliver the required levels of efficiency gain, or maintain financial control and deliver on financial targets	Controls for mitigating financial risks include: • Agreement of the model that assesses the impact of the closure of the A&E at KGH on the three relevant EDs • Financial strategies for the organisations in support of the programme • Lines of financial accountability for relevant stakeholders engaged in the programme governance • Urgent care and A&E delivery plans • Finance monitoring reports raised to internal project board and project groups • Efficiency programmes supported by the STP wide collaborations • Liquidity plans for the organisations to support in delivering on the reconfiguration programme in NE London. • Audit of financial control on a regular basis and external audit review of annual financial positions for the organisations
Deliver best possible outcomes for the local community through effective collaboration of partner organisations	Failure in realising the STP transformational benefits and achieving system wide financial and qualitative suitability	Active involvement of the organisations in the non-elective care transformation programme through: • Effective collaboration for delivering on the STP programme supported by the ELHCP Partnership Agreement • Regular updates to the appropriate project office support teams as well as to the overall Programme Board.

Deliver continuous performance improvement	• Failure to establish continuous performance improvement • Inability to improve sustainability of services	Establish an appropriate performance management framework, including an improvement programme for Urgent Care at KGH and the quality of care at Queen's Hospital.
Reduce agency spend and improve workforce stability	• Both BHRUT and Barts Health (Whipps Cross and Newham) are heavily reliant on agency staff • This may reduce service quality and impacting the delivery of the programme's objectives	As part of the reconfiguration programme, develop a workforce plan to deliver on medical staff recruitment and retention programmes.
Achieve best possible outcome through effective communication	• Failure to build the necessary stakeholder support resulting in opposition to clinical change	• Effective clinical and staff engagement during planning ensuring the clinical narrative is robust and clinically led • Developing an effective communication action plan with agreed arrangements for strategic and tactical communications both proactive and reactive
Agree a planning and implementation process that supports the STP ambition	• There are a number of complex developments underway that may impact the delivery process of the project	• Agree the governance and decision making processes for the planning and implementation of the project

iv) Information on the evolving STP system approach to mitigating any negative financial impact at an individual provider level.

Business cases for each of the partner organisations will consider the impact on operational finances by incorporating appropriate activity and financing assumptions.

The current context in NEL must be framed in light of the existing financial envelope with alignment to prioritised developments for the STP, the Naylor Report (on NHS property and estates) as well as other existing plans in NEL (for example the Whipps Cross redevelopment SOC).

v) The reconfiguration programme master timeline to support a successful case for change, underpinned by individual statutory organisation accountability for delivery

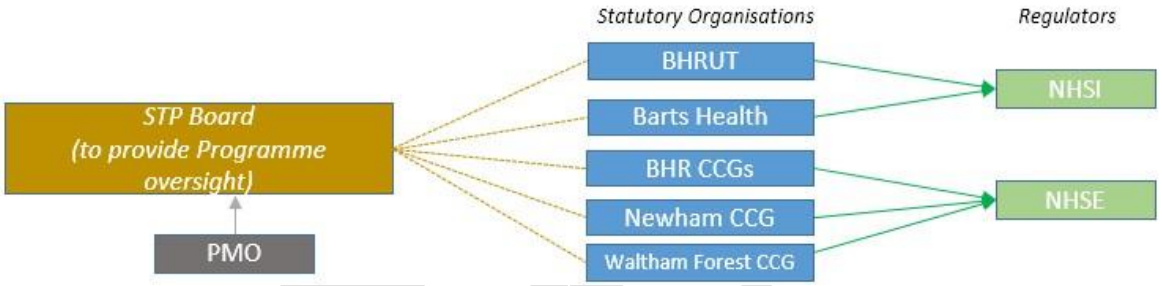
and key delivery dates by individual organisation towards the overall programme master timeline.

Subject to the status of the revised SOC (per Section 5. Next Steps, above) - while the Boards of BHRUT and Barts Health as well as the governing bodies of BHR CCGs, Waltham Forest CCG and Newham CCG will be asked to consider and approve the recommendations of this Paper, the completed SOC will also require approval from the STP Project Board by the end of September. NHSI expect to receive SOC in October and further approval required if the financial case is greater than £50m, as is anticipated.

Individual OBCs (to evaluate a range of options) for each organisation to commence no earlier than December 2017.

vi) Clarity on a robust STP governance and delivery framework to provide collective oversight and accountability for the implementation of the changes.

To ensure cohesion, interdependent processes (e.g. Whipps Cross business cases, the KGH UCC spec, BHRUT's updated model of care) will require overview at STP-level.



Internal governance timetables in mid-2017

Organisation	*Board / Governing Bodies*
BHR CCGs	
- B&D CCG	18 July 2017
- Havering CCG	12 July 2017
- Redbridge CCG	20 July 2017
Barts Health NHS Trust	13 September 2017
BHRUT NHS FT	6 September 2017
Newham CCG	11 October 2017
Waltham Forest CCG	27 September 2017