

Arden PCT Cluster with  
George Eliot Hospital NHS Trust &  
University Hospitals Coventry and Warwickshire Hospitals NHS Trust

# Paediatric & Maternity Services at George Eliot Hospital

## Business Case

# Paediatric & Maternity Services (GEH)

## Business Case

### DOCUMENT CONTROL SHEET

Version	Date	File Name	Status
1.0	16 <sup>th</sup> November 2011	111116 GEH Paediatric & Maternity Services Business Case_Draft V1.0	Final draft issued for review and sign off by Delivery Team
1.1	22 <sup>nd</sup> November 2011	111122 GEH Paediatric & Maternity Services Business Case_Draft V1.1	Updated following comments from Project Team; re-issued for sign off by Ardent PCT Cluster, GEH and UHCW Boards
2.0	22 <sup>nd</sup> March 2012	120322 GEH Paediatrics & Maternity Services Business Case_Draft V2.0	Updated to reflect SWFT arrangements For submission to the Steering Group
2.1	1 <sup>st</sup> May 2012	120501 GEH Paediatrics & Maternity Services Business Case_Draft V2.1	Updated for revised deanery income calculations and updated implementation milestones

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### 1. EXECUTIVE SUMMARY

#### 1.1 Background to the Business Case

##### 1.1.1 Paediatric & Maternity Services at GEH NHS Trust

George Eliot Hospital NHS Trust (GEH) currently provides Paediatric, Obstetric, Gynaecology and Level 1 Neonatal Care to the population of North Warwickshire, while Paediatric emergencies by ambulance (i.e. “blue lights”) are directed to University Hospitals Coventry and Warwickshire NHS Trust (UHCW).

Services are primarily delivered from the GEH site and by the Trust’s own workforce, with the exception of out of hours Paediatric and all Neonatal care, which is currently delivered by a cross-site medical staffing rota comprising GEH and UHCW Consultants. Community Midwifery services are delivered from community and primary care settings.

Concerns have been raised over recent years – in particular by the West Midlands Children’s, Young People and Maternity Services Configuration Group (WMCG) in 2008, and by the West Midlands Deanery in 2011 - about the viability and sustainability of Paediatric services at GEH. This is due to the relatively small numbers of patients being seen there and as a consequence, the limited range of conditions and illnesses that are treated, and the impact this has on staff and their development. Such concerns have culminated in the West Midlands Deanery withdrawing Junior Paediatric Doctors’ training from September 2011.

This Business Case has been prepared to examine the options that are available to GEH to improve and deliver innovative services by an appropriately trained and sustainable workforce.

##### 1.1.2 Purpose of the Business Case

The purpose of this Business Case is to:

- Set out the case for reviewing the delivery and configuration of Paediatric and Obstetric services at GEH;
- Identify the objectives and benefits to be achieved by this exercise;
- Identify and evaluate the options available to GEH and the local health economy for delivering Paediatric and Obstetric services for the population served by the Trust;
- Set out the results of the option appraisal;
- Set out the future proposed project management and governance arrangements to implement the preferred solution;

#### 1.2 Background to the Organisations

##### 1.2.1 Arden PCT Cluster

The Arden PCT Cluster was formed in May 2010 by bringing together the Primary Care Trusts (PCTs) of NHS Coventry and NHS Warwickshire. The Cluster serves the populations of Coventry and Warwickshire, which is estimated to total circa 910,000, and in 2011/12, has a budget of £1.4 billion.

The majority of services are commissioned from 3 acute Trusts – UHCW (acute services only), GEH (acute, community and primary care), South Warwickshire Foundation NHS Trust (acute

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and community), 1 mental and community health provider – Coventry and Warwickshire Partnership NHS Trust, as well as from West Midlands Ambulance Service NHS Trust, 139 GP Practices, 109 dental practices, and 105 optometry contractors.

#### 1.2.2 George Eliot Hospitals NHS Trust

GEH is an integrated provider of acute, community and primary care services, to a population of over 300,000 people in North Warwickshire, South West Leicestershire and North Coventry. The Trust's main hub is the George Eliot Hospital which opened in 1948, and stands on a 32-acre site on the outskirts of Nuneaton, from which a range of acute surgical, medical, women's and children's services are delivered, including orthopaedics, accident and emergency and maternity care.

In 2010/11, the Trust's annual activity included 65,000 A&E attendances, 17,000 planned admissions, 15,000 emergency admissions, 160,000 outpatient attendances and 2,500 births. The total income for the Trust in that year was £108m.

The Trust's main commissioner is NHS Warwickshire, with the PCT accounting for 71% of healthcare income, with Leicestershire County and Rutland PCT accounting for 12.8% and NHS Coventry 6.6%.

#### Women's & Children's Services

A high level summary of the Women's & Children's Services currently delivered from GEH is summarised below:

##### Women's & Children's Services - GEH

	Paediatrics	Obstetrics	Neonatal	Gynaecology
<b>Services</b>	<ul style="list-style-type: none"> <li>Inpatients</li> <li>Outpatients</li> <li>Day Case Surgery</li> <li>Emergencies to Paediatric Assessment Unit or main A&amp;E Department (24 hours a day/7 days a week)</li> </ul>	<ul style="list-style-type: none"> <li>Inpatients (both Consultant and Midwifery Led Care &amp; Births)</li> <li>Outpatients</li> <li>Community Midwifery (North Warwickshire)</li> </ul>	<ul style="list-style-type: none"> <li>Level 1 SCBU care (Consultant supported medical middle grade neonatal resuscitation)</li> <li>Level 2 &amp; 3 transfers to UHCW</li> </ul>	<ul style="list-style-type: none"> <li>Inpatients</li> <li>Outpatients</li> <li>Day Cases (Colposcopy &amp; Hysteroscopy)</li> <li>Emergency Out of Hours Admissions</li> </ul>
<b>Facilities</b>	<ul style="list-style-type: none"> <li>1 Paediatric ward (12 beds)</li> <li>Paediatric Assessment Unit within the Main A&amp;E Department</li> </ul>	<ul style="list-style-type: none"> <li>1 x 10 bedded Labour Ward</li> <li>Obstetric Theatres and recovery space</li> <li>Antenatal outpatients</li> <li>3 Ultrasound Scan Rooms (supported by sonographers)</li> </ul>	<ul style="list-style-type: none"> <li>12 Level 1 cots</li> </ul>	<ul style="list-style-type: none"> <li>No designated Gynaecology ward – beds on a surgical ward</li> <li>Emergency out of hours admissions seen in main A&amp;E</li> <li>Gynaecology outpatients</li> </ul>

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	Paediatrics	Obstetrics	Neonatal	Gynaecology
<b>Facilities (contd.)</b>		<ul style="list-style-type: none"><li>• Triage/Maternity Assessment Unit in antenatal clinic</li></ul>		<ul style="list-style-type: none"><li>• Early Pregnancy Assessment Unit</li><li>• Gynae Diagnostic Suite</li></ul>
<b>Activity</b>	<ul style="list-style-type: none"><li>• 17,242 A&amp;E attendances / 1,676 admissions</li></ul>	<ul style="list-style-type: none"><li>• 2,474 births (2010/11)</li><li>• 1.3% home birth rate</li><li>• 21.52% Caesarean Section rate</li></ul>	<ul style="list-style-type: none"><li>• 3,216 SCBU cot days (2010/11)</li></ul>	<ul style="list-style-type: none"><li>• OOH non elective admissions: 273 spells and 480 occupied bed days</li></ul>

#### Physical Location of Services

Both inpatient and outpatient maternity and newborn services are delivered in a standalone maternity unit which opened in the 1960s, on the main GEH site. The building is acknowledged as being tired and in need of refurbishment or replacement.

Children's emergencies are dealt with in a Paediatric Assessment Unit in the main hospital on the GEH site, with gynaecological emergencies dealt with in the main A&E department.

#### 1.2.3 University Hospitals Coventry and Warwickshire NHS Trust

UHCW provides district general hospital services to 500,000 people and tertiary services to over 1 million. With an income of £472 million (2010/2011), the Trust provides services across both its sites with approximately 6,400 staff, 1,200 beds and 27 operating theatres.

In 2010/11, the Trust's annual activity included 135,813 planned admissions, 161,462 emergency admissions (including specialist children's A&E), 548,927 outpatient attendances, 43,979 operations in Theatres, and 6,006 babies delivered.

The Trust's main commissioners are NHS Coventry, accounting for 51.6% of its income, NHS Warwickshire (25.3%) and West Midlands Specialist Commissioners (16.4%) for specialised services including Neonatal services.

#### Women's & Children's Services

A high level summary of the Women's & Children's Services delivered from UHCW is summarised below:

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Women's & Children's Services - UHCW

	Paediatrics	Obstetrics	Neonatal	Gynaecology
<b>Services</b>	<ul style="list-style-type: none"> <li>Inpatients</li> <li>Outpatients</li> <li>Day Case Surgery</li> <li>Children's Emergency Department</li> </ul>	<ul style="list-style-type: none"> <li>Inpatients (both Consultant and Midwifery Led Care &amp; Births)</li> <li>Outpatients</li> <li>Community Midwifery (Coventry &amp; Rugby)</li> </ul>	<ul style="list-style-type: none"> <li>Level 1 (SCBU), 2 (Neonatal Unit) and 3 (Neonatal Intensive Care Unit) care</li> </ul>	<ul style="list-style-type: none"> <li>Inpatients</li> <li>Outpatients incl Colposcopy and Hysteroscopy</li> <li>Day Cases</li> <li>Emergency Out of Hours Admissions</li> </ul>
<b>Facilities</b>	<ul style="list-style-type: none"> <li>3 wards with 52 beds including 4 HDU beds</li> <li>Dedicated Children's Emergency Department</li> </ul>	<ul style="list-style-type: none"> <li>1 x 22 bedded Labour Ward, 6 triage beds &amp; 2 HDU rooms</li> <li>2 Obstetric Theatres with 2 recovery spaces</li> <li>Foetal Medicine Unit (Consultant led)</li> <li>Maternity Assessment Unit with 4 beds (midwifery led)</li> <li>6 Ultrasound Scan Rooms (midwife led)</li> <li>Antenatal outpatient clinics</li> </ul>	<ul style="list-style-type: none"> <li>Level 3 Unit with 27 cots (16 SCBU, 11 HDU/ITU)</li> <li>Therapeutic Hypothermia and Neuro-Intensive Care</li> </ul>	<ul style="list-style-type: none"> <li>28 dedicated Gynaecology beds</li> <li>Gynaecology outpatient clinics</li> <li>Gynaecology Outpatient Suite Early Pregnancy Assessment Clinic</li> <li>Gynaecology Emergency Beds (triaged on Gynae ward)</li> </ul>
<b>Activity</b>	<ul style="list-style-type: none"> <li>30,500 Children's Emergency Department attendances / 4,905 admissions</li> </ul>	<ul style="list-style-type: none"> <li>6,006 births (2010/11)</li> <li>1.8% home birth rate</li> <li>27.87% Caesarean Section rate</li> </ul>	<ul style="list-style-type: none"> <li>1,656 ITU cot days</li> <li>1,891 HDU cot days</li> <li>5,802 SCBU cot days</li> <li>1,512 Transitional Care cot days</li> </ul>	

### Physical Location of Services

In late 2004, UHCW re-located its maternity, paediatric, neonatal and gynaecology services into the West Wing of a new purpose built University Hospital, located in the north east of Coventry.

Paediatric emergencies are dealt with in the Children's A&E Department, adjacent to the main A&E within University Hospital, with minor injuries services available for children at the Hospital of St Cross in Rugby.

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### 1.2.4 South Warwickshire NHS Foundation Trust

South Warwickshire NHS Foundation Trust (“SWFT”) is an acute Trust that serves a population of around 270,000 from the south Warwickshire and surrounding areas, and employs just under 3,700 staff (1,600 full time equivalent), based at either one of its four hospitals and / or in the community. It achieved Foundation Trust status in March 2010, and from 1<sup>st</sup> April 2011, took on community services previously provided by Warwickshire Community Health.

Of the four Hospitals, the majority of the Trust’s acute services are delivered from Warwick Hospital, including Accident & Emergency services; Medical and Surgical admissions wards; Diagnostic and Pathology Departments; Maternity and Special Care Baby Unit; Main and Day Surgery Theatres and an Intensive Unit and Coronary Care Unit. The other Hospitals are the Stratford-upon-Avon Hospital (a community hospital), Ellen Badger Hospital in Shipston-on-Sour (providing outreach clinics), and Royal Leamington Spa Rehabilitation Hospital (rehabilitation services).

## 1.3 Case for Change

### 1.3.1 Local Issues

The current Children’s service model at GEH is a traditional three tier medical staffing model, reliant on a resident tier of experienced middle grade Paediatricians who are experienced junior doctors, supported by a more junior tier of resident doctors and by a non resident senior tier (Consultant Paediatricians and Neonatologists). There is however, a requirement for a presence resident on site for 24 hours a day.

Training numbers have been steadily decreasing and training placements are hard to fill, with a significant shortfall predicted. For many years, GEH has not always received its full allocation of doctors from the Deanery. In addition, the introduction of the European Working Time Directive (EWTD) has meant that the total numbers of these doctors required to staff the service has increased because of an overall reduction in the number of hours that individual doctors can work. Non-training grade doctors are difficult to recruit since changes to visa regulations, and the pool of available expertise has shrunk quite dramatically for many specialties.

There remains a mismatch between the number of trainees currently on training placements and the actual number of consultant vacancies. The Royal College of Paediatrics and Child Health have advocated new ways of working and suggest a need for an expansion in the number of Consultant Paediatrician posts. This expansion has not yet happened, and even if it were to at the pace described in their paper, there would ultimately be a need to further reduce the number of trainee placements in an attempt to address the current surplus.

In summary, there are currently too few trainees to fill EWTD compliant middle grade rotas in all of the existing UK services providing inpatient Paediatrics and the situation is expected to worsen.

The Royal College of Paediatrics and Child Health (RCPCH) very clearly recognises the problems facing “very small” Paediatric inpatient units. The volume of activity does not give the trainee doctors enough experience to develop or maintain their skills and competencies, and they are therefore recommending a concentration of patients requiring admission to hospital into larger inpatient units where the local geography allows, with local service

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provision being modified allowing for short stay assessment, treatment and observation facilities where appropriate.

Concerns over the level of exposure and the appropriateness of training have led to the withdrawal of trainee Paediatric doctors from the George Eliot Hospital by the West Midlands Postgraduate Deanery. These recognised training posts, under the current service configuration, is unlikely to be reinstated and has compounded the problem of recruitment.

The service is currently covered by a joint rota between GEH and UHCW at consultant level. The consultant body at both UHCW and GEH have expressed concerns over the staffing arrangements at GEH, with gaps in rotas being regularly filled by locum doctors, with the withdrawal by the Deanery of trainees further compounding the problem. UHCW are currently honouring their service agreement but have specified certain staffing and quality standards in order to assure quality and safety. The GEH is incurring premium costs in order to fill vacant middle tier posts with expensive agency doctors. Although these doctors are now providing a robust middle grade tier, they may well be seeking more permanent employment elsewhere, are unlikely to have any allegiance to the GEH and can leave at very short notice. Clinicians from both UHCW and GEH do not believe that this service model is sustainable for anything more than the short term whilst a more appropriate model of care is sought.

Other local providers are unlikely to offer support to this model of care for the reasons described above.

#### 1.3.2 National Strategy

There are several areas of national strategy that cover the health and well being of pregnant mothers, babies and young children, which focus on providing high quality and safe care to help improve health outcomes, through the delivery of services with an appropriately trained and skilled workforce.

In terms of supporting the need for change, the Royal College of Paediatrics & Child Health's (RCPCH) *Facing the Future: A Review of Paediatric Services* (April 2011) paper referred to above is the key driver for the reconfiguration of Paediatric services. It states that the UK's Paediatric workforce is facing significant pressures to safely and sustainably staff all inpatient Paediatric rotas; comply with the European Working Time Directive; and continue with the present levels of Paediatric consultants and trainees.

The report makes five interlocking proposals to resolve the workforce pressures, insisting that they must be tackled together and not piecemeal, seeking to:

- Reduce the number of inpatient sites;
- Increase the number of consultants;
- Expand significantly the number of registered children's nurses;
- Expand the number of GPs trained in Paediatrics; and
- Decrease the number of paediatric trainees.

The report recommends the reconfiguration of inpatient units be based on the UK's capacity, given existing and future medical workforce, to safely staff an appropriate number of units that are capable of meeting the ten service standards that should be achieved by all acute general paediatric services.

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The report suggests that many very small and small units will need to close over the next five years, although they could be replaced by Short Stay Paediatric Assessment and Observation Units. (Based on the classifications used in the paper, GEH is classified as “very small”).

Other policy documents which have been taken into consideration in developing a new clinical model and services are outlined below:

- Saving Mothers Lives (Centre for Maternal and Child Enquiries, 2011);
- Modelling the Future (Royal College of Paediatrics and Child Health, 2007-2009);
- 2009/10 NHS Operating Framework;
- Toward Safer Childbirth (2007);
- The National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004);
- Maternity Matters (Department of Health, 2007); and
- Standards of Care for the Critically Ill and Injured Child (Department of Health, 2008).

#### 1.3.3 Key Drivers & Issues

The key issues driving the review of the options available for Paediatric and Obstetric services across Coventry and North Warwickshire, are:

- The need for a long term and clinically sustainable model of care for the women and children of North Warwickshire; and
- The need for high quality and safe services, provided by an appropriately skilled and trained workforce who have the ongoing opportunities for continuing training and development, and with access to the volumes and types of patients required to support their professional competence.

### 1.4 Key Project Objectives & Benefits

#### 1.4.1 Objectives

By seeking to review the options available for the configuration and delivery of Paediatric and Obstetric patients, this work seeks to ensure effective delivery of an integrated service within which:

- There is a clear and shared vision of the aims of the service and benefits for patients;
- There is a provision of effective, efficient and high quality maternity, neonatal and paediatric care that best serves the needs of the community;
- Care is clinically safe and sustainable;
- There is agreement on the service specification and models of care that will meet the requirements of access, quality and financial viability;
- The scope of the service with regard to activity and capacity across the whole health economy is clearly defined;
- There are clearly aligned management and governance models for the delivery of the service;
- The contractual arrangements reflect the agreed models of care;
- An integrated, responsive and effective service is achieved for all mothers, children and young people across all of Coventry and Warwickshire;

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- Clinical, local authority, public health expertise and user opinion are involved in developing and implementing the service;
- Services work well and integrate across primary and community services as well as tertiary services; and
- National policy, regional reviews and guidance on standards of care are taken into account.

#### 1.4.2 Benefits

The benefits being sought in agreeing a new model of service are to:

- Create a model of service that supports the continued maintenance of staff competence, and meets expected service standards to be safe and sustainable;
- Maintain the confidence of local people and stakeholders about the future of services;
- Have the flexibility to innovate, improve quality and deal with changes in workload, clinical practice and workforce issues;
- Provide a more attractive and rewarding service for patients and staff;
- Take account of national policy, regional reviews and guidance on standards of care; and
- Provide local women with a choice of care settings.

### 1.5 Options

#### 1.5.1 Long-list of Options

An initial long list of 6 options was prepared, 5 of which originated from work undertaken by NHS Warwickshire in conjunction with GEH and UHCW, documented in a paper entitled *Clinical Assessment and Options Proposal for Maternity, Newborn and Children's Services for George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust* (January 2011). An additional option was later introduced to look at the feasibility of moving inpatient Paediatrics only to UHCW, and for GEH to retain all other services with support and partnership from SWFT.

As part of the process for developing the Business Case, all 6 options outlined above were further reviewed, and in doing so, consideration was given to the RCPCH's *Facing the Future: A Review of Paediatric Services* report (April 2011), which puts forward a model for having a Short Stay Paediatric Assessment & Observation Unit (SSPAOU) at smaller units. As a result, some options were revised to either include a SSPAOU within the option or as a variant, which resulted in the following long-list of 8 options being put forward:

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### Longlist of Options

Option	Description
<b>Option 1</b>	<ul style="list-style-type: none"><li>• No change to current services and arrangements</li></ul>
<b>Option 2</b>	<ul style="list-style-type: none"><li>• Transfer Inpatient Paediatrics to UHCW</li><li>• Restructured Paediatrics Services with 16 Hour SSPAOU, Paediatric APNP and Neonatal ANNP Support at GEH</li><li>• No transfer of Obstetric services</li></ul>
<b>Option 3a</b>	<ul style="list-style-type: none"><li>• Inpatient Paediatrics &amp; Consultant Led Obstetrics to transfer to UHCW</li><li>• Midwifery Led Unit &amp; 16 Hour SSPAOU at GEH</li></ul>
<b>Option 3b</b>	<ul style="list-style-type: none"><li>• Inpatient Paediatrics &amp; Consultant Led Obstetrics to transfer to UHCW</li><li>• Midwifery Led Unit at GEH</li></ul>
<b>Option 4a</b>	<ul style="list-style-type: none"><li>• Transfer Inpatient Paediatrics &amp; All Inpatient Obstetrics to UHCW</li><li>• 16 Hour Paediatric SSPAOU at GEH</li></ul>
<b>Option 4b</b>	<ul style="list-style-type: none"><li>• Transfer Inpatient Paediatrics &amp; All Inpatient Obstetrics to UHCW</li></ul>
<b>Option 5</b>	<ul style="list-style-type: none"><li>• Strengthen and Develop Paediatric Services &amp; Workforce at GEH</li></ul>
<b>Option 6</b>	<ul style="list-style-type: none"><li>• Transfer Inpatient Paediatrics to UHCW</li><li>• 16 Hour SSPAOU at GEH</li><li>• Work with SWFT as clinical network partner</li></ul>

### 1.5.2 Reducing the Long-list of Options

Consideration was then given to the underpinning clinical models and the feasibility of implementing each option, with a view to putting forward only those options that are clinically safe and supportable, that meet all clinically required standards, and that can be implemented. With this in mind, it was agreed that both options 2 and 5 could not be supported for the reasons listed below, and should therefore be discounted.

#### **Option 2 – Inpatient Paediatrics at UHCW / Restructured Paediatrics Services with 16 Hour SSPAOU, Paediatric APNP and Neonatal ANNP Support at GEH**

This service model requires Advanced Neonatal Nurse Practitioners (ANNPs) to provide Neonatal resuscitation support and Advanced Paediatric Nurse Practitioners (APNPs) to provide Paediatric non-elective support, to replace that which is currently provided by middle grade doctors. Whilst national models exist that utilise ANNPs and APNPs exclusively to deliver services, these are in places where support is provided by a body of on call consultants.

Both staff groups are notoriously hard to recruit and to retain, as experienced by UHCW, and there is no existing large cohort of readily available staff to recruit from. To locally train and develop these Specialist Nurses will take between 2-4 years. There is therefore a general consensus that this model of service is unattainable and unsustainable, and on this basis, the option was discounted from further consideration.

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#### Option 5 – Strengthen and Develop Paediatric Services & Workforce at GEH

The RCPCH very clearly recognise the problems facing “very small” Paediatric inpatient units such as GEH. The volume of activity does not give the trainee doctors enough experience to develop or maintain their skills and competencies, and the RCPCH are therefore recommending a concentration of patients requiring admission to hospital into larger tertiary inpatient units where the local geography allows. GEH has already conceded that the provision of inpatient Paediatrics ought to sit with larger central units where the trainee workforce is being concentrated.

It is also recognised that national and local bodies such as NHSLA, CNST, CQC and CCGs, are increasingly likely in the future to require that all Paediatric services are compliant with the RCPCH defined minimum standards.

On this basis, it was agreed that this option does not meet the requirements that clinical bodies will increasingly require and therefore cannot be supported, and was discounted from further consideration.

#### 1.5.3 Shortlisted Options

Having discounted Options 2 and 5, the shortlisted options put forward for appraisal were Options 1, 3a and 3b, 4a and 4b and 6, which are described at a high level below.

It should be noted that under all options, outpatient services at GEH remain unchanged.

#### Option 1 – No Change (from 5<sup>th</sup> September 2011)

Under this option, Paediatric and Maternity services as currently provided to patients at GEH would remain unchanged, with a cross-site Consultant rota across GEH and UHCW being maintained for out of hours Paediatrics and Neonatal services.

#### Option 3a – Inpatient Paediatrics and Inpatient Consultant Led Obstetric Care at UHCW / 16 hour SSPAOU and Midwifery Led Unit at GEH

Under this option, all inpatient Paediatric services would transfer to UHCW, as would all inpatient consultant led Obstetric care and births, some Paediatric Day Case surgery and Gynaecology out of hours services. A 16 hour SSPAOU and a MLU will also be established at GEH.

#### Option 3b – Inpatient Paediatrics and Inpatient Consultant Led Obstetrics at UHCW / Midwifery Led Unit at GEH

This option is the same as Option 3a except for the exclusion of the SSPAOU and the level of Paediatric day case surgery that would transfer, ie:

- All inpatient Paediatric services would transfer from GEH to UHCW, as would all Paediatric day case surgery;
- All Obstetric consultant led inpatient care including deliveries would transfer to UHCW, and as a consequence of this, out of hours emergency Gynaecology would also transfer;
- A Midwifery Led Unit would be established at GEH.

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#### Option 4a – Inpatient Paediatric & Inpatient Obstetric Services at UHCW / 16 Hours SSPAOU at GEH

Under this option:

- All inpatient Paediatric would transfer from GEH to UHCW, as would some Paediatric day case surgery;
- All inpatient obstetric care – both consultant and midwife care and deliveries - would transfer to UHCW, with antenatal clinics and diagnostics remaining at GEH;
- As a result of the above, out of hours emergency Gynaecology admissions would transfer to UHCW; and
- A 16 hour SSPAOU would be established at GEH.

#### Option 4b – Inpatient Paediatric & Inpatient Obstetric Services at UHCW

This option is the same as Option 4a, except for the exclusion of the SSPAOU and the level of Paediatric day case surgery that would transfer, ie:

- All inpatient Paediatric services and as a result, all day case surgery would transfer from GEH to UHCW;
- All inpatient obstetric care – both consultant and midwife care and deliveries - would transfer to UHCW, with antenatal clinics and diagnostics remaining at GEH; and
- As a result of the changes to Obstetric care, out of hours emergency Gynaecology admissions would transfer to UHCW.

#### Option 6 – Transfer Inpatient Paediatrics to UHCW / 16 Hour SSPAOU at GEH

Under this option:

- GEH will enter into a partnership with SWFT, to assist with recruiting and supporting the medical workforce;
- Inpatient Paediatrics would transfer to UHCW;
- All other services would remain at GEH, with the establishment of a 16 hour SSPAOU.

Whilst SWFT will recruit the additional medical workforce required at GEH, therefore ensuring it has an in house Paediatric team on site, strong mutually agreed network arrangements need to be established with other inpatient and tertiary units to maintain Consultants' exposure and experience in more complex paediatric services and to optimise skills and resources. To facilitate this and to ensure that the GEH consultants maintain their competence and develop new skills, the job plans and rotas for each consultant have 2 Supporting Professional Activities per week built in to enable them to work at the partner organisation.

#### 1.5.4 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been undertaken on the shortlisted options, and the main impact which has been identified concerns the additional journey time for patients, their carers and for staff under all options except Option 1, and the consequential time and cost impact.

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Work has been undertaken around how best to mitigate these impacts, and the following mitigating actions have been identified:

- The reimbursement of transport and parking costs for patients on low income;
- Reimbursement of excess travel costs for staff; and
- The potential for developing improved bus services.

An estimate of the financial impact of the above measures has been included in the financial analysis.

### 1.6 Options Appraisal

#### 1.6.1 Non Financial Appraisal

A non financial evaluation of the shortlisted options was undertaken that covered: selection of the evaluation criteria to be used; weighting of the criteria; consideration and scoring of the options; and analysis and sensitivity testing of the weights applied to test their robustness.

#### Selecting the Evaluation Criteria

It was agreed that the evaluation criteria to be used would be based on those recommended by the Department of Health and commonly used in option appraisals in the NHS. At a high level, these were:

- Better access to services;
- Improved clinical quality of services;
- Improved environmental quality;
- Development of existing services, and/or provision of new services;
- Improved strategic fit of services, including regeneration;
- Meeting national, regional and local policy imperatives;
- Meeting training, teaching and resource needs;
- Making more effective use of resource; and
- Ease of delivery.

#### Weighting the Evaluation Criteria

A Non Financial Evaluation Panel was established to undertake the weighting of the evaluation criteria and scoring of the options against the criteria.

The weightings as agreed by the panel were as follows:

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#### Criteria Weighting

Criteria	Weighting		
	Rank	Score	Weight
Better access to services	=1	100	16.4%
Improved clinical quality of services	=1	100	16.4%
Improved environmental quality	=8	40	6.6%
Develop existing services / provide new services	5	60	9.8%
Improved strategic fit of services, incl regeneration	=6	50	8.2%
Meeting policy imperatives	4	80	13.1%
Meeting teaching, training and resource needs	3	90	14.8%
Making more effective use of resource	=6	50	8.2%
Ease of delivery	=8	40	6.6%
<b>Total</b>		<b>610</b>	<b>100.0%</b>

#### Scoring the Options

Scoring was undertaken by members on an individual basis, to score each option against each evaluation criteria, using a 10-point scoring system (10 being the highest possible score, and 1 the lowest).

#### Results of the Non Financial Evaluation

Having combined the individual Panel member's scores, the total weighted scores and results of the non-financial evaluation exercise were as follows:

#### Non Financial Evaluation - Weighed Scores and Results

Criteria	Weighted Scores					
	Option 1	Option 3a	Option 3b	Option 4a	Option 4b	Option 6
Better access	1.42	0.81	0.68	0.65	0.51	1.32
Improved clinical quality	0.92	1.13	1.14	1.09	1.15	1.19
Improved environmental quality	0.32	0.36	0.40	0.39	0.40	0.37
Development of existing/new services	0.49	0.57	0.55	0.51	0.51	0.67
Improved strategic fit of services	0.41	0.47	0.48	0.47	0.45	0.56
Meeting policy imperatives	0.62	0.73	0.78	0.66	0.69	0.87
Meeting teaching, training & resource needs	0.53	0.92	1.01	0.93	0.99	0.92
Making more effective use of resource	0.38	0.43	0.48	0.43	0.48	0.47
Ease of delivery	0.33	0.36	0.37	0.33	0.35	0.41
<b>Total Score</b>	<b>5.44</b>	<b>5.78</b>	<b>5.88</b>	<b>5.47</b>	<b>5.53</b>	<b>6.77</b>
<b>Rank</b>	<b>6</b>	<b>3</b>	<b>2</b>	<b>5</b>	<b>4</b>	<b>1</b>
<b>% Difference</b>	<b>19.71%</b>	<b>14.64%</b>	<b>13.20%</b>	<b>19.26%</b>	<b>18.38%</b>	<b>0.00%</b>

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The results show:

- A clear preference for Option 6 by a margin of 13% over Option 3b, and by 14% over 3a, the second and third preferred options;
- Options 1, 4a and 4b have the lowest scores (18%-20% below Option 6);
- Option 6 scored highest against 5 of the 9 the criteria, i.e. for improved clinical quality of services; developing existing and/or providing new services; strategic fit; meeting policy imperatives; and ease of delivery;
- Option 1 scored highest against the criterion of better access to services;
- Options 3b and 4b scored highest against the criteria of improved environmental quality and making most effective use of resources; and
- Option 3b also scored highest for meeting teaching, training and resource needs.

Detailed analysis of the scores by each constituent group represented shows:

- Service users preferred option 6 by a margin of 14% over option 3a;
- Commissioners marginally preferred option 4b over option 6 (by 3%);
- Overall, providers preferred Option 6 over Option 3b by a margin of 11%; however a breakdown of both providers show:
  - GEH favours Option 6 over Option 1 by a margin of 19% and scored the other options considerably lower; and
  - UHCW providers prefer Option 3b over 4b by a margin of 6%, with Option 6 (the overall preferred option) being ranked 5<sup>th</sup> in their order of preference.

### Sensitivity Analyses

A series of sensitivity analyses were undertaken to assess what, if any, impact there would be in the event that certain changes were made to the weightings. The results were as follows:

- All criteria are given an equal weighting;
- The criterion “meeting policy imperatives” was given a lower weight;
- The criterion “effective use of resources” was given a higher weight;
- “Better access to services” was given a slightly lower weight; and
- “Improved clinical quality of service” was given a lower weight.

With the exception of the “meeting policy imperatives” change, which switched the rankings of the two lowest-scoring options (Options 1 and 4a), all other tests made no difference to the ranking of the options.

### 1.6.2 Financial Appraisal

#### Capital Costs

An assessment has been made of the likely order of capital cost for each option, based on the information currently available, the results of which are shown below:

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#### Capital Costs

Option	UHCW (£000)	GEH (£000)	Total (£000)
Option 1	-	-	-
Option 3a	1,712	350	<b>2,062</b>
Option 3b	2,276	250	<b>2,526</b>
Option 4a	1,712	100	<b>1,812</b>
Option 4b	2,276	-	<b>2,276</b>
Option 6	919	100	<b>1,109</b>

The revenue consequences of the costs have been considered within the relevant option.

#### Revenue Costs

##### Annual Revenue Costs

The impact on annual revenue costs has been calculated for each option based on the assumptions identified, with the impact on each provider organisation summarised in the table below. For other providers, income has been used as a proxy for cost.

##### Annual Revenue Costs

	OPTION 1 £000's	OPTION 3a £000's	OPTION 3b £000's	OPTION 4a £000's	OPTION 4b £000's	OPTION 6 £000's
<b>UHCW</b>	0	+7,484	+8,278	+8,384	+9,218	+922
<b>GEH</b>	0	-7,621	-8,674	-8,612	-9,705	-1,088
<b>Other Trusts</b>	0	+1,212	+784	+1,212	+765	+250
<b>TOTAL</b>	<b>0</b>	<b>+1,075</b>	<b>+388</b>	<b>+984</b>	<b>+278</b>	<b>+84</b>
<b>Ranking</b>	<b>1</b>	<b>6</b>	<b>4</b>	<b>5</b>	<b>3</b>	<b>2</b>

The table above illustrates that all options assessed at this stage are likely to increase costs to the NHS, with Option 6 adding the least cost of the options which involve changes to the existing to the existing service provision.

#### Overall Financial Impact on GEH and UHCW

The overall financial impact of each option for GEH and UHCW has been undertaken by comparing the projected changes in income with the projected changes in costs.

##### Overall Financial Impact on GEH and UHCW

	OPTION 1 £000's	OPTION 3a £000's	OPTION 3b £000's	OPTION 4a £000's	OPTION 4b £000's	OPTION 6 £000's
<b>GEH</b>	0	+1,072	+99	+1,406	+473	+663
<b>UHCW</b>	-89	-1550	-678	-1,792	-961	-388

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This illustrates that all options would have a beneficial financial impact for GEH as the reduction in its costs would be greater than the reduction in its income. Conversely, all options would adversely affect UHCW, since the increase in its costs would exceed the additional income accruing to the Trust. The health economy will therefore need to agree a local mechanism to ensure that individual Trusts are not financially disadvantaged whichever option is implemented.

#### 1.6.3 Economic Appraisal

##### Methodology

An economic appraisal of the options has been undertaken in line with the requirements of Department of Health Business Case Guidance and the HM Treasury Green Book. All costs have been modelled to establish, for each option:

- The Net Present Cost (“NPC”) of the discounted annual cash flows over the whole 31-year appraisal period; and
- The Equivalent Annual Cost (“EAC”), being an annualised equivalent of the NPC.

##### Results

The results of the economic analysis are summarised in the table below, which shows the Net Present Cost and Equivalent Annual Costs for each option.

##### Economic Analysis Results

	OPTION 1 £000's	OPTION 3a £000's	OPTION 3b £000's	OPTION 4a £000's	OPTION 4b £000's	OPTION 6 £000's
NPC	1,054,487	1,078,330	1,065,978	1,076,842	1,064,148	1,066,888
EAC	54,377	55,607	54,970	55,530	54,875	55,017
<b>Economic Ranking</b>	<b>1</b>	<b>6</b>	<b>3</b>	<b>5</b>	<b>2</b>	<b>4</b>
Marginal Impact Over Option Ranked 1 <sup>st</sup>	0	1,024	387	948	293	434
Difference (%)	0.0%	1.9%	0.7%	1.7%	0.5%	0.8%

As context for assessing the economic impact of these options, it should be noted that the revenue cost inputs are significantly higher than those for capital and in all options account for over 99% of the cash flows.

The economic appraisal thus indicates that:

- There is only a marginal difference between the options in Value for Money terms, with a 2% gap between the 1<sup>st</sup> and 6<sup>th</sup> ranked options, Option 1 and Option 3a, respectively;
- Of the development options, there is virtually no differential between Options 3b, 4b and 6 and all three options are within 1% of Option 1;
- Options 3a and 4a are the least preferred, but the margins are only 2% and 1.9% respectively.

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#### Sensitivity Analysis

The results of the economic appraisal have been subjected to a sensitivity analysis to assess the extent of change in cost estimates required to change the overall results of the appraisal, both in terms of capital and revenue costs. The results show that only relatively minor differential changes in revenue costs would be needed for any of the options to have the lowest economic cost.

#### Sensitivity Analysis – Revenue Costs (incl Non-Recurrent, excl Capital Charges)

	OPTION 1 £000's	OPTION 3a £000's	OPTION 3b £000's	OPTION 4a £000's	OPTION 4b £000's	OPTION 6 £000's
Forecast Revenue Costs	54,808	55,780	55,434	55,760	55,404	54,808
Change required	294	(1,031)	(392)	(955)	(297)	(436)
Change %	0.5%	-1.8%	-0.7%	-1.7%	-0.5%	-0.8%

#### 1.6.4 Summary of the Results

The results of the non-financial and financial/economic appraisals have been combined in order to establish the overall results of the option appraisal.

#### Overall Results

	OPTION 1	OPTION 3a	OPTION 3b	OPTION 4a	OPTION 4b	OPTION 6
Weighted Non-Financial Scores	544	578	588	547	553	677
EAC Impact of Options (£m)	£54.583	£55.607	£54.970	£55.530	£54.875	£55.017
<b>Benefit Point per £m EAC</b>	<b>10.0</b>	<b>10.4</b>	<b>10.7</b>	<b>9.9</b>	<b>10.1</b>	<b>12.3</b>
Combined Ranking of Options	5	3	2	6	4	1
Margin	-19%	-15%	-13%	-20%	-18%	-

The overall results show that Option 6 has the highest Benefit : Cost ratio, which reflects the fact that there are only marginal differences between the economic costs of the options over a 30 year period, which is in turn due to the relatively small differences in the overall annual revenue costs of the options. The overall results therefore broadly reflect the results of the non-financial appraisal.

The results show that:

- Option 6 was ranked 1<sup>st</sup> in the non-financial appraisal and has the lowest annual revenue cost of the options which involve changes to the existing to the existing service provision;
- Option 3b was ranked 2<sup>nd</sup> in the non-financial appraisal, has the 4<sup>th</sup> lowest annual revenue cost, and is ranked 2<sup>nd</sup> in terms of overall results;
- Option 4b was ranked 4<sup>th</sup> in the non-financial appraisal, but was ranked 1<sup>st</sup> by Service Commissioners and 2<sup>nd</sup> by UHCW service providers; it also has the 3<sup>rd</sup> lowest annual revenue cost and the 2<sup>nd</sup> lowest economic cost;

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- Option 3a was ranked 3<sup>rd</sup> in the non-financial appraisal, but has the highest annual revenue cost of the options which involve changes to the existing service provision, and is therefore ranked 6<sup>th</sup> in economic terms;
- Option 4a was ranked 5<sup>th</sup> in the non-financial appraisal, but has the 2<sup>nd</sup> highest annual revenue cost of the options which involve changes to the existing to the existing service provision, and is therefore ranked 5<sup>th</sup> in economic terms;
- Option 1 was ranked 6<sup>th</sup> in the non-financial appraisal, but would have the lowest annual revenue cost.

### 1.7 Implementation Plan & Project Management Approach

#### 1.7.1 Implementation Plan & Key Milestones

On completion of the Business Case, the results will be shared with the provider organisations, PCT Cluster and Clinical Commissioning Groups for agreement. In addition, work will commence on producing the documentation required for public consultation, and for this to be shared with key stakeholder organisations, including the Hospital Oversight & Scrutiny Committee, the Maternity Services Liaison Committee and PCT Cluster Maternity & Paediatrics Steering Group.

The key milestones moving forward are:

##### Key Milestones

Milestone	Date
Business Case and Consultation Document sign off by relevant Boards	Cluster Board on 9 May 2012 and other Board meetings to follow
Launch Consultation	14 May 2012
Implementation Delivery Board members agreed, and 1 <sup>st</sup> meeting of Board held	End May 2012
Sign-off implementation preparation plans in readiness for post consultation implementation phase. To include proposals for:- <ul style="list-style-type: none"> <li>• Programme Steering</li> <li>• Implementation Delivery</li> <li>• Project manager and team support</li> <li>• Subject matter task and finish groups (finance and activity; HR &amp; Staff Side; Estates and Facilities; Pathway redesign; external communications and engagement; commissioner/business model)</li> </ul>	14 May 2012
Approve membership, governance framework and TORs for all	7 June 2012
Project plans produced by Task & Finish Groups	7 June 2012
Consultation closes	30 July 2012
Complete analysis of submissions received during consultation and produce Consultation Report	7 August 2012
Report from all Task & Finish groups on emerging implementation issues and risks in readiness for implementation planning	10 August 2012

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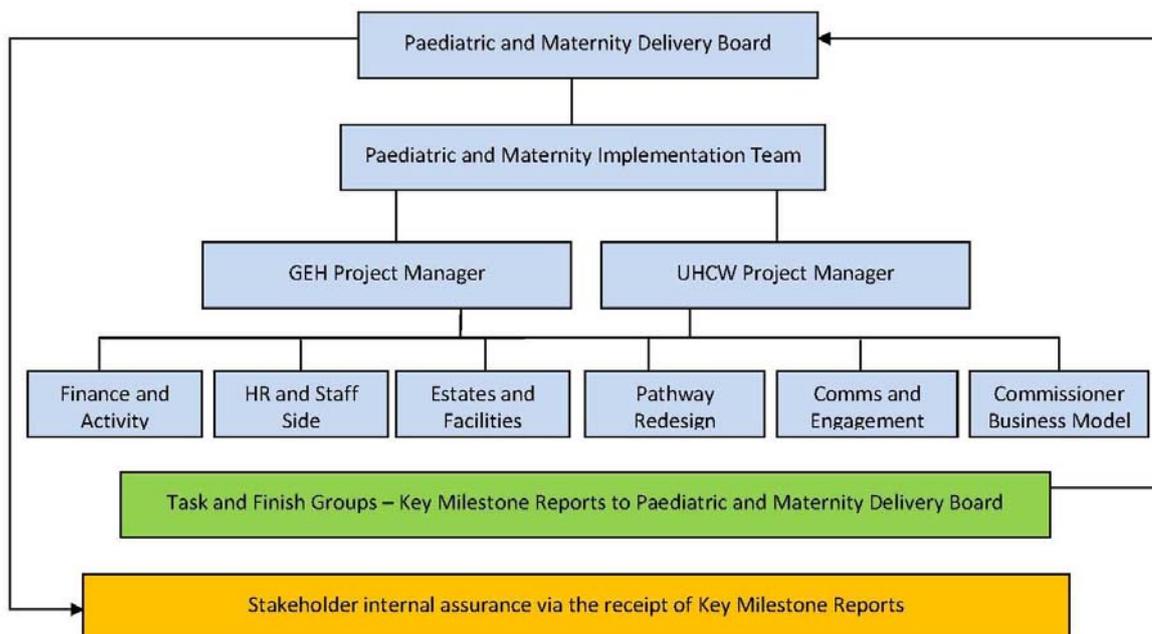
Milestone	Date
Submit consultation report to Boards, HOSCs	mid/end August 2012
Announce outcome	End August
Proceed with implementation	31 August
Implementation plans for all task and finish groups	4 September
Communications and engagement plan being followed	Ongoing

#### 1.7.2 Project Management & Governance Arrangements

Once the preferred solution is identified, it will be implemented and managed in line with best practice, using PRINCE2 (Projects in a Controlled Environment) project management methodology.

The Paediatrics & Maternity Reconfiguration Programme has, to date, been led by commissioners. Post consultation, responsibility for ensuring successful implementation of the preferred model and for execution of plans to achieve this will more appropriately rest with providers whilst commissioners will remain engaged with the programme via membership of a Delivery Board that will be established to oversee the implementation phase. The governance structure for the implementation phase will be as follows:

##### Governance Structure – Implementation Phase



The Paediatric and Maternity Delivery Board will be chaired by the Chief Executive of GEH, and the Paediatric and Maternity Implementation Team will be chaired by a Programme Director to be identified by the GEH.

An initial implementation plan has been developed, which seeks to have the additional Consultant workforce required at GEH in place by the end of 2012, and inpatient Paediatric services transferred to UHCW by April 2013.

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#### **1.7.3 Risk Management**

Risks will be managed by the preparation and management of a formal risk register which will be regularly reviewed by the Delivery Board and the Implementation Team, and risk mitigation plans will be prepared for all risks quantified as being “high”.

#### **1.7.4 Post Project Evaluation**

A detailed benefits realisation plan will be developed, identifying the benefits to be realised by the implementation of the preferred option, and in line with the benefits outlined in section 1.4.2 above.

As part of the post-project evaluation, a multi-disciplinary Evaluation Team will be established, comprising a range of key stakeholders, to evaluate and monitor the benefits of the preferred solution. Membership will comprise representatives from the provider organisations, commissioners, service users and carers and others as required.