1 Terms of Reference

The Whittington Hospital NHS Trust commissioned Finnamore Management Consultants to carry out an independent review of the work undertaken to date on plans to redevelop facilities in support of maternity and neonatal services. The objective was to determine whether the process followed had been carried out with the degree of rigour necessary and had addressed satisfactorily all of the key issues. In particular, the Trust was seeking a view on the robustness of the conclusions reached and to identify the need for any additional work to be undertaken prior to engaging with NHS London:

Stage 1: a detailed assessment of the documentation provided to determine the robustness of process and conclusions; and

Stage 2: preparation of a briefing paper to inform discussions with NHS London on the way forward and the extent of SHA support required to deliver the project.

This report deals with Stage 1, although issues which should be addressed in the context of Stage 2 discussions with the NHS London have also been identified.

2 Introduction

This report is based on a desk top review by Finnamore Management Consultants of the documentation provided by the Trust, together with discussions with Fiona Elliott, Director of Planning and Performance and Sophie Harrison, Planning and Performance.

The report is structured as follows:

Section 3:	Summary of findings.
Section 4:	The Trust's development plans
Section 5:	How does the maternity redevelopment contribute to wider Trust and public sector stakeholder strategies?
Section 6:	Is the strategic case complete and robust?
Section 7:	Are the scope, scale and requirements realistic, clear and unambiguous?
Section 8:	Conclusions

3 Summary of Findings

The Phase 1 interim schemes avoid the need to cap the service at the current level of 3,700 deliveries. The Trust's Phase 1 schemes are nearing completion.

The Trust's view is that the Phase 2 schemes proposed will improve the quality of the maternity accommodation and will expand NICU by 5 cots, ensuring sustainability of the Level 2 NICU service. These are short term measures designed to address the Trust's ability to continue to care effectively for women. Finnamore considered whether these developments could be included in a more substantial redevelopment option. At the time the Trust undertook the work, due consideration was given to the short term need for these schemes. The Trust concluded that they represent minimal enhancements to capacity and focus principally on urgent quality considerations, hence the decision to proceed in advance of more significant development. On the basis of the documentation reviewed and discussions with the Trust, Finnamore agrees that the basis of the Trust's decision to proceed with the Phase 2 schemes is reasonable.

The Trust has used the London Maternity Review growth projections as the basis for its five year planning assumptions. The Trust considered a range of growth projections and chose an intermediate position. Given the data available to the Trust at the time, the methodology used and the interpretation given by the Trust to determine future demand levels was, in Finnamore's view, robust.

The latest available data from the London Health Observatory (LHO) and the Greater London Authority (GLA) shows significant disparity in growth projections. Whilst the analysis undertaken by the Trust was robust at the time, the most recent LHO report[1] concludes "Historical trends show that large swings (of the order of 20%) in numbers of births have occurred over periods of 10 years or so, and could therefore occur in the future…Consideration should be given to flexibility in planning strategies." Finnamore believes that no further work should be undertaken independently by the Trust. Rather, there should be a wider, sector based strategic review of maternity activity projections, commissioned by the SHA in conjunction with all relevant commissioners.

[1] "Estimating Future Births in the Capital: A Discussion Document Technical Report", London Health Observatory, December 2008.

Taking the assumed 10 year capacity of 4,700 deliveries as a given, neither of the development options relating to this level of capacity is affordable to the Trust. Finnamore challenged the Trust as to whether the process they had undertaken had given proper consideration to a sufficiently wide ranging set of options, including the "Do Minimum" option. Finnamore was assured, both by documentation and on the basis of discussions with the Trust that the scope for a more modest development option had been explored and had been discounted because of the configuration of the existing buildings and the physical constraints on any sustainable, smaller scale modular development.

Recommendation

The key issue for the Trust relates to planning assumptions around future activity levels. Finnamore believes the Trust should now engage with NHS London and all relevant commissioners to agree assumptions across the sector. It would not be appropriate for the Trust to undertake any further work independently.

3.1 Project Management, Governance and Background to the Project

The Trust established a Redevelopment Steering Group (RSG), a senior group chaired by the Trust Chief Executive including the Medical Director, the Director of Finance and the Director of Facilities and representatives of maternity and neonatal services and planning. The Steering Group reports to the Trust Board. A Project Initiation Document was established setting out the project objectives.

The proposals for redevelopment of the maternity and neonatal facilities date back to September 2006. The Trust developed a service model covering all clinical services. This model was based on the principles set out in "Healthcare for London: A Framework for Action" and was approved by the Trust Board in May 2007.

The Trust initially assessed the need for a large scale investment in facilities to support delivery of the clinical model. Initial estimates ranged from £87m to £123m, based on 6,000 deliveries, and prompted a more detailed review. This focused on the services accommodated within the Victorian buildings, co-ordinating clinical facilities in a smaller, more flexible building. The project objectives and the PID were amended accordingly to focus on maternity, neonatal and rehabilitation (rehabilitation was subsequently removed from the project – the need to reprovide rehabilitation derives solely from the potential sale of surplus land). The financial modelling accompanying these revisions was taken forward within the first iteration of the Trust's Integrated Business Plan (IBP).

A long list of development options was identified by the project team and a set of non-financial evaluation criteria was agreed by the Project Board. These criteria were used to shortlist four of the six long listed options.

By December 2007, the service model had been translated into activity levels, initial affordability assessment had been undertaken and a long list of options had been identified.

At this point, a decision was taken to incorporate into the IBP the impact of short term capacity expansion and modernisation within existing accommodation over the next five years. This would allow the Trust the flexibility to test the shortlisted long term options as well as the full range of investment opportunities.

From the period December 2007 to March 2008, the Trust developed the four shortlisted options based on activity projections of 6,000 deliveries.

In March 2008, a decision was taken at the RSG to focus further work on 3 options (the Do Minimum, Hybrid and New Build). In addition, it was agreed to revisit the activity assumptions for maternity and consider alternative solutions for non-maternity elements of the scheme.

From March to June 2008, the project focused on the two phases of interim (5 year) schemes and development of the new build option with a reduced capacity of 4,700 deliveries (including 100 home births) in response to affordability constraints and uncertainty in relation to the ability to attract the higher level of activity. At this stage, a revised Do Minimum was proposed based on a combination of the original Do Minimum and the Hybrid (refurbishment and new build) options.

From June to December 2008, the work focused on the development of the two design options, the non-financial appraisal and the financial analysis.

Set out below is our assessment of a number of the key components of the planned maternity and neonatal redevelopment.

3.2 Case for Change

The case for change comprises two elements – quality and capacity. The former is based on the need to offer a safe, high quality maternity and neonatal service within an environment that meets the needs and aspirations of women. The Trust believes that the location, configuration and quality of buildings do not currently meet these requirements. Short term plans have been developed to address these concerns for the next 5 year period and include:

- Phase 1 – additional capacity to avoid serious clinical incidents and the need to cap the service when demand exceeds capacity. The schemes included under Phase 1 are nearing completion.
- Phase 2 – improvements in the clinical and environmental quality for Maternity and Neonatal Intensive Care Unit (NICU) services to support choice and the expansion of NICU to sustain the Level 2 service.

Phases 1 and 2 require total capital investment of £4.5m. It has been assumed by the Trust that the impact of these schemes on income and expenditure will be neutral as the revenue costs will be offset 100% by additional income. The financial analysis shows this to be the case in broad terms.

Phase 1 expenditure has already been incurred. Finnamore understands that consideration was given to whether the expenditure planned for Phase 2 could be spent more effectively as part of a substantial redevelopment option rather than on short term interim schemes. This is discussed further below.

In the longer term, the Trust's own market assessment shows that a number of Trusts are planning significant investment in maternity facilities. Choice may become a significant risk to the Trust without addressing factors such as the availability of single rooms, for example. There are also a number of significant clinical issues to be addressed including the availability of a dedicated second obstetric theatre and the configuration of ward accommodation. The long term case for change on grounds of service quality is, in Finnamore's view, compelling. However, without a clear sector wide view of activity projections, the Trust should not progress such investment until the scale of investment requirement is understood. Long term clinical and financial sustainability can only be secured through joint agreement by all relevant commissioners on future activity and income levels.

3.3 Development Options

As part of this review, Finnamore assessed whether the Trust had considered all possible development options. The Trust was asked to demonstrate that:

- a full range of development options was considered, in particular, the potential for a short term/modular development - along the lines of West Middlesex (maternity) or Hillingdon (planned wider hospital development) – had been assessed;
- why the interim schemes (Phase 2) should not, in fact, be progressed as part of a redevelopment option rather than progressing in advance, as currently planned; and
- a genuine “Do Minimum” option had been included in the appraisal.

The analysis undertaken by the Trust shows a long list of six options was identified. A shortlist of four options was identified through assessment against a comprehensive set of non-financial evaluation criteria. The narrative which summarises this assessment demonstrates robust process and thinking together with a sufficiently diverse, multidisciplinary Project Board participating in the evaluation. This process is consistent with NHS capital investment guidance.

Finnamore was assured by the Trust that the configuration of the existing Victorians buildings and the availability of sufficient space on site precluded either a more modest development (due to the inability to accommodate 4,700 deliveries) or a modular building (space constraints, clinical adjacency restrictions). Finnamore’s understanding of the site and building layout confirms this to be a logical conclusion.

The Phase 2 interim schemes focused on short term, urgent quality issues and were not intended to address capacity. In our view, there is no merit in delaying these schemes to incorporate them into a wider development option. The Trust was of the view that these schemes related more to short term issues rather than longer term, strategic capacity constraints relating to growth projections and, on that basis, there is little to be gained from deferring these schemes.

The Trust’s approach to development of the Do Minimum option was to prepare this option on the basis of the lowest cost scheme that would deliver the same project objectives as the other schemes being considered. An alternative approach to the Do Minimum could be adopted but this would only be able to generate a lower quality of environment. Finnamore’s assessment is that the approach taken to development of the Do Minimum option is consistent with capital investment guidance.

3.4 Procurement/Partnerships

Finnamore understands that joint venture opportunities with the independent sector have been deemed by the Trust as "high risk" in the current climate. The Trust should consider joint venture development opportunities which deliver wider Trust/stakeholder benefits. There is insufficient Trust funding available either as a NHS trust or as a Foundation Trust to finance a major development of the scale envisaged under Options 1 and 2. A joint venture approach may generate potential for a solution which achieves quicker delivery, reduced I&E impact and more flexible timing and availability for site development opportunities. Consideration of this type of approach would be more appropriate after discussions across the sector on activity projections have taken place.

4 The Trust's Development Plans

In developing the Trust's Integrated Business Plan, proposals were included to expand the capacity of the maternity and NICU unit from 3,700 deliveries and 26 cots to 4,400 deliveries and 29 cots by 2013/14. The most recent activity projections considered by the Trust envisage demand growing beyond 2013/14 indicating a target capacity of 4,700 deliveries in 10 years time.

The Trust's view is that this growth is likely to result in the need to cap at 4,400 deliveries without significant investment in additional capacity which needs to be planned now. In addition, the interim plans to address environmental issues are intended to meet needs over the next 5 year period only and do not fully address all issues of quality. Critically, the need for investment in further capacity hinges on two key assumptions – that demand projections are robust and that there is no overlap in the growth predicted by the Whittington and other maternity units in the area.

Delivering 4,700 deliveries was not considered feasible within the current building standards nor financially viable. The net additional cost of the Refurbishment Option 1 (gross additional expenditure of £9.50m less additional income of £1.87m) was £7.63m and £6.92m for the new build option (gross expenditure impact £8.81m less additional income of £1.87m). The new build option has a lower impact on expenditure due to the effect of surplus land sale proceeds.

Flexing occupancy was also discounted because of the consequential impact on staff morale and the quality of service offered to patients.

The option of the Whittington independently progressing development of a unit with a capacity of 6,000+ deliveries would require SHA support for reconfiguration of service provision across the sector. However, the Whittington believes it is in a strong position to develop such a unit on the grounds of expertise, quality of service and availability of land.

5 How does the Maternity Redevelopment contribute to Wider Trust and Public Sector Stakeholder Strategies?

Finnamore understands that the existing facilities to support maternity and neonatal services have a number of significant constraints. They are housed in old Victorian buildings, which are not suitable for modern maternity and neonatal care. The configuration of the maternity accommodation means that it is difficult when the service is busy to ensure appropriate separation of each stage of the pathway of care. The quality of the environment and the ability to offer single rooms may become an increasingly inhibiting factor should women begin to exercise choice on a larger scale.

The service is projected to grow by 17.5% over the next five years which will place significant pressures on existing capacity.

There are operational issues, notably with regard to main theatres. There are four lists within the main theatres for caesarean sections, in addition to the dedicated obstetric theatre within the maternity unit. Centralising theatre facilities in support of maternity services would be better for women who currently undergo c-sections in main theatres – where they also recover – before being transferred back to the maternity unit for post-natal care. In addition, this would allow for greater flexibility within the main theatre block.

It may be possible to procure a joint venture approach which could generate wider stakeholder benefits whilst utilising the surplus land proceeds more effectively, increasing the benefit to the Trust. Potentially the redevelopment could also be delivered more quickly. Finnamore understands there are no restrictions on wider site development within the existing PFI deal. There are also significant tranches of surplus land available if the site is redeveloped appropriately. Both of these characteristics would help support a new joint venture approach being developed elsewhere in London. This would benefit the NHS through:

- Sharing in the timing, risk and reward of realising the surplus land values;
- Development geared to Trust revenue certainty with the flexibility to expand quickly at a later date; and
- Creating a scheme which embraces wider stakeholders within the community and therefore is more likely to engender local support.

The lack of Trust access to significant capital, either as a NHS trust or as a foundation trust, further strengthens the case for exploring this approach. However, in Finnamore's view, this should be considered after sector wide analysis of activity projections has been undertaken.

6 Is the strategic case complete and robust?

The Trust's plans for maternity and neonatal services comprise two stages of development: proposals to manage capacity for the next five years, as set out in the IBP, and requirements beyond 2013/14.

The Trust has undertaken an analysis of its share of the Camden, Islington and Haringey activity. This shows that the Trust has 41.1% of this market. Other providers include University College London Hospitals NHS Foundation Trust (27.7%), the Royal Free Hampstead NHS Trust (17.9%), North Middlesex University Hospital NHS Trust (5.4%) and others (7.9%). This market covers the overwhelming proportion of The Whittington's maternity activity, although it is not clear about the exact level. UCLH currently has capacity for 4,000 deliveries, including the new unit, with plans to increase capacity by adopting measures of improved efficiency (reduced lengths of stay). The Royal Free operates at 3,400 deliveries and plans to increase its inpatient bed numbers but not delivery capacity. The North Middlesex's new build will cater for existing activity levels only. The planned reconfiguration of Barnet and Chase Farm Hospitals will result in one maternity unit serving both sites. Key assumptions being made by the Trust in relation to its competitors are as follows:

- UCLH will cap capacity at 5,000 deliveries;
- Some overflow from Barnet and Chase Farm may move to The Whittington; and
- There will be no expansion in capacity for the Royal Free or North Middlesex in the short to medium term.

The Trust's view is that as a Level 2 NICU and with a good reputation locally, it is in a strong position to influence patient choice.

The Trust's analysis also makes reference to support for the Trust's maternity services from Islington PCT. However, the support from Haringey will also be critical and similar evidence of long term commissioner support should also be obtained.

The activity projections are fundamental to the financial viability of the Trust's plans for maternity services. Since the Trust undertook its activity projections, the credit crunch may have affected the rate of increase in the growth of birth rates. Finnamore recommends that sensitivity analysis be undertaken to determine the impact of the financial down turn on birth rates locally, in conjunction with a sector wide review of maternity activity.

7 Are the scope, scale and requirements realistic, clear and unambiguous?

The Trust is firmly of the view that the current nature and scale of facilities for maternity services is inadequate in terms of quality of environment, clinical adjacencies and capacity. Finnamore visited the site and concurs that the quality of the facilities is not consistent with 21st century maternity and neonatal care. The key questions are to what extent could the Trust maintain a viable service with a minimum level of investment ie ("Do Nothing" or "Do Minimum") and, if investment is required, have all possible options been explored in terms of scale and configuration.

Given the potential impact of choice on the Trust's maternity services and the plans in place for a number of adjacent maternity units to invest in maternity facilities, Finnamore agrees with the Trust's assessment that do nothing is not tenable. The Trust has already invested in Phase 1 of its five year interim schemes. Phase 2 focuses on achieving sustainability of services for women by increasing neonatal cot capacity and improving the quality of maternity accommodation in response to choice.

However, it is recognised that investment is about both capacity and the quality of the service offered. The interim schemes – both those nearing completion and about to commence - do not address issues such as single room accommodation, second dedicated obstetric theatre, patient access to the service, or optimisation of ward size.

Finnamore understands that the Trust's current plans are based on a Refurbishment "Heritage" option, which consists of major refurbishment of "D" and "E" blocks at a gross estimated capital cost (including fees and equipment) of £46.9 million, and a new build option at a cost of £58.5 million. Whilst both options could generate capacity of 4,700 deliveries, neither is affordable. The key issue for the Trust, therefore, is the ability to achieve a step change in activity which delivers maternity unit expansion which is sustainable both financially and in terms of quality of service. A strategic view on sector wide maternity capacity and location is therefore critical to long term maternity service viability at the Whittington.

8 Conclusions

Finnamore agrees with the Trust that, currently, it would not be prudent to commission a business case for Options 1 or 2 on the grounds of affordability and risk, based on the analysis carried out to date.

Finnamore also concludes that the analysis undertaken to date by the Trust has been based on a robust process and methodology.

No further work should be undertaken by the Trust independently. The Trust should now seek to engage with NHS London on the case for investment in maternity and neonatal services.

The principal areas for further consideration in conjunction with NHS London are as follows.

1. Current available evidence on maternity activity growth shows only that there is increasing uncertainty about what will happen with maternity activity (up or down) and reinforces the need for sector wide discussion with the SHA.
2. In conjunction with a sector wide review of maternity activity projections, Finnamore recommends that sensitivity analysis be undertaken to determine the impact of the financial down turn on birth rates locally.
3. Further work should be undertaken to understand long term commissioning intentions.
4. Following the sector wide analysis of maternity activity projections, the Trust will be in a position to explore the scope for a new type of joint venture which could deliver increased capacity more flexibly and more rapidly than conventional capital development based on an agreed set of activity planning assumptions which will inform appropriate scale of development.