NHS Ealing and Harrow Community Services

NHS Ealing Hospital NHS Trust

NHS Harrow

NHS Ealing

Integrated Care Organisation

Business Case

Part 1

"Committed to Local Healthcare"

A) Executive Summary

This Business Case sets out an exciting vision of new ways of providing health care by a new type of health organisation.

An Integrated Care Organisation, combining acute and community services, will focus on excellent care, locally managed, for our populations. It will integrate the majority of the services that are currently run by the two primary care trusts, NHS Harrow and NHS Ealing, and Ealing Hospital NHS Trust.

It is completely in line with the Healthcare for London strategy, that where possible, routine healthcare services should be delivered locally, with some specialist acute services only being available at central locations. It sets out to be ahead of the curve, anticipating major changes in the running of acute hospital services in this part of London.

It responds to the national strategy to provide more care outside hospital – not by retrenching, but by deliberately setting out to re-shape the way care is provided for many common and long-term conditions. It relies on clinicians from different disciplines and historically different settings working together to break down barriers that have traditionally got in the way of the best care for patients. This is not guaranteed to be easy, but the benefits for patients of arranging care around them, rather than our institutions, will be worth the effort.

Whilst integration of community and acute health services defines the new organisation, its chosen way of working will be to also provide integrated care with colleagues in primary care and social care. It will challenge professionals to provide people with continuity of care across these longstanding divides. It will continue to have a strong borough basis, building upon existing integrated arrangements with the Local Authorities.

The Integrated Care Organisation provides an opportunity to develop clinical practice, and individual skills, bringing established good practice from one area to another – whether this is between teams in different geographical areas, or in hospital and community settings. It will also offer new career pathways and new job roles, as we develop new ways to meet patients' needs.

Another innovation is the aim to incentivise health care organisations to provide care outside hospitals. Having an organisation with arms in both hospital care and community care means that commissioners can work together with the provider to shift resources and care in ways that are not stifled by pricing structures that only recognise activity that happens in hospital. Committing to move money into the grey area between primary and

secondary care is a crucial part of the strategy behind creating the Integrated Care Organisation.

Using money wisely by sharing support functions and reducing the overheads of separate organisations is another motivation for this change. Together with making the best use of clinical resources, this is a necessary response to the worsening financial climate for health care, along with the rest of the economy. The consequences of the highly challenging financial position over the coming five years will have to be faced, whichever organisational form is chosen. But choosing a form that brings clear financial gains in the short term, as well as opportunities for more gains in the longer term as care is re-designed, is a sensible move to make.

The aim is to create an organisation that is large enough, and flexible enough, to stand on its own, while enabling significant changes in services to take place. The role of Ealing Hospital is expected to change in the coming years, as it develops its role as a local hospital, and some other hospitals become more major centres for acute care. Managing this change locally, and staying focused on the long-term needs of our diverse local populations is key to sustaining high quality care for Ealing and Harrow. There will also be opportunities to provide more community services, particularly in Harrow, and to extend into new areas, as a stronger competitor, by combining community and acute clinicians and the skills they bring.

We can expect significant changes in community services too – in fact there is a big need to do this, and a strong expectation. Whether this is in response to the changing pattern of our workforce, or the chance to use new technology and make the best use of scarce skilled staff, strengthening our multi-disciplinary working and promoting innovation will play a significant role.

Concentrating on community services is behind the move to separate the provider functions of primary care trusts from their commissioner functions. This national policy forces us to find new organisational frameworks within which to run services. Similarly, the move for all acute hospitals to be run within Foundation Trusts, when Ealing Hospital Trust is one of the smallest acute hospitals in London, means that the acute services also need to find a new organizational framework to work within.

In this Business Case, we examine all of these drivers and opportunities. A range of possible organisational solutions has been assessed. All of them would involve significant changes in organisations, involving mergers of one form or another, to achieve organisations that are viable clinically and financially.

The provider organisations have each assessed the Integrated Care Organisation as the best solution from their perspectives. This is demonstrated in the Business Case, alongside other potential scenarios. But it is also important to recognise that the main commissioners of care, the primary care trusts, also see this as a way to design an organisation capable

of being commissioned to provide integrated care in the best possible way, with the right mix of professionals, and the right incentives.

The conclusion of the health organisations in Ealing and Harrow is that creating an Integrated Care Organisation is the best possible way of managing these important changes if they are to lead to the best possible care for patients.

There will be further, more detailed planning and assurance undertaken in the coming months. However, this is the main decision point.

Achieving this is not going to be easy, and there are also major risks considered in the Business Case. There is also not a large span of time before April 2010, the target date for the “new” organisation to emerge.

Formally we will be using the statutory framework of Ealing Hospital NHS Trust – with a new operating name, new legal purposes and new management arrangements – and the majority of staff from the two primary care trusts joining (technically by a transfer), to create the “new” organisation that will be the Integrated Care Organisation.

Structural change can only be an enabler - something which makes a positive change more likely to happen. It will be for the staff, leaders and partners of the new organisation to really deliver the benefits together.

B) Structure of the Document

Part 1

A) Executive Summary

B) Structure of the Document

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Section 1
Introduction & Purpose of this Document

1.1 Introduction

This document is the business case for the formation of a new Integrated Care Organisation, which joins together the community and acute hospital services currently provided by NHS Ealing, NHS Harrow (working together as Ealing and Harrow Community Services) and Ealing Hospital NHS Trust. This paper builds on the extensive work undertaken in partnership by the 3 statutory NHS organisations over the course of the past year.

The paper describes the need for change, driven by a number of national and London wide initiatives to improve the effectiveness, efficiency and quality of NHS service delivery. It reviews the potential options for the acute hospital services in Ealing and the community service provision across the Boroughs of Ealing and Harrow.

The Business Case illustrates the financial sustainability and commercial viability of the Integrated Care Organisation (ICO) as the preferred organisational model to deliver the services currently provided by Ealing Hospital Trust (EHT) and Ealing and Harrow Community Health Services (EHCS).

The paper makes a number of recommendations for approval by the Boards of NHS Ealing, NHS Harrow and Ealing Hospital NHS Trust.

The creation of the ICO aims to facilitate the integration and development of services locally in partnership with local primary care providers, social care services, other Local Authority services, the Voluntary Sector, the 3rd Sector more broadly, public, patients and other partners. The ICO (subject to Board approval) will be operational from the 1 April 2010 with a comprehensive timeline to integrate services over the next 2 to 3 years.

NHS Ealing, NHS Harrow and Ealing NHS Trust have been working together to develop an appropriate organisational model for acute hospital and community health services that is fit for purpose and capable of responding to the challenges described in this document.

The Integrated Care Organisation will be formed from the 'shell' of Ealing Hospital NHS Trust (EHT) with the PCT provider services transferring into the 'shell' so that together a 'new' organisation is formed.

1.2 Purpose of this Document and Recommendations

The purpose of this document is to provide the Boards of NHS Ealing, NHS Harrow and Ealing Hospital NHS Trust with sufficient assurance that the proposed option is the optimal solution for developing services for the local populations across the London Boroughs of Ealing and Harrow.

The Boards of NHS Ealing, NHS Harrow and Ealing Hospital NHS Trust are asked to:

1. Approve the Business Case for the development of an Integrated Care Organisation by transferring the provider services from NHS Harrow and NHS Ealing into an Integrated Care Organisation using Ealing Hospital NHS Trust as the "shell" organisation.

2. Authorise work to produce a Full Business Case to be agreed by Boards in late February or early March, which will take the final decision, dependent upon:
    a. Agreement of the legal transfer document
    b. Satisfactory due and careful enquiry
    c. Consultation with PCT staff on the arrangements for the staff transfer which will straight after the November decision.
    d. Approval by NHS London following review by the national Co-operation and Competition Panel.

3. Re-confirm that authorization is delegated to Chairs and Chief Executives through the Project Board to manage the programme to create the Integrated Care Organisation.

Section 2
The Drivers for Change

2.1 Introduction

In Section 2 we provide an overview of the national, London regional and local drivers for change. The local implications of these drivers are then considered in more detail in Section 3 where we review how we are responding locally and how the ICO will facilitate this.

2.2 National & London-wide Context for Change

This section reviews some of the key national and London regional drivers for change and considers the impact on the way services will have to be provided locally. The main drivers are:

Healthcare Strategy:

- *Healthcare for London – A Framework for Action (July 2007)* - The strategy for the capital:
- Healthcare for North West London – Bringing about changes to Acute Hospital Services in North West London
- Transforming Community Services – The national strategy to bring about radical change in community services
- Increasing competition and choice in the market for Acute & Community Services - a national strategy

These healthcare strategies require us to transform the way services are delivered, with more care provided closer to people's homes, particularly for long-term conditions, with greater sub-specialisation and centralisation of more complex care on fewer hospital sites, to ensure effective service delivery and the best possible health service locally.

Healthcare Policy:

- All NHS Trusts are expected to achieve Foundation Trust status by 2010/11.
- Separation of PCT Provision from PCT Commissioning

These policies mean that there must be a change to the current organisations.

The Financial Context:

- Responding to the Financial Outlook

The NHS is not immune from the global financial downturn and services need to be provided in the most cost effective way, ensuring value for money for the taxpayer. This financial outlook will need to be responded to by major changes in provision, whichever organisational form is chosen.

The Local Context:

- Health Needs of the People in Ealing and Harrow
- Commissioners' aspirations to shift care out of hospitals, and to use financial incentives in their contracts to bring this about

Responding to the health needs of the local population demands some radical shifts in the way care is provided. By joining acute and community services within one organisation, the commissioners will be able to incentivise more care to be provided outside hospital.

These drivers are altering the environment within which NHS organisations are operating. All NHS providers need to respond to these drivers to ensure that they have the capability and capacity to deliver high quality services that are accessible, affordable, responsive, safe, and lead to a reduction in health inequalities.

It is within this changing environment that NHS Ealing, NHS Harrow, and Ealing Hospital NHS Trust have been working in partnership during 2009 to develop an appropriate organisational model for acute hospital and community health services that is fit for purpose and capable of responding to the challenges described above.

In Section 3 we look at these drivers in some more detail and what they mean for services locally, and go on to describe how creating an ICO would bring about positive changes.

Section 3
How Ealing & Harrow are Responding to the Drivers for Change

3.1 Introduction

In Section 3 we review in more detail the national and, London-wide drivers for change and how Ealing and Harrow are responding to the drivers for change.

3.2 Healthcare for London

In *Healthcare for London – A Framework for Action (July 2007)* Lord Darzi identified eight reasons why the time was right for a co-ordinated programme of change across London:

1. The need to improve Londoners' health
2. The NHS is not meeting Londoners' expectations
3. One city, but big inequalities in health and healthcare
4. The hospital is not always the answer
5. The need for more specialised care
6. London should be at the cutting edge of medicine
7. Not using our workforce and buildings effectively
8. Making the best use of taxpayers money

The report took into account the views of patients, public, staff and partner organisations, and considered national and local patient and public surveys and identified 5 principles in developing *A Framework for Action*:

1. Services should be focused on individual needs and choices
2. Services should be localised where possible and regionalised where that improves the quality of care
3. There should be joined-up care and partnership working, maximising the contribution of the entire workforce
4. Prevention is better than cure
5. There must be a focus on reducing differences in health and healthcare.

The report also highlighted some compelling observations as to why the provision of health services was not world class.

- London has one of the smallest average catchment populations per hospital in the country.
- Productivity levels in London are lower than elsewhere in England e.g. doctors in a large acute hospital in London see 24 per cent fewer patients than their counterparts.

- Staff are not employed in ways that make it easy for them to move between hospital and community settings.
- The NHS estate is a huge and hugely under-utilised resource.

On this basis *Healthcare for London* proposed the following way forward, which is now being actively implemented across London under 2 major themes:

1 Provide a new kind of community-based care at a level that falls between the current GP practice and the traditional district general hospital providing a greater range of services.

2 Develop hospitals that are more specialist, delivering excellent outcomes in complex cases.

Healthcare for London also highlights that "many of our district general hospitals try to provide a wide range of specialist care, [and] there are simply not the volumes of patients with complex needs to make this either viable or as safe as possible for patients. We need fewer, more advanced and more specialised hospitals to provide the most complex care, some linking directly into universities to foster research and development".

Healthcare for London therefore proposed seven models of provision for the future:

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

Based on the above as well as all of the other drivers in this section, the stage is set for major change across London's health system.

The implementation of this change programme has already commenced. *Healthcare for London* launched a major healthcare consultation *Consulting*

the Capital from November 2007 to March 2008 and specific consultation on Stroke and Major Trauma Services, *The Shape of Things to* Come from January 2009 to May 2009.

As a result of this consultation there will be four major trauma centres that will treat the most seriously injured patients. Patients with less serious injuries will continue to be treated by their local A&E departments. Each local trauma service will be linked to a specialist centre as part of a network designed to share expertise and resources.

Ealing Hospital has already been designated as a local hospital, which means that, for example, our local Trauma Centre will be St Mary's Hospital, to ensure that patients get the best possible trauma care. Patients with more minor trauma, such as a broken arm can continue to be treated safely at Ealing Hospital, Northwick Park Hospital and elsewhere.

It is within this context that NHS Ealing and NHS Harrow are re-shaping their provider landscape for the benefit of the local population, to provide the best possible local care for local people.

Implications Locally

How the ICO will help deliver *Healthcare for London*

The main theme is care closer to home with much more care outside the hospital setting and centralisation of specialised care for complex cases in order to raise standards and quality of care provided.

The proposed Integrated Care Organisation (ICO) will respond by:

a) Streamlining the care pathway and breaking down barriers to service delivery by having integrated care pathway teams for chronic conditions such as respiratory disorders, diabetes, and heart failure. This will reduce the need for patients to make multiple visits simply to see different health professionals.

b) Facilitating hospital-based clinicians, including consultants, to work with primary and community health service colleagues in a range of settings to manage patients and reduce admissions to hospital. The ICO will also provide advice in ways that prevent unnecessary travel for both staff and patients, such as telephone advice, e-mail and electronic exchange of information.

c) Providing more appropriate care in more affordable surroundings, closer to where people live and thereby deliver care more cost effectively.

d) Providing care across the whole pathway, for long-term conditions such as COPD and Diabetes, will enable care to be commissioned in ways that dis-incentivise multiple attendances and hospital admissions and incentivise efforts to help patients be managed at home.

e) Working in partnership with major acute hospitals to ensure that local people have access to high quality sub-specialty care when they need it, with as much of that care as possible being delivered close to home, even if they need to visit a major centre for a complex procedure.

3.3 Healthcare for North West London - Reviewing Acute Hospital Services in North West London

As Healthcare for North West London, a review has commenced of the configuration of acute hospital services across this part of the capital.. This review is focused on local population need and the wider strategic context facing small acute providers and is expected to lead to:

- A reduction in the number of acute hospital organisations
- Some acute hospitals not being able to achieve Foundation Trust status in their current configuration
- Re-configuration of more specialist acute services, being provided on fewer sites for large populations (e.g. stroke and trauma services)
- Re-configuration of acute services, for example planned surgery being concentrated on fewer sites, and similarly emergency surgery or inpatient paediatrics.
- Consequent changes to patient flows to different hospitals and accident and emergency units
- Local Hospitals maintaining a full range of outpatient and diagnostic services
- Potential for more than one acute provider operating on some hospital sites

Implications Locally

How the ICO will respond to the reconfiguration of Acute Services in NW London

Ealing Hospital NHS Trust is the smallest acute trust in London, and although successful in delivering good clinical care, and financially sound, it has patchy performance against targets. The drive to greater sub-specialisation in several acute specialties, and other changes such as the implementation of the European Working Time Directive have meant that the viability of some acute services at small acute hospitals is questionable in the long term.

a) The ICO sets out a new focus for local healthcare, concentrating on excellent integrated care close to home and at home.

b) The ICO provides an organisation of sufficient size for the local health economy to benefit from economies of scale. One of these benefits is that the ICO would be able to withstand the loss of some acute services to other organisations, without destabilising financial viability. At the same time, the, community services are currently in small units, and will benefit from economies of scale by being part of an ICO

c) Most Harrow residents receive their acute care from North West London Hospitals NHS Trust (NWLHT), mainly delivered at Northwick Park Hospital. This is expected to continue. The ICO will work with NWLHT to ensure that patients who need hospital care at Northwick Park Hospital receive a service which is 'joined up' with community services to make sure they are cared for at or near home whenever possible with easy access to specialist support either from NWLHT or from clinicians of the ICO.

d) The creation of the ICO will increase the capability of the community services in Harrow to provide more intensive care at home, for example by utilising support from acute clinicians within the ICO. It will also increase the potential for some services currently run by NWLHT to be run by a strongly community services focused organisation, for example community therapy services, some services for children, or sexual health services.

e) In the longer-term the ICO also provides the potential to run services in other boroughs, for example Brent.

3.4 Foundation Trust Status

It is national policy that all NHS Trusts are expected to achieve Foundation Trust status by 2010/11, and be governed in this new way.

EHT originally intended to become a Foundation Trust in its own right. However, since the first submission for FT status by EHT the healthcare environment has changed dramatically.

An application to become a Foundation Trust (FT) was submitted on I October 2007, which received Strategic Health Authroity (SHA) approval. Deloitte completed the due diligence phase and the Monitor assessment

phase began. The Trust undertook further work during the summer of 2008, but in November 2008 the SHA expressed the view that EHT could not achieve Foundation Trust status in its current form, given the changes being put forward across London under the *Healthcare for London* strategy..

In January 2009 the EHT Board made the decision to withdraw the Trust's FT application on 28th February 2009. At that time the Board considered 3 possible ways forward: (i) merger with an existing NHS Trust, (ii) acquisition by a Foundation Trust or, (iii) vertical integration with Ealing PCT's provider arm. EHT's conclusions on these options is set out in section 4.2. EHT's process to becoming an ICO as a route to Foundation Trust status is described more fully in Attachment 1.

Implications Locally

How the ICO will achieve Foundation Trust Status

The ICO is being developed in a way that will enable it to meet the criteria required of a successful Foundation Trust application. In summary it will be:

- Financially viable with a 5 year financial model that enables it to withstand a range of possible futures, including a 'downside scenario'
- Clinically stable, providing a range of high quality services which meet best practice standards, either alone or in partnership with others
- Well governed - with a leadership team capable of delivering a challenging business case whilst properly managing clinical and financial risk
- Able to meet its duty to work in partnership with other local health and social care organisations as part of the North West London sector.

3.5 Separation of PCT Provision from Commissioning

The NHS Operating Framework for 2008/09 set out the requirement for all PCTs to "create an internal separation of their operational provider services, [and] agree SLAs based on the same business and financial rules as applied to all other providers".

In April 2009 all PCT provider services moved into a contractual relationship with their PCT commissioners under the 2009/10 national contract for community services. This meant ensuring sufficient separation of roles within the PCT to avoid direct conflicts of interests.

By October 2009, PCT provider services were expected to have reviewed their long-term future, and proposed the most appropriate organisational form for their services.

The view from the Department of Health is that it would be inappropriate to create new NHS Trusts for community services, as this would run contrary to current policy for the development of NHS Foundation Trusts. The only exception would be as the intermediary stage necessary to the process of moving to Community Foundation Trust (CFT) status. (*Source: Transforming Community Services; Enabling new patterns of provision -13 Jan 2009*).

This policy shift away from PCTs providing care directly to focus on commissioning means that the way community care is organised in Ealing & Harrow has to change.

Implications Locally

How the ICO will achieve Separation of Commissioner from Provider

Ealing and Harrow Community Services (EHCS) was established as an autonomous provider organisation (APO) on 1st April 2009, as per national policy. The EHCS APO arrangement is still part of the structures of NHS Harrow and NHS Ealing, with accountability to their Boards. The APO demonstrated it had successfully achieved a degree of autonomy from its PCTs, being awarded 'business ready' status in October 2009. However full separation as soon as possible is still required to allow both commissioners and providers to focus on their distinct role, and remove a conflict of interest.

The establishment of the ICO will

a) Achieve complete separation between commissioners and providers. NHS commissioners locally, will be able to concentrate in becoming world-class commissioners as per the World Class Commissioning Assurance programme.

b) Achieve this between one and three years sooner than options which involve forming a new Foundation Trust, or a new Social Enterprise.

c) Prevent the need to establish a whole new organisation – which would be very costly for the local health economy.

d) Create a much larger organisation with a larger catchment population, more capable of achieving critical mass of expertise, both clinical and non-clinical. and achieving greater efficiencies through economies of scale.

3.6 Transforming Community Services

The *Transforming Community Services* initiative to improve community health services was launched by the Department of Health in January 2009.

As well as the move to separate provision from commissioning, central to this initiative is the need to make significant changes in the way that community services are provided. There is a recognition that community services have for too long been left lower down the NHS's priorities, in terms of focus, funding, workforce and service re-design, and yet they are central to achieving a range of important priorities for the whole health and social care system (Source: Transforming Community Services website).

Factors important to success in transforming community services have been identified as:

- Strong leadership from senior clinicians and managers
- Involvement of the full range of clinicians, including nurses, therapists and doctors.
- Teams dedicated to facilitating and driving changes
- Strong organisational focus on community services
- Continuing involvement of primary care and social care professionals
- A focus on workforce – changing how we utilise scarce professionals, and ensuring they are attracted to work in community services.
- Having a portfolio of services which can work together to integrate care in line with the six service areas highlighted in the Transforming Community Services programme, namely:

    - Health, Well-being and Reducing Inequalities
    - Acute Care Closer to Home
    - People with Long-Term Conditions
    - Rehabilitation Services
    - Services for Children, Young People and Families
    - End of Life Care

Implications Locally

How the ICO will support Transforming Community Services

The ICO will build on the initiatives within EHCS to transform community services, but be able to go further and be more effective by being an organisation capable of:

a) Attracting senior clinical leaders to an organisation with a clear focus on community services and care closer to home.

b) Including a broader range of senior clinicians, including nurse consultants, medical consultants, consultant therapists and others, to provide strong leadership and deliver change.

c) Extending continuity of care across hospital and community settings, involving the same professionals in a variety of settings, or working together as an extended team.

d) Re-designing how patients flow through the system, to remove artificial barriers, speeding up patients accessing each stage in the process, instead of patients having to start again when referred elsewhere.

f) Using evidence based practice to design care, instead of models based on organisational structures.

g) Developing one-stop services, with a range of professionals from different disciplines all working together within one co-ordinated system.

h) Achieving better flows of information between professionals, through using the same record systems, avoiding repeated re-assessments, and greater use of protocols.

i) Having clear leadership arrangements for each of the six TCS care groups, together with strong Board leadership

j) Working with local partners to deliver real health improvement for the local populations of Ealing and Harrow in a way that is culturally sensitive and appropriate to the needs of a diverse community.

3.7 Healthcare Needs of the People in Ealing and Harrow

Ealing and Harrow have particular health needs arising from the nature of their populations. An integrated healthcare provider will be able to focus on these needs and work closely with the PCTs in delivering services, which target the specific requirements of both Boroughs.

The population of Harrow is approximately 219,700. Harrow is the ninth most ethnically diverse borough in England & Wales. In 2001, 51% of Harrow's residents were white, and 41% belonged to black ethnic groups. The rest were unknown or white ethnic groups. There were 41 ethnic groups in Harrow with a population of 200 or more.

People from 137 countries live in Harrow. The largest ethnic minority group was the Indian category (45,300 people - 22% of the population). The second largest was 'Other Asian' (10,700 people); and 13.6% of population is 65+ (29,300 people). This is slightly greater than London average of 11%

Harrow has an overall life expectancy at birth of 78 years for men and 82.7 years for women. This is 2.3 years and 2.2 years respectively above the average for London.

Ealing is the third largest borough in London, with a total population of over 303,000 people and approximately 75,000 children and young people aged 0–19.

It is a highly diverse borough, with a young and significantly transient population, who connect less well with primary care services. This leads to an over-reliance on secondary care, in particular urgent care.

Over 40% of residents come from ethnic minorities, making Ealing the fourth most ethnically diverse borough in the country. This includes significant numbers of refugees and asylum seekers.

There is a large Polish community, an increasing number of Somalian families and the largest Sikh population outside India.

Its diversity is reflected in its maintained school population, where 72% were recently classified as being of minority ethnic origin compared with 17% nationally.

The borough is an area of contrasts and, despite areas of affluence; there are also many areas of high deprivation (Northolt, Norwood Green, Dormer Wells, social housing estates in west and central Ealing and also South Acton). People in these areas have low household incomes, high levels of benefit dependency and poorer health outcomes.

There is, for example, a huge variation in Coronary Heart Disease mortality rates between neighbourhoods and life expectancy at birth for men is 75.8 and for women is 80.8, but again with significant inequalities between wards.

How the ICO will help address the Health Needs of the Population across the Boroughs of Ealing & Harrow

There is a strong tradition of working across organisations in Ealing and Harrow, including a number of well-targeted initiatives (for example, the development of an integrated service for children with disabilities). In Harrow there is one of the first Polyclinics providing a great choice of services closer to where people live. Jubilee Gardens in Ealing is another example, which is in development.

However, such examples are patchy across both Boroughs and services are not fully integrated. The ICO will bring a new dimension by being a central player in improving the level of integration of care and services.

The ICO will be well placed to respond to the needs of the transient population by developing agreed protocols across acute and community services, providing more continuity of care and reducing the use of acute hospital services particularly urgent care.

By providing care integrated across acute and community provision the ICO will:
- Improve the uptake of services and the health of local people and
- Improve local performance against some of the national performance indicators (e.g. percentage of women participating in breast screening programmes, cancer and cardiology mortality rates, four week smoking quitters and childhood obesity).

The ICO will provide:

- a combined focus on health needs across acute and community professionals
- the development of integrated clinical teams, particularly for long-term conditions, with
- the hospital extending clinical expertise and services beyond traditional boundaries and
- community services sharing their detailed knowledge of the needs and requirements of local people.

3.8 Commissioning Intentions and the Developing Market for Acute & Community Services

The drivers above have led to commissioning intentions that will impact on the way that acute and community services will need to be provided in the future. These can be summarised as follows:

- **Care Closer To Home**
  - More care in the home, rather than in hospital
  - More activity in primary care, rather than hospital outpatients
  - More interface services being commissioned, such as
    - polyclinics,
    - intermediate care teams,
    - intermediate inpatient services,
    - urgent care centres
    - community assessment and treatment services

- **Increasing demand**,
  - From an ageing population
  - From more people living with long term conditions, and
  - From population growth in Ealing and Harrow.

- **New forms of competition**
  - Some individual services will be put out to tender, to test the market, drive up quality and drive down price.
  - Commissioners deliberately choosing a mixed economy of providers, from traditional NHS providers to independent sector and voluntary sector providers.
  - Commissioners seeking to expand the number of NHS providers competing for their tenders, rather than a reduced number of providers.
  - More niche providers entering the healthcare market and crossing borough and county boundaries, and specialising in particular services.

- **Commissioning in new ways**

  - **Commissioning along pathways**
    Local commissioners have an ambition to commission care along pathways (e.g. diabetic care), or on a population basis (e.g. number of older people). This would take the place of commissioning by activity or by professional groups in specific settings. This would encourage healthcare providers to manage conditions, maintain wellbeing and promote self-care.

  - **Changing incentives for providers**
    Combined with this, there is an ambition to incentivise providers to provide more care at home, in place of care in a hospital setting, which is often more expensive, in particular inpatient care. This would involve moving away from using fixed tariffs for one-off activities. It would share the risk of unnecessary inpatient activity between commissioners and the provider, enabling a more financially sustainable health economy.

  - **Removing barriers to integrated care**
    These new ways of commissioning would remove some of the barriers to integrating acute clinicians with community and primary care clinicians. For example, at present there is no payment mechanism to fund consultants spending time on
    - supporting patients cared for at home,
    - supporting patients cared for in nursing homes,
    - assisting community nurses to manage caseloads,
    - advising GPs on their management of patients with long-term conditions.

    This results in more fragmented care for patients, slower access to expert advice, more use of hospital services – as outpatients and inpatients – and more occasions where the patient travels to hospital.

- **Developing care through Polysystems (or "Local Health Communities")**
  NHS Ealing and NHS Harrow are developing arrangements for greater co-operation between commissioners and providers, through the development of polysystems (also called "local health communities"). This is a clinically led model of care (based on a population of at least 50,000) involving all partners in the network and supported by a primary care led polyclinic hub at its heart. It provides the opportunity to transform primary and community care y working together at a local level. The polysystem can be focused around a polyclinic hub based in the community or on a hospital site.

How does the ICO respond to the Commissioning Intentions and the Developing Market in Ealing & Harrow?

By integrating acute and community health services under a single governance structure, the ICO will be a provider of sufficient size and critical mass to:

a) Manage long-term conditions in an integrated way, in close partnership with primary care, as the ICO would be able to provide both acute and community services.

b) Introduce common clinical protocols across a wide area, to enable conditions to be well managed in a variety of settings, since it would be a single organisation, with a single governance structure, and more able to be flexible with its workforce.

c) Provide the increasing range of interface services (examples of which are given above), as they would fall naturally into the core of the work of the ICO, instead of being an addition at the extreme end of the spectrum of services for an exclusively acute or an exclusively community services organisation.

d) Compete in this more complex and challenging market, being large enough to support a strong bidding and service development function. In particular the ICO would pursue local opportunities to build on the critical mass of its core services. An example would be seeking to provide community therapy services in Harrow, or a broad range of community services in Brent.

e) Withstand the effects of potential losses to competitors, whether this is of acute or community services.

f) Compete more strongly to provide services commissioned as whole pathways, as the organisation will contain a richer mix of professionals and settings, be focused on providing integrated care, and so generate new sources of income and better care for patients.

g) Be a stronger competitor in Harrow with North West London Hospitals NHS Trust for the types of services on which the ICO is focused, which may not be the natural core of Northwick Park Hospital's services as it develops its role as a major acute hospital. Examples include community services for children, and community therapy services.

h) Be a stronger competitor for some services than EHT has been, in those parts of Ealing which are closer to Imperial's hospitals, because of the ability to provide more integrated care, whilst moving away from providing some aspects of specialist acute care.

i) Be able to contract with its local commissioners with incentives to provide more care outside hospital – being more able to adjust its provision of both community and acute services, and manage the financial risk associated with this.

j) Become the natural provider of local polyclinic services in Harrow and in Ealing, competing effectively with organisations which provide solely acute or solely community services.

k) Become the key local provider involved at the heart of polysystems. This contrasts with what would happen if EHT became a part of the Imperial group, for example, where it would become a small part of a distant provider focused on major acute services across a much wider catchment area.

3.9 Responding to the Financial Outlook

Section 7 describes the financial sustainability and commercial viability of the ICO. Here we consider the financial drivers for change.

The global economic downturn has led to renewed focus on the potential for efficiency savings within the NHS at a time when growth in health spending was already planned to reduce. David Nicholson, Chief Executive of the NHS, has said that between £15 billion and £20 billion will be required in efficiency savings over the three years from 2011 to 2014.

The global economic downturn has major implication for public spending and the NHS is not immune from that. There will therefore be considerable constraints on public sector spending in the years ahead. This means:

- A greater focus on productivity,
- Pressure to reduce unnecessary overheads costs, multiple organisations and duplicate departments

- Greater pressure from politicians and the tax-payer for major service changes
- Increased focus on achieving savings through managing demand well
- More use of competitive tendering by commissioners along care pathways to seek price reductions and quality improvements.

How the ICO will help to address the Financial Downturn in Public Spending

The ICO will provide a number of opportunities to achieve savings via:

a) Service integration and synergy, by being able to keep patients out of hospital with acute hospital clinicans supporting primary care and community clinicians to treat patients closer to and in their own homes.

b) Providing opportunities to increase productivity by removing barriers to effective working between community and acute clinicians.

c) Reducing duplication in management and back-office functions e.g. Human Resources, Finance and Information and Communication Technology.

d) Preventing the need to create an extra new organisation to run the community health services.

e) Providing the potential for further economies of scale from future expansions to other boroughs or service areas.

The financial benefits that will be delivered by the ICO are described in Section 7.

3.10 Summary on the Drivers for Change

The separation of community service provision from PCT commissioning , the need to achieve Foundation status, the changes to acute services likely to emerge from implementing the Healthcare for London strategy, the need to respond to the economic downturn, and the opportunity for commissioners and providers to work together with incentives to reduce care in hospital, all require a change in the current configuration of NHS organisations and the way care is delivered currently.

The local population is one, which, in parts, experiences severe deprivation resulting in a reduced life expectancy and an incidence of diabetes, heart disease and tuberculosis considerably in excess of those in the national population.

If healthcare delivery and health inequalities locally are to be addressed effectively then these drivers need to be addressed locally. The alternatives are likely to involve more work being 'sucked in' to other acute providers. Ealing and Harrow residents remain relatively high users of secondary care services and concerted effort to change patterns of care and health outcomes is required to avoid changes which simply move the same activity between providers in a way which increases cost and reduces access to care.

The local impact has been outlined above and there is much work already in hand to integrate care pathways, and to develop polysystems and polyclinics. The ICO will facilitate the integration of care pathways, improve communications between GPs, Hospital, Community Services and Social Care, which in turn will help it to address the challenge posed by economic downturn.

By creating an ICO, the local acute and community health services will be in a much better position to pursue the national requirement to achieve Foundation status.

In Section 4 below we look at the work undertaken on the options and the rationale for the preferred organisational model and illustrate how the Integrated Care Organisation (ICO) best manages this change.

Section 4
Reviewing the Options
The ICO as the preferred Organisational Model

4.1 Options Appraised by Ealing & Harrow Community Service (EHCS)

Early in 2008 London PCTs commenced separation of their community provider functions in order to concentrate on becoming world-class commissioners.

In late 2008 the decision was taken by Ealing PCT and by Harrow PCT (now known as NHS Ealing and NHS Harrow) for their provider arms to become an Autonomous Provider Organisation (APO). Both PCTs agreed to the formation of a community health services alliance with a single management team, and its own governance structures. The PCTs remain the statutory bodies "hosting" the APO until a decision is made on the best statutory organisational model for the community health services.

Ealing and Harrow Community Services (EHCS) came into being as an autonomous provider organisation (APO) in April 2009, as a step towards full separation.

Advantages of this arrangement were seen to include:

- Strengthening governance processes,
- Sharing good practice across two boroughs,
- Retaining a focus on services in each borough and the close working relationships with the borough social care and education services,
- Avoiding duplicating costs by establishing two top teams.

This arrangement allows for the possibility of other local PCT community APOs to be included, forming a larger Community Health service, such as the community services in Brent and Hillingdon at some point in the future.

The drivers for change illustrate the need for a new organisational model, to allow full separation from commissioning PCTs and preferably one that will facilitate the integration of services across care pathways in the Boroughs of Ealing and Harrow.

In arriving at a preferred organisational model, an options appraisal was undertaken over the summer of 2009. Six options were identified, many of which involved an interim step, on the way to a long-term form such as a Community Foundation Trust or Social Enterprise.

The options assessed were as follows

A. Create a Directly Provided Organisation within Ealing PCT,
then becoming a Community Foundation Trust.
B. Create a Directly Provided Organisation within Ealing PCT,
then becoming a Social Enterprise.
C. Create a Directly Provided Organisation within another Trust,
then becoming a Community Foundation Trust.
D. Join with a Major Acute Trust
and becoming part of a Foundation Trust.
E. Create an Integrated Care Organisation (ICO),
then becoming a Community Foundation Trust.
F. Join Another Community Services Provider
then becoming a Community Foundation Trust.

The possibility of staying 'as is' currently was discounted prior to the full options appraisal. The reasons for this were:

- The national policy for Primary Care Trusts states that there should be a separation between commissioning and service delivery.
- Staying as single borough providers would be too small to be financially viable, making both vulnerable to market forces.

49 clinical and managerial leaders, members of staff and staff side representatives took part in an options appraisal scoring event on 7 September 2009. The six options were scored against nine criteria that had been agreed by the Provider Alliance Board.

Criterion 1: Full Separation from Commissioners
Criterion 2: Capability to Transform Community Services
Criterion 3: Focus on Transforming Community Services
Criterion 4: Able to improve services beyond Ealing and Harrow
Criterion 5: Attracts Staff to Work in Community Services
Criterion 6: Viability: Balanced Budget; Capital; and Revenue
Criterion 7: Viability: Likely to Grow, and Withstand Losses in Services
Criterion 8: Scope to reduce spending on overheads and inefficiencies
Criterion 9: Meeting Commissioners' Aspirations

The results of the EHCS options appraisal are summarised in Table 1 below. The preferred option is Option E, the Integrated Care Organisation.

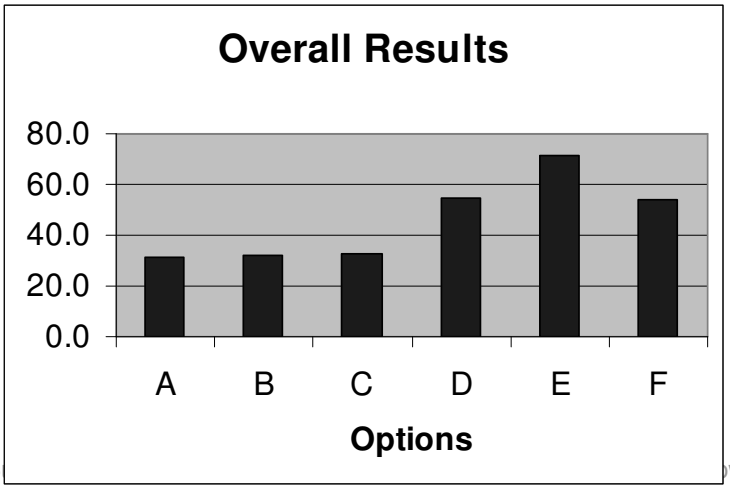


Table 1

A detailed sensitivity analysis was also undertaken, to see if certain factors were changed would they materially affect the result. This illustrated that option E continued to be the preferred option.

On 16 September 2009 the Provider Alliance Board agreed "to recommend to the Boards of NHS Harrow and NHS Ealing the creation of an Integrated Care Organisation, preferably from April 2010, by the transfer of services and staff into Ealing Hospital NHS Trust, on the basis that there will be a new name and changes to its legal purposes to reflect its new role."

A full copy of the EHCS Options Appraisal is attached as Attachment 2

4.2 Options Appraised by Ealing Hospital NHS Trust

From December 2008, the Board of Ealing Hospital Trust (EHT) undertook a review of potential organisational models in the light of NHS London's view that EHT was not 'FT-viable' in its current form. The review was undertaken within the context of the changing environment in the North West London Sector and that the status quo of 'do nothing' was not an option given *Healthcare for London* and the other policy drivers outlined in this paper.

The national expectation is that all Hospital Trusts must be Foundation Trusts by 2010 (or merge with another Foundation Trust).

The options considered by the Board of Ealing NHS Trust were as follows with the conclusion reached given in *itallics*:

Option 1 Local Community FT based on Uxbridge Road site

Under this model a new organisation providing community and acute services would be formed from some of the existing EHT and Ealing PCT's provider services (i.e. integrating services between the acute hospital and community based services). The organisation would focus on providing high quality, local community and acute care to meet the specific diverse needs of the local population. Under this model some aspects of secondary care currently provided by EHT would be provided by other organisations with the location of services being determined based on clinical and financial viability (See Section 7 for a review of the financial analysis).

This option disappeared at the point where Ealing and Harrow entered into an alliance to provide their community services jointly. However, the benefits of this model for EHT are replicated in the ICO model.

Option 2 Incorporation within Imperial Healthcare Trust (IHCT)

Under this option EHT would cease to exist. Some secondary care services would be provided on the Uxbridge Road site by IHCT. An alternative solution would be sought for PCT provider arm services.

This option could not be pursued in the short term as Imperial are pursuing their own FT application, which would have been delayed by a merger. Whilst tertiary flows to Imperial are strong, there was a concern that merger with such a large organisation would detract from a locally focused service. From a commissioning perspective merger with Imperial would be more expensive due to the higher Market Forces Factor and would make shifts from hospital to community more difficult to achieve than if acute and community services were integrated.

Option 3 Boutique Site on the Uxbridge Road

This option would involve the PCT using a Property Company arrangement to run the Uxbridge Road site. EHT would cease to exist and the PCT would coordinate the provision of a range of secondary care services on site from multiple NHS providers e.g. (for illustrative purposes only) renal from Imperial, ophthalmology from Moorfields, cardiology from Brompton & Harefield, children's services from Great Ormond Street Hospital (GOSH).

A variant on this option would be for the PCT to tender to private and NHS organisations for the provision of services on the site.

This option was rejected on the grounds that there would be no coherence to the services on the Ealing hospital site and that this would lead to an unacceptably high level of clinical risk. There was a concern that patient care would be very fragmented and that this would be difficult for the large numbers of complex patients with co-morbidities. The role of the PCT in coordinating services did not fit with a modern focus on commissioning care.

Option 4 A new acute organisation

4.1 Merger with Hillingdon - Assuming that Hillingdon's FT application is approved then Hillingdon could acquire EHT. Some acute services could be retained on the Uxbridge Road site.

Hillingdon is continuing to pursue an active FT application based on a 'stand alone' model. Merger could not therefore be pursued at this time.

4.2 Merger with North West London Hospitals (NWLH) - Assuming that NWLH is FT-viable at some point in the future it could merge with EHT. Again some acute services could be provided on the Uxbridge Road site. A variant on this option would be an FT-viable merger to provide local hospital services

between EHT and Central Middlesex Hospital with a separate Northwick Park Trust

The strategic future of North West London Hospitals remains unclear and therefore this is not an option in the short term.

4.3 Merger with West Middlesex University Hospital Trust (WMUHT) - a FT-viable merger to provide local hospital services between EHT and WMUHT with reduced duplication across the two sites and potentially a range of acute services retained on the Uxbridge Road site.

WMUH are producing a prospectus to look for a future partner. Initial work suggested that a merger between EHT and WMUH would not of itself be sufficient to create viable Foundation Trust in the future.

Option 5 EHT as a stand-alone FT

This is the closest to a 'do nothing' option available and would see EHT pursuing its FT application. This option would potentially allow a vertical integration model (integrating acute hospital and community based services) to be pursued at a later stage.

This option was effectively rejected when EHT withdrew its FT application at the end of February 2009. Without SHA support an application for FT on a stand alone basis would not succeed.

EHT's Conclusion

As a result of the above analysis EHT's Board reached the conclusion that the best option in terms of both short term stability and long term viability was the development of an Integrated Care Organisation (ICO). The ICO would be consistent with the aims of Healthcare for London and would also have the potential to create the kinds of service transformation necessary to significantly reduce the cost of healthcare locally whilst driving improved quality and outcomes for patients.

4.3 Conclusions to the Options Review

The three statutory organisations having independently assessed the potential options have concluded that the best organisational model is the establishment of an Integrated Care Organisation (ICO).

This conclusion has been taken in the light of the very significant drivers described in sections 2 and 3 above.

Section 5

What Do We Mean by an Integrated Care Organisation?

5.1 Making a Real Difference to Patient Care Locally

The main focus for service delivery by the ICO will be the integration of acute and community services along the acute and community care pathway. The ICO will also work with partners in primary care and social services and other providers of health and care services to ensure care is integrated locally.

Attachment 3 provides a list of the current services provided by EHT and EHCS. These services will be provided from the commencement of the ICO, pending further work on the integration of service delivery over the next couple of years. A very small number of exceptions are not expected to transfer from NHS Harrow, and these are listed at the end of attachment 3.

The development of new care pathways by the ICO will be undertaken in conjunction with NHS Commissioners, Local Authorities, North West London Hospital Trust (NWLHT is the local Trust for Harrow residents), GPs in Ealing and Harrow, Practice Based Commissioners, hospital and community clinicians and with patient and public involvement. Services will continue to have a strong borough basis, building on existing integrated arrangements with the two Local Authorities. Care pathways will be integrated based on the needs of the people of Ealing and Harrow.

The new pathways and models of care that the ICO could facilitate include:

- The management of chronic conditions in partnership with general practice. The greatest needs are in respiratory (chest conditions), heart failure, and diabetes, but increasingly it is people with two or more complex conditions who are significant users of acute care.
- Integration would allow the development of an integrated acute/community service with a single point of access, thereby streamlining service delivery in a much more timely way.
- Integration would allow community matrons and district nurses to become part of a joint clinical team (with staff currently working in the acute hospital) providing co-ordinated care to patients at different points of illness and recovery, along the care pathway.
- The integrated team approach would act in support of a core, multi-disciplinary home care service.
- Integration would shift the focus from reacting to illness to one of maintaining health and independence.
- The integration of community and secondary care services would provide the basis for managing elderly people in need of health care, in terms of “step-up” and “step-down” care to prevent people having to go into hospital and, when they do have to be admitted to hospital, allow patients to be discharged more quickly.

- Vulnerable patients can be managed with a major focus on a single assessment process, shared information and case management of individuals.

Below are 3 scenarios that demonstrate, from a patient's perspective, how the ICO will facilitate integrating service delivery. They are followed by 2 scenarios contrasting typical situations now and with integrated care. All the cases are composite, and do not describe actual individuals.

Scenario 1 - Diabetes – long-term condition in the young

Hussein is a 10 year old boy who lives with his parents and younger sister and brother in Northolt. His mum is worried as he is increasingly listless, is losing weight and always thirsty. The GP thinks Hussein has diabetes and immediately refers him to the nearest next day local one stop diabetes clinic. Here, Hussein is seen by the Diabetic Consultant and Specialist Diabetes Nurse who confirm the diagnosis of Type 1 diabetes. They agree that he needs to start insulin injections immediately. The Adolescent Diabetes Nurse shows his parents how to give the injection and then books them and Hussein into a bespoke training package to support his family as they learn to help Hussein manage his diabetes. As part of the package a dietician works with the family to talk about healthy eating and Hussein and his family are told about and introduced to the podiatrist and retinopathy screener who Hussein will see in the future. His specialist nurse liaises with his GP and his school where she and the school nurse meet the staff along with Hussein's mum to talk about his needs. Hussein comes initially weekly to see the diabetes nurse until he is feeling more confident with his condition and visits are reduced, although he knows he can still come to the weekly drop in session at his nearest health centre if necessary

Scenario 2 – Care during Pregancy in a Diverse Population

Sanitha is recently married and just arrived from Sri Lanka, she speaks little English and is pregnant. Her neighbour also from Sri Lanka has just taken her children to a story telling session at the new Jubilee Gardens library where she has seen a poster in Tamil giving details of a local baby group. She suggests Sanitha should go. Here Sanitha meets a Tamil speaking Maternity Support Worker who explains that she will need to see a midwife and also helps her register with local GP. Sanitha is able to have all her maternity care at Jubilee Gardens as there is a daily ultrasound service, there is a phlebotomist on site and her midwife is based at the Clinic. Her midwife talks to Sanitha about going to local English language classes and tells her about the local children's centre where she can go with her baby. Although her Consultant has a regular session at Jubilee Gardens and liaises closely with her midwife, Sanitha has all her care from her GP and midwife. Jubilee Gardens also hosts antenatal classes jointly provided by her midwife and staff from the children Centre. She only has to go to hospital twice, once to be shown around and once for her safe delivery.

Scenario 3 – Integrating Care for Chronic Conditions in the Elderly

Sid B is 78 year old widower who lives alone in a flat on the South Acton estate. He has always smoked and recently has been in hospital four times in an 18 month period with a worsening of his COPD. Following his last admission his Consultant has referred him to a Community Matron and to the local pulmonary rehabilitation team whom the Consultant sees regularly to review the progress of patients. The Consultant reviews Mr B's care plan and agrees with his GP and Community Matron via a telephone case conference that should Mr B's condition worsen again he would be admitted directly to Magnolia ward at Clayponds. The Consultant also tries again to persuade Mr B to stop smoking and arranges for him to see the smoking cessation advisor. In conjunction with the Community Matron the Consultant also talks to Mr B's Social worker who assesses Mr B's eligibility and arranges for him to have a personal budget which he then uses to visit a local Age Concern lunch club. The Consultant also arranges to see Mr B at his monthly session at Acton Health Centre where he also sees the pulmonary rehab team and community matrons to review the care packages of patients on a COPD pathway.

Scenario 4 –Care in a Nursing Home at the End of Life

Marjorie is an 84 year old lady living with a terminal illness, in a nursing home. One Saturday evening Marjorie is feeling unwell, and the nurse in charge of the shift talks on the phone to her son, who is understandably concerned.	
As things stand The nurse feels uncertain, and is concerned to resolve the situation safely. The Out of Hours GP visits, and notes that she is safe and warm. However, by 11pm, Marjorie's daughter has arrived and is very anxious. The nurse calls an ambulance. Marjorie arrives at hospital, and the A&E staff receive a brief handover. They start intravenous antibiotics and admit her to a ward. When she is reviewed the next day, the team discover that there had been conversations with the relatives about not seeking active interventions if she became ill. However, by this time Marjorie has had a therapy assessment, and is being fed by a tube. Marjorie stays in hospital for some days before dying in the hospital ward.	**With Integrated Care** The nurses in the home have been receiving training in end of life care and have regular in-reach visits from specialist nurses. Marjorie was reviewed by a consultant at a quarterly visit to the home a few weeks ago. The team and family have discussed the options for her care should she fall ill, and an anticipatory care plan has been prepared. As the nurse is still concerned, she rings the advice line, and talks to a specialist nurse who is on-call covering a large area by phone. If desired, the nursing home is able to administer intravenous antibiotics with the help and monitoring of the community nurses. When Marjorie dies, she does so in the familiar surroundings of the nursing home.

Scenario 5 – Musculo-skeletal care in a community setting

Claire has just reached fifty and lives in Wealdstone. While otherwise healthy she is suffering from a painful arm and shoulder. She spends long hours at her computer. Her GP advises more exercise, but as things do not improve, she wants to refer her for an assessment.	
As things stand The GP can choose between waiting for a community physiotherapy appointment, or a fast appointment with a consultant. By now Claire is very keen to get some help quickly, and the GP chooses the consultant option. At her appointment, the consultant decides to refer Claire to the hospital physiotherapy service. After several journeys to the hospital for treatment, Claire is referred to a hospital doctor who can give a joint injection. She has another visit, and the injection relieves the pain, and she continues with physiotherapy. Gradually things improve, and she no longer finds the pain a problem.	**With Integrated Care** The GP refers Claire to a service that is run between the community physiotherapists, a GP with specialist training and experience, plus advice and support from hospital consultants. She sees a specialist physiotherapist, who assesses her quickly at a nearby centre, and sees her again several times for treatment. If she needs to see a doctor or a psychologist, there is one in the team, and they all use the same electronic records, so Claire does not need to keep repeating her story. The physiotherapist has trained to give joint injections, saving Claire a visit to hospital. Her therapist can discuss the case with a consultant physiotherapist from Ealing who runs the service in both boroughs. Claire's condition gradually improves and the pain is no longer a problem.

Section 6
The Benefits of the ICO

6.1 Benefits of the Integrated Care Organisation (ICO)

For the people who live in our community and work in our services there are major benefits in creating an ICO. By improving the system by which healthcare is delivered, we will ensure that the patient experience and staff satisfaction are improved.

We have grouped the benefits that will be delivered into six areas:

Benefits for Patients
- Enabling new models of service provision and patient care.

Benefits for Staff
- Greater support for clinical practice and enabling clinical leadership.

Benefits for the local Healthcare System
- Focusing on local services and on services provided in the community.
- Better use of resources.
- Achieving a viable organisation.
- Encouraging providers and commissioners to work together with incentives that promote care out of hospital.

6.2 Benefits for Patients

- Enabling new models of service provision and patient care

There are many opportunities to improve patient care by removing boundaries between acute and community services, in line with the policy of Transforming Community Services. Examples include:

- **Greater continuity of care** – as care is organised across hospital and community settings, involving the same professionals in a variety of settings, or working together as an extended team.
- **Fewer barriers for patients and faster access** – as care is re-designed so that patients flow more easily through the system, removing artificial barriers, speeding up patients through each stage in the process, instead of patients having to start again when referred elsewhere.
- **More focus on long-term conditions** – as the organisation focuses on the whole of the individual's needs over a longer

period, instead of the occasion when the patient presents to one service.

- **Care based on the best evidence** – as models of care are designed on evidence, instead of being based on organisational structures.
- **Fewer visits to hospital** – as more one-stop clinics are developed, with a range of professionals from different disciplines all working together within one co-ordinated system.
- **Fewer duplicated assessments and tests** – as information is able to flow better between professionals, through using the same record systems, and greater use of shared guidelines.

6.3 Benefits for Staff

- Greater support for clinical practice and enabling clinical leadership, which also benefits patients

- **Specialist skills and expertise** can be accessed by teams in different care settings.
- **Clinical practice developed** with more support across disciplines, and by larger central teams.
- **Clinical leaders** are more able to develop their services across a wider community, and apply their skills and experience for the benefit of more teams and patients.
- **Learning and best practice** being brought from one area to another
- **Senior clinical leaders** being attracted to an organisation with a clear focus on community services and care closer to home.
- **A broader range of senior clinicians** will be involved in leading service improvements, including nurse consultants, medical consultants, consultant therapists and others, to provide strong leadership and deliver change.
- **New career pathways and new job roles** will be developed, around delivering integrated care across the acute and community services.

6.4 Benefits for the local Healthcare System

- Incentives which Promote Care within the Community

- Incentives could be agreed which promote care out of hospital, by Commissioners working with a unified organisation, replacing the current pricing structure that encourages multiple visits to hospital and inpatient care.

- Focusing on local services and on services provided in the community

- **A strong focus on care closer to home and care in the home**, from an organisation dedicated to this, with experienced leaders capable of delivering improvements
- **Care that is local where possible and central where necessary**, following the strategy of Healthcare for London, promoting.
- **Stronger links with primary care** for some acute services, by integration with community services.
- **A locally managed future for some acute services** is more secure, rather than becoming part of a much larger acute organisation

- Better use of resources

- **Clinical costs** will be better used, in providing new models of care.
- **Overhead costs** of creating a whole extra community services organisation are avoided - or two extra organisations (one for Harrow and one for Ealing).
- **Support service departments** can be shared, so reducing costly duplication
- **Capital funds** for community services would be more available, which were very limited while in PCTs.

- Achieving a viable organisation

- **An organisation large enough to stand on its own**, and progress to Foundation status would be created. This is the only long-term future for NHS acute hospitals, and the preferred long-term future for community services.
- **The separation of PCTs' provider and commissioner functions** would take place, so that each can focus on their own core purpose.
- **Swift and certain separation** would take place, instead of a two or three-year delay and uncertainty whilst trying to create a brand new Community Foundation Trust.
- **A strong business development function** would be justified by a larger organisation, capable of competing in a rapidly developing market for health care.
- **Vulnerability would be reduced** - from the loss of services to other organisations, either through transfers or through competition.

In summary, establishing an ICO will create a single organisation with a single governance structure to allow the benefits described here to be realised more

easily and reliably than through collaboration across organisational boundaries.

Section 7

Financial Assessment of the ICO Model

7.1 Financial Context

7.1.1 The financial context which prevails looking forward is a difficult one. The current NHS spending settlement ends in 2010/11 and that is the last year of significant growth in resources for the foreseeable future.

7.1.2 The Operating Plan framework for 2010/11 is expected to be issued by the DH during December. This will set out the changes proposed to both tariff and non tariff services and may impact on the financial plans in this Business Case. At the present time, average PCT allocations are expected to rise by 5.1% next year but beyond that are likely to be restricted to no growth, with the cost of activity increases having to be compensated for by efficiency gains across the NHS.

7.1.3 In addition to the national picture, NHS London and London PCTs are pressing ahead with the implementation of Healthcare for London qualitative improvements and the introduction of polysystem based models of care. There are costs attached to these changes which also have to be met within existing resources.

7.1.4 Thus the financial outlook for provider organisations is one which requires new approaches. Average NHS organisation efficiency gain levels from recent years will not be sufficient going forwards and full tariff funding for additional acute activity is not sustainable.

7.1.5 In this context, whilst it will be challenging for any organisation, one which has a greater critical mass, can reduce corporate overheads and can best integrate community and acute care, would seem to be better placed to operate successfully.

7.1.6 This chapter will examine the financial challenge facing the proposed ICO.

7.2 Five Year Income and Expenditure Model

7.2.1 The attached financial schedules (Attachment 9), use a spreadsheet model to provide an Income and Expenditure Account, Balance Sheet, Cash Flow and key compliance ratios for the next five years for the ICO. Income and Expenditure Account performance will be the key determinant of financial success for the ICO and the key numbers on the other statements are largely driven by this.

7.2.2 The approach taken to the Income and Expenditure Account has been to model it based on achievement of circa 1% surplus in year 1 and a minimum of 2% thereafter, in line with the minimum requirements from which to establish a Foundation Trust

7.2.3 Taken together with commissioner intentions in relation to aspects of activity and known national changes to income/tariff inflation and savings requirements, the resultant financial challenge in terms of cost reduction and risks is set out in the model and features described below.

7.3 Start Positions

7.3.1 The start position for the income and expenditure model is the combined 2009/10 budgets of the Ealing and Harrow APO (APO) and Ealing Hospital NHS Trust (EHT). The turnover of the former is £69.0m (Ealing, £50.2m, and Harrow, £18.8m) and its planned out-turn is a surplus of £0.3m (Ealing, breakeven, Harrow, £0.3m surplus). EHT's budgeted turnover is £132.0m and it has set a breakeven out-turn target.

7.3.2 It is important that the forecast out-turn positions are met by all parties in 2009/10 in order to preserve the viability of the modelling going forward.

7.3.3 The combined turnover is reduced by £3.2m, reflecting current inter-ICO trading, principally between EHT and the Ealing element of the APO. This gives a total turnover of £197.8m and this is used as the base for the future modelling. The nominal combined current year income and expenditure budget is shown in the 2009/10 column of the I&E Account table in the financial schedule (Attachment 9).

7.4 Income Changes

7.4.1 There are a number of changes to income incorporated in the model over the next five year period. These result from:-

- World Class Commissioning Plans for Acute Activity
- Urgent Care Centre Tender
- Changes to APO Income
- Loss of Acute Income for Stroke
- Increased Income for Maternity
- Increased Non-NHS Income Generation
- Annual Inflationary Uplifts

7.4.2 NHS Ealing has signalled in its commissioning plans for the next five years its intention to reduce activity in acute settings as part of the transformation of community and primary care services. While these plans are still being developed, NHS Ealing has signalled the following reductions in activity affecting the ICO :-

Elective	11%
Non Elective	23%
Outpatients	50%
A&E	75%

The above activity changes are not considered as absolute but indicate the changes that are likey as polysystems are developed as envisaged by Healthcare for London. The financial impact is a reduction of the ICO's acute income of:-

2010/11	2011/12	2012/13	2013/14	2014/15	Total (£m)
7.2	10.0	5.8	6.0		29.0

Other than an element of activity which will no longer be commissioned, the activity removed from the acute setting will still need to be undertaken. This will be either by GPs or by community based elements of the ICO. The financial model assumes that around 40% of the acute work transferred will be undertaken by the ICO. In line with NHS London guidance, it has been assumed that this work will priced at 60% of the current acute tariff. The impact of this (excluding Urgent Care/A&E) is income to the ICO of:-

2010/11	2011/12	2012/13	2013/14	2014/15	Total (£m)
1.1	3.0	1.4	1.4		6.9

7.4.3 NHS Ealing is currently out to tender for the provision of an Urgent Care Centre on the Ealing Hospital site. This is a competitive process and the ICO bid may be unsuccessful, but the financial model assumes success, with income determined by a similar pricing regime to that described at 7.4.2 applying.

7.4.4 There are a number of changes to the APO income incorporated in the model, principally additional resources including a new MSK contract from 2010/11 (£2.6m) and the loss of non-recurrent funding, £0.4m in 2010/11 and £1.5m in 2011/12. In the future there will be other opportunities to increase the income of the ICO as neighbouring PCTs tender services.

7.4.5 Ealing Hospital has not been designated as a site for the provision of stroke services under the recent Healthcare for London process and will therefore lose £1.6m of related income from 2010/11.

7.4.6 Ealing Hospital is currently planning an upgrade to maternity facilities aimed at attracting additional births to a level of 4,000 (currently c. 3,000). Additional income at national tariff is included for this activity with the increase staged between the first two years of the ICO.

7.4.7 The model reflects increased levels of non-NHS income, with a 0.5% increase across each year. This is added to in 2010/11 by a specific increase in relation to a private patient scheme.

7.4.8 Inflationary uplifts applied to clinical income reflect the expected national tariff levels for the five years in the model, namely 1.2% for 2010/11 and -0.5% thereafter. For other NHS income (e.g. teaching and R&D) an uplift in line with the pay element of the tariff uplift is included. Non NHS income has been inflated at 2.5%.

7.4.9 Taking the above together the ICO's income changes from that of the aggregated budgets of £197.8m in 2009/10 to:-

2010/11	2011/12	2012/13	2013/14	2014/15
£200.9m	£194.9m	£190.8m	£186.8m	£187.3m

Giving growth in income over the five years of:-

2010/11	2011/12	2012/13	2013/14	2014/15
1.5%	-2.98%	-2.08%	-2.13%	0.30%

7.4.10 There is also a significant shift in the proportions of clinical income which are tariff and non tariff based. At the outset, 54% is tariff based and this moves to 42% by the end of the modelled period.

7.5 Expenditure Changes

7.5.1 Expenditure changes incorporated in the model relate to specific developments described at 7.4 above, cost inflation and savings/expenditure reduction requirements.

7.5.2 In terms of specific development expenditure, that associated with the urgent care tender, changes to APO income, loss of stroke and increased maternity activity is included.

7.5.3 Cost inflation is included at 4.7% in 2010/11 and 3.5% for each of the years from 2011/12, in line with national guidance. The incidence of the inflationary uplift is assumed to be in line with that of 2009/10 in 2010/11, with a reduction in pay inflation thereafter, following the end of the current three year national settlement.

7.5.4 Annual national savings levels are set at 3.5% in 2010/11 and 4% thereafter. Based on the ICO's opening turnover, these lead to a need to generate c. £39m cost reductions over the next five years. When added to the need to manage out cost in response to the commissioning changes, plus deliver a modest annual surplus, the overall requirement is £60.4m.

7.6 Cost Reduction and Efficiency Savings

7.6.1 As described at 7.5 above, the main feature of the change in expenditure facing the ICO in the financial model is the cost reduction requirement. This is £60.4m over the next five years, with yearly incidence of:-

2010/11	2011/12	2012/13	2013/14	2014/15	Total (£m)
£14.3m	£15.7m	£11.5m	£11.2m	£7.7m	60.4
7.2%	7.8%	5.9%	5.9%	4.1%	

7.6.2 Of this sum, £5.3m is being addressed via non-NHS income increases, leaving £55.1m of expenditure reductions. These will be addressed under four broad savings streams.

7.6.3 Firstly, in relation to the need for reduction of costs in light of lower activity commissioned in the acute sector, the approach in the model is to reduce directly variable costs from the year in which the activity change is made and take out semi-variable and fixed costs over three years. This methodology is consistent with that being used in the Healthcare for North West London planning work and needs to yield £17.1m over the next five years.

7.6.4 The second stream of savings relates to clinical redesign and efficiency programmes established by both EHT and the APO, the former relating to its 'Better care, better value' approach to length of stay and pre-operative bed day reduction, better outpatient attendance and lower follow up levels. The latter relates to the APO's lean/six sigma and skill mix/role development work. Together, these are planned to provide £20.1m of savings over the next five years. The bringing together of the Trust's and APO's services under the management of one organisation will provide opportunities to eliminate barriers between organisations and reduce service overlaps.

7.6.5 The next main area for gain is the ICO's corporate costs. The combined corporate costs, including that of the estate, for the APO and EHT are £27.5m. Excluding the estate and clinically related corporate costs, this reduces to £13.5m. However the expected level of corporate functions overhead would be no more than 4%, £7.6m on the £190m turnover by 2012/13. A saving of circa £6m in corporate costs should therefore be the minimum required. This level of saving reconciles with the formula of adding 20% to the cost of current corporate functions at EHT to give the cost envelope available for these departments in the ICO.

7.6.6 The final substantial area of savings relates to procurement (non pay) and estate efficiencies. Levels consistent with the national requirement have been included in all years but are added to by an additional 0.5% in each to reflect additional estate savings which are planned for the EHT site, and a 1% gain by 2011/12 from the harmonisation and re-tender of the ICO's non-pay contracts as opposed to those held by the separate organisations currently, taking advantage of the greater combined purchasing power.

7.6.7 The table below summarises the main expenditure savings themes by year:-

Saving Theme	2010/11 (£m)	2011/12 (£m)	2012/13 (£m)	2013/14 (£m)	2014/15 (£m)	Total (£m)
Activity Reduction	3.1	4.2	4.1	4.0	1.7	**17.1**
Clinical Efficiency	4.6	4.5	4.1	4.0	2.9	**20.1**
Corporate Costs	3.0	3.0				**6.0**
Procurement and Estate	2.1	2.9	2.3	2.3	2.3	**11.9**
Total	**12.8**	**14.6**	**10.5**	**10.3**	**6.9**	**55.1**

7.7 Capital Expenditure

7.7.1 The approach taken to capital expenditure in the ICO financial model is to set it to the level of depreciation which is generated in each year. This will allow for the continuation of ongoing rolling ward refurbishment, communal area and equipment replacement programmes in the hospital, together with continued ICT and systems development across the organisation. The sums available over the next five years are:-

2010/11	2011/12	2012/13	2013/14	2014/15	Total (£m)
4.631	5.105	5.560	6.008	6.448	27.752

7.7.2 One of the benefits of this approach is that the ICO's available loan funding will be fully available for new revenue generating capital developments. The only development reflected in the model is the upgraded maternity facilities at Ealing Hospital, with a £4.4m loan planned to be taken out in 2009/10.

7.7.3 The second benefit is that of maintained revenue affordability with the depreciation only rule meaning that any increases in capital charges on the existing asset base are limited to the level of the figure included within the annual inflationary uplift.

7.7.4 The APO's property assets remain in the ownership of the respective PCTs in the ICO financial model. The ICO will pay a rent to the PCTs and therefore maintenance expenditure on these assets will remain their responsibility.

7.8 Balance Sheet

7.8.1 A forecast balance sheet for the ICO is included in the financial model. This is based upon the closing EHT 2009/10 balance sheet and changes over the five year period only to reflect the Income and Expenditure Account surpluses and cash generated over this term.

7.8.2 There are no changes to fixed asset values given the combination of APO premises being retained by the PCTs, therefore being off the balance sheet, and year on year capital expenditure being equivalent to depreciation.

7.8.3 In terms of APO working capital balances the assumption used in the financial model is that closing 2009/10 debtor and creditor balances would remain with the PCTs, as they hold the related cash position.

7.8.4 The alternative is to transfer the balances and an equivalent net cash sum, which also has a neutral impact on the ICO's opening balance sheet. The due diligence and financial transition workstream processes will finalise the approach to be taken here and may result in changes to gross numbers within the presented working capital balances but not the net position.

7.8.5 There are no forecast significant changes to the underlying EHT working capital position from 2010/11 and this leaves the ICO with a relatively strong position in this respect with the level of cash held always exceeding creditors and net current assets of:-

Net Current Assets	**End 2010/11 £m**	**End 2011/12 £m**	**End 2012/13 £m**	**End 2013/14 £m**	**End 2014/15 £m**
	6.4	9.2	12.1	15.0	18.9

7.8.6 Other balance sheet ratios including fixed assets to turnover (50%) and debtor and creditor days are relatively low, giving the ICO a good workable start position in these respects.

7.8.7 Given that the net inflationary change is within the range +/- 1% through the five year period of the model and therefore not significant, no adjustment has been made to inflate/deflate working capital balances on the balance sheet. EHT fixed asset values reflect a 2009 revaluation.

7.9 Cash

7.9.1 A cash flow statement reflecting the key movements over the next five years is included within the financial model appendix (Attachment 9). This shows that delivery of the yearly income and expenditure surpluses as planned would enable the ICO to generate cash and increase balances held.

7.9.2 The only current annual call on these cash surpluses is loan repayments for the maternity development (£0.4m per year for 11 years).

7.9.3 This means cash balances build up as follows (from EHT's closing planned 2009/10 cash balance of £4.4m):-

Closing Cash Balance	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
	5.2	8.0	10.9	13.8	17.7

7.9.4 Such balances provide protection against the cash impact of short-term income and expenditure performance downturns. They also provide an additional potential resource for capital expenditure.

7.9.5 EHT has a longstanding record of paying 98-99% creditors in time under the Better Payment Practice Policy and the modelled arrangements for the ICO would ensure that this could be continued.

7.10 Foundation Trust Regime Risk Rating

7.10.1 The ICO aspires to become an NHS Foundation Trust (FT) and as such its financial performance will be measured against the risk ratings in Monitor's Compliance Framework.

7.10.2 The rating system is scored 1 to 5, with 1 being the lowest rating (most risk) and 5 the best rating (least risk). The metrics are split into four categories and five ratios as follows:

- Achievement of Plan – Normalised Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) Margin
- Underlying Performance – EBITDA Margin
- Financial Efficiency – Return on Assets Employed (ROA) and I&E Surplus Margin (2 ratios)
- Liquidity – Liquid Ratio

7.10.3 The financial model appendix provides details of the thresholds which are used for the 1 to 5 scores for the individual ratios and calculates the ICO's prospective overall annual risk rating, given Income and Expenditure Account performance as described above. The results are:-

2010/11	2011/12	2012/13	2013/14	2014/15
3	4	4	4	4

7.10.4 The normal minimum acceptable rating is 3 and for a successful FT application, this level must be maintained even after downside scenarios that Monitor will apply to the model and assumptions.

7.10.5 A level 4 rated Trust is permitted to borrow up to 25% of its net assets under Monitor's Prudential Borrowing Code (PBC) and a level 3 Trust, 15%. This is subject to satisfaction of further ratios which assess an organisation's ability to service any loans applied for. Based on the financial model, these prudential borrowing ratios are also met and so

borrowings for new capital in line with the overall risk rating would be possible.

7.11 Financial Risk

7.11.1 There are significant risks in the financial model as it stands. These risks principally relate to the financial context, income, savings and costs of change.

7.11.2 In terms of the financial context there are two risks that are most readily evident, firstly that the tariff uplift is reduced to reflect either a higher savings requirement or lower cost inflation than forecast, and secondly, that the overall financial position across London deteriorates such that greater savings are required locally. These risks cannot be quantified at this stage but, on its own a 1% impact of either is manageable in the short term from 2011/12 onwards.

7.11.3 The main risks around income as it stands in the model are:-

- Gaining 40% of the work transferring from acute through service redesign (risk of up to £6.1m per annum by year 4)
- Winning the Urgent Care Centre tender (risk of up to £2.3m per annum)
- Increasing Maternity activity (risk of up to £4m per annum by year 2)
- Increasing non-NHS income (risk of up to £5.3m by year 5)

7.11.4 The main risk around savings is that of being able to remove semi-fixed and fixed costs in relation to acute activity reductions and clinical efficiency programmes, whilst maintaining good quality, safe services.

7.11.5 The final risk area is that related to costs of change, the assumption being that these can be largely avoided using a mixture of vacancy management and role re-modelling.

7.12 Comparison with Standalone Organisations

7.12.1 The most striking aspect of the financial risk analysis at 7.11 above is that all of the risks would still be present, with at least the same value, for the standalone organisations going forward, if the ICO does not proceed.

7.12.2 However, what the ICO does is provide a better financial basis from which to deal with the risks and challenges.

7.12.3 There is firstly a significant element of the ICO savings plan which would not be available to the standalone organisations. Whilst they

would be able to achieve some corporate cost reductions, these would be only a small proportion of the £6m minimum achievable together. The dividend from aggregating non pay procurement would also not be available.

7.12.4 A second variation of the financial model is appended to the case which shows the position of the aggregated standalone organisations (excluding inter-trading) over the next five years. As can be seen, significant losses are made when the benefits from coming together are lost:-

2010/11	2011/12	2012/13	2013/14	2014/15
-£2.9m	-£6.3m	-£6.6m	-£7.0m	-£6.0m

The balance sheets presented in this second model are illustrative but show how the cash position would deteriorate rapidly unless additional substantial savings were found. Capital expenditure would have to be reduced and working capital stretched, both of which are only sustainable in the short-term, or cash would run out mid-2011/12. The Monitor risk ratings would be below the acceptable level in all years.

7.12.4 In addition to the immediately quantifiable differences, costs of change would be higher for the standalone organisations as there would not be any opportunity to manage vacancies across the ICO, or to re-design roles to reflect different settings for care.

7.12.5 Opportunities with potential financial gain for the ICO would also be lost, including those of applying the Ealing and Harrow model of integrated acute and community care to win new contracts, as would the opportunity to remodel pricing mechanisms across the ICO's contracts with its commissioners to promote care in the most appropriate setting.

Section 8

Governance of the ICO

8.1 Governance arrangements

The Integrated Care Organisation will be formed from the 'shell' of Ealing Hospital NHS Trust (EHT) with the PCT provider services transferring into the 'shell'.

The organisation will be formed using the statutory framework of Ealing Hospital NHS Trust as its 'shell', together with a series of changes which produce the "new" organisation including:

- Choosing a new "operating name" for the organisation. We will involve staff and other stakeholders in considering the options. At a later date, we expect to change the legal name of the organisation.

- Changing the legal purpose of the Trust (the "Objects" in its "Establishment Order") so that it can provide healthcare in all settings, and remove the current geographical limitation.

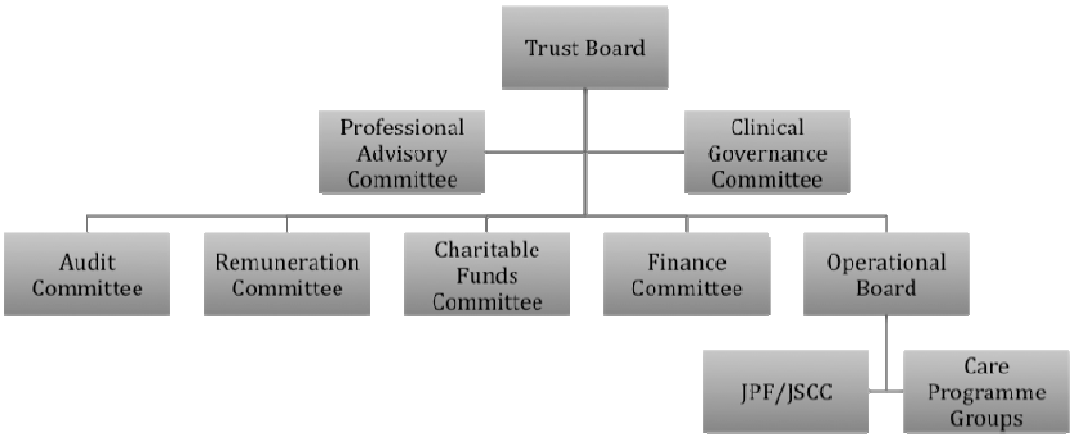
- Changing the senior leadership arrangements, appropriate for an organisation providing a broad range of services in hospital and community settings. An example of this would be to involve general practitioners in the senior leadership of the organisation, as Primary Care Trusts have done.

Over time we expect to develop a new management structure, which integrates community and acute services.

Formally we will be "transferring" the community services and some of their support services into an existing organisation, Ealing Hospital NHS Trust. But the Integrated Care Organisation, which it will become, will have many of the characteristics of a brand "new" organisation, fit for its new purpose.

The ICO will have a governance structure, which meets the Monitor 'well governed' test from the outset. The draft committee structure is shown below:

Committee Structure for ICO



Section 9

Assessing Risk

9.1 Introduction

There are a number of work-streams, as part of the Integration Programme and each of these will develop a more detailed risk log as the programme proceeds. Risks have been assessed under 2 major headings namely the risk to establishing the ICO and the risk to the ICO as a 'going concern'. We also consider the risks to co-operation and competition locally by creating an ICO.

9.2 Risks to Establishing the ICO

The potential top risks associated with establishing the ICO are reviewed in Attachment 4 (Table A). This reviews each of the risks, likely consequence and mitigation plans in place to deal with the risk.

9.3 Risks to the ICO as "Going Concern"

The potential top risks associated with ICO as a 'going concern' are reviewed in Attachment 4 (Table B). This reviews each of the risks, likely consequence and mitigation plans in place to deal with the risk.

9.4 Risks to Co-operation and Competition Locally

Here we give consideration to the fact that the commencement of the ICO from the 1st April 2010 is subject to NHS London and Cooperation and Competition Panel (CCP) approval processes.

The CCP will make a recommendation to NHS London on the effects of the change on the competitive environment. The CCP's recommendation, if approved by NHS London, would stop the creation of the ICO.

Therefore we have undertaken in Attachment 5 an in-depth assessment of what would happen to competition if the ICO were not created, and the likely scenarios that would occur, with acute and community services combining with other other organisations instead.. This assessment concludes that:

- The Integrated Care Organisation provides the scenario with the least reduction in competition.
- All the other scenarios would result in a greater reduction in competition, some of them by two whole providers.
- The Integrated Care Organisation would actually increase competition in Harrow, eastern Ealing, and in areas surrounding Ealing and Harrow, by creating a stronger community competitor.

See Attachment 5 for further details.

Section 10
Implementation Plan, Time Line and Communications

10.1 Implementation Plan and Timeline

An outline of the Implementation Plan to achieve the ICO for 1 April 2010 is given in Attachment 6 and key elements of this are shown in the accompanying Gantt charts. Thie charts focus on displaying the tasks which are most important to achieving the organisational change in time for 1st April 2010, and their dependencies.

In December, subject to Board approval on 26th November, a further phase of planning will take place. This will provide more detail on the periods January to March 2010, and April to June 2010, and add elements, such as Information, Organisational Development and Estates.

The planning for this programme is running to very tight timescales. To implement the new organisation in four months will require considerable investment of time from senior managers across the four organisations. Consequently, tasks which are essential to be delivered by 1 April 2010, will be given priority.

The tight timescales for the implementation requires intensive actions across a wide range of the organisations' functions. Therefore, some tasks will have to be undertaken after the "Go Live" date of 1 April 2010.

10.2, Communication and Stakeholder Engagement Strategy

As part of the implementation process, a detailed Communications and Stakeholder Engagement Strategy has been prepared. This is appended as Attachment 7. The major focus initially will be internally with the staff to be transferred, and with key stakeholders externally. This broadens to include a wider group of staff and stakeholders, including the public, as the plan progresses.

This concludes the Business Case.

Part 2 contains 8 Attachments giving more detail on sections above. Attachment 9a and 9b are separate financial spreadsheets.