ELLIOT COLBURN MP

HOUSE OF COMMONS

LONDON SW1A 0AA

Improving Healthcare Together
Freepost
IMPROVING HEALTHCARE TOGETHER 2020-2030

1 July 2020

Dear Sir or Madam,

RE: Improving Healthcare Together

Ahead of the meeting of the South West London and Surrey Heartlands Clinical Commissioning Groups (CCGs) on Friday 3 July 2020, the Improving Healthcare Together team has invited further written statements on any additional information for consideration to be submitted to the Committees in Common.

We understand a decision will be made on 3 July about the next steps following the publication of the responses to the IHT consultation. We would like to reinforce our support for the proposals but also issue a statement with additional information on the following two areas of importance: i) a rebuttal to many of the claims made by other representations about the programme, and ii) a declaration of agreement with local health leaders that in the context of COVID-19 we need speedy investment into our local health services.

Foreword by Elliot Colburn MP

"Why would they say it if it wasn't true?"

That is no doubt a question that will be asked upon reading submissions to this consultation from some who seem to equate a £500 million investment to the local NHS Trust as a reduction/removal/closure of services.

In this note, we hope to issue a rebuttal to a number of the responses we have seen to the IHT consultation, particularly those from Labour MPs, various constituency Labour Parties, political groups such as KOSHH and Trade Unions, among others. We have identified a number of core themes that form the basis of their arguments and explained why we believe they are mistaken in their assessment of the situation.

However, I wanted to begin with a little bit of context and political background that may be unknown to the decision makers, to help inform them as to why these submissions have been made.

For years, even decades, 'Save our hospital', especially St Helier Hospital, has been a staple of the political scene in Sutton and Merton. There is no doubt that the hospital has been in danger of partial or even total closure over this time, but without fail, some form of this campaign will appear at every single election, whether national, regional or local. This has included petitions, public meetings, leaflets, etc.

From a political perspective, campaigning to 'save our hospital' is much simpler, and reaps greater rewards, then attempting to explain how a £500 million investment will improve local

services, especially when an opposing political party is responsible for the investment.

This may seem a cynical view, but take, as an example, the fact that the same voices were noticeably quiet in 2007 at the decision to centralise stroke services in London, which incidentally produced much better outcomes for stroke victims as per a number of studies conducted since then. It is worth nothing the differing political scene at the time.

As I said in my maiden speech in the House of Commons, there are those who seem to believe that either the Trust does not need any investment, or that somehow a £500 million investment equates to a downgrade or closure. Activists from my Party, including myself, have had such assertions aimed at us, sometimes, in the very worst cases, coupled with some pretty vile abuse. It has been difficult not to conclude that such assertions are possibly party political in nature, rather than based in fact.

The submissions we are rebutting in this letter are based on an assumption that some form of the existing model of healthcare is possible, i.e. that no changes are needed. However, the Trust has comprehensively rejected this possibility for a number of reasons. Not only is it not financially or clinically viable for the Trust to do so, it is also based on outdated healthcare delivery models and practices – the investment isn't just an improvement in buildings, it's an improvement in delivery. The 'do nothing' option is most likely to lead to service closures and/or financial destitution.

I hope this has been useful in understanding the background to this issue, which may help to qualify and better contextualise some of the submissions that have been received. We will now turn to the themes in turn.

i) rebuttal to many of the claims made by other representations about the programme

Claim 1

The proposed model will not close the NHS staff shortage gap in Surrey Downs, Sutton and Merton.

Rebuttal

It is well understood that NHS departments are currently experiencing staffing pressures across England, particularly with regards to specialist consultants. But, many of the criticisms of the IHT proposals misinterpret the objectives of the proposed model. It is correct that the outcomes of the IHT proposals do not close the staff shortage gap with regards to the number of staff; however, the overall objective of the proposals is not to achieve that.

The pre-consultation business case makes it clear that recruitment and training of new specialist consultants will not solely address the need. A series of recruitment schemes have already been conducted over the years, including: a national media campaign, advertisements and recruitment agencies, maximising trainees, exploring overseas partnership, improving attractiveness of role, etc.[1] Despite this, the Trust still faces consultant shortages in key areas.

It is projected that bringing in new staff through recruitment exercises like the above is not a realistic solution to meet specialist requirements (including recruitment, training and using staff from other Trusts). Therefore, the NHS needs to find other solutions to meet requirements, and this is exactly what the proposals do.

Rather than focusing solely on the number of consultants (which cannot be realistically boosted to meet requirements), the proposals address solutions to increase access to specialist staff and improve healthcare outcomes for patients: *"Based on local, regional and national growth projections, it is unlikely significant additional staff will be recruited or trained to meet requirements this has led us, and ESTH, to conclude that it is not clinically sustainable*

*in its current configuration. Addressing these issues is therefore the focus of our work."***[2]**

The proposals do, however, embrace some structures to help with recruitment and training of new specialist staff, for example through more attractive working schemes and the ability for trainee staff to have better access to specialist staff. This is not the main focus of the proposal objectives, though.

Ultimately, patient outcome is the priority, and the proposals embrace a realistic solution to address this, rather than repeating the well-accepted need to fill staff shortages without any realistic proposals to do so.

Only considered potential solutions that utilise existing local workforce are feasible. The proposals, therefore, suggest amending the very structure of how local healthcare operates to ensure that the right resources can be pooled together under a dedicated facility to improve patient outcomes.

Some responses to the IHT consultation claimed that by locating the new facilities at the Sutton site it would deter current and potential new staff from working there. These claims, however, are entirely unsupported by evidence and the independent IHT Consultation Report demonstrates this. There is overwhelming staff support for the site to be based in Sutton, with 78% of NHS staff surveyed selecting it as a good/very good solution.[3]

Claim 2

The proposed model will result in an overall loss of hospital beds.

Rebuttal

The accusation that the proposals will result in an overall loss of beds is misleading. If circumstances were not to change, services would be less efficient and, therefore, would require more beds in 2025/26 than under any of the three proposed options.[4] Under the Sutton option, the need would be for 1,052 beds and availability of beds under that option would be 1,052.

The Clinical Advisory Group concluded that *"an effective consultant-led model of care has been shown to lead to quicker and more appropriate decision making. This can result in a decreased length of stay, more efficient use of beds, decreased rates of readmission and decreased need for patient follow-up."***[5]**

There are two elements to the efficiencies, in terms of beds:

- QIPP delivery: Quality, Innovation, Productivity and Prevention (QIPP) programmes are intended to result in quality improvements while driving efficiency by providing more care out of hospital. The impact of schemes across our geography is expected to result in a decrease of 68 beds. This includes many of the out of hospital initiatives as described as part of the clinical model.
- LOS improvement: Due to improvements made through the clinical model, it is assumed that the average length of stay will be decreased to the top quartile of peers.

Further, the Department of Health and Social Care states that bed numbers are not an accurate marker for good care, with improvements in treatment meaning that good care does not necessarily require lengthy hospital stays.[6] Research published in the British Medical Journal supports this and demonstrates that mental health, learning disability and geriatric services has seen a more marked reduction in hospital beds because of the shift to community services.[7] Likewise, the OECD state that the overall reduction in hospital beds per capita

"has been driven partly by progress in medical technology which has enabled a move to day surgery and a reduced need for hospitalisation".[8] The UK may have fewer beds per capita on average in the Western World, however it has higher than average numbers of MRI and CT scanners.[9]

Comparisons have also been made by some submissions between the proposed model (as well as the overall NHS model) and that of other countries, for example Korea: under the Sutton option, there are 2.01 beds per 1000 capita, whereas the average in South Korea is 12.27 per capita.

However, 35% of the South Korean hospital beds are dedicated to long-term care.[10] As already touched upon, there is a stronger intention for home and community care in the UK for long-term conditions. Korea is globally unique for treating such a high proportion of long-term patients in hospitals.[11] This is likely due to their structurally different healthcare system with over 90% of hospitals and beds privately owned.[12] Further, despite the high bed per capita rate in Korea, there is a lower doctor per capita rate compared to the UK.

Comparing per capita bed data between the UK and other countries isn't always on a like-for-like basis and needs to be put into context.

Finally, queries have been raised about the located of all the beds within the model. *"Sutton as the major acute site: There would be 496 major acute beds at Sutton Hospital, 285 district beds at Epsom Hospital; 221 district beds at St Helier Hospital, and* ***50 beds moving to other providers."*** **[13]**

The other providers are:

- Ashford and St Peter's Hospitals NHS Foundation Trust (St Peter's Hospital, St Peter's)
- Croydon Health Services NHS Trust (Croydon Hospital, Croydon)
- Kingston Hospital NHS Foundation Trust (Kingston Hospital, Kingston)
- Royal Surrey County NHS Foundation Trust (Royal Surrey County Hospital, Royal Surrey)
- St George's University Hospitals NHS Foundation Trust (St George's Hospital, St George's)
- Surrey and Sussex Healthcare NHS Trust (East Surrey Hospital, East Surrey)

Claim 3

The proposed Sutton site is too far away.

Rebuttal

58.7% of people in the catchment area will be able to access the Sutton site within 30 minutes, compared to 53% for St Helier and 49.1% for Epsom.[14] The Sutton site is geographically the most central of the three site options. Particular concerns were raised about the distance of Sutton site from patients in Merton, yet only 10% of patients who use Epsom and St Helier live in Merton. Merton residents also attend St George's Hospital, Kingston Hospital and Croydon University Hospital.

The preferred Sutton site will be located within walking distance of Belmont railway station, serviced by two trains an hour to London Victoria and two trains an hour to Epsom Downs. Despite this, the Sutton site is criticised for having "extremely poor" transport connections and "up to a 20-minute walk" from the nearest station. Google maps currently shows an eight-

minute walk from Belmont station to the current Royal Marsden site.[15] The walk from Belmont station is compared by some with the “extremely strong” transport connection to St Helier with “nearby” Morden tube station, Sutton rail, St Helier rail and Carshalton rail stations. Morden station is a 40-minute walk from St Helier,[16] Sutton station is a 40-minute walk from St Helier, St Helier station is a 21-minute walk from St Helier,[17] and Carshalton station is a 26-minute walk from St Helier.[18]

Some criticisms of the proposed model noted that there was no parking visible in the architectural plan, unlike with the other options. However, when this was brought up during one of the group workshops, participants reacted overwhelming positive when told of plans to instate underground parking.[19]

Concerns were also raised that the model may create confusion amongst the population with regards to which services are conducted by which hospital, and that this could cause delays to care. There is no evidence to support this hypothesis. The logistics of acute care is likely to be managed by ambulance staff who will be trained to know which of the hospitals the patient needs. For non-acute services, it will be the responsibility of the trust to ensure patients are aware of the location of required services, similar to now.

Despite this, there are legitimate concerns regarding transport queries should the Sutton site be selected, as expected when services for a large organisation change location. I understand that Improving Healthcare Together will be taking these concerns on board before producing their decision-making business case.

Claim 4

The proposed model will negatively impact maternity care.

Rebuttal

Linked to the location and travel issues, there have repeated concerns that the centralisation of hospital births, and the separation of pre-natal, ante-natal and maternity care, will produce complications for those who may now have to travel further, should Sutton be selected as the new site.

The clinical model being proposed will further enhance multidisciplinary team or larger clinical team working which will support the sharing of good practice and learning. For maternity services, evidence suggests that effective or “real” multi-professional teams train together to improve outcomes for women and babies and enjoy increased job satisfaction as a result.[20] Despite legitimate worries about the location of services, the overall quality of care and patient outcomes are the priority.

Claim 5

The proposed model will reduce St Helier to a “glorified walk-in”.

Rebuttal

Under the proposed model, St Helier and Epsom Downs would continue to provide district hospital services, with GPs, community health, public health, social care and mental health services coming together with hospital clinicians to support people in their communities. Both hospitals would have urgent treatment centres (UTCs) which would be open 24 hours a day, 365 days a year. The UTCs would be staffed by doctors and specialist nurses.

The NHS themselves describe UTCs as being equipped to deal with “many of the most common ailments people attend A&E for.

*"UTCs will also ease the pressure on hospitals, leaving other parts of the system free to treat the most serious cases. The UTC offer will result in decreased attendance at A&E, or, in co-located services offer the opportunity for streaming at the front door. All UTC services will be considered a Type 3 A&E."***[21]**

Attempts to undermine the work of UTCs is both insulting to the hard-working staff that work there and also a dangerous form of scaremongering, which could create confusion about the proposed model.

Examples of the types of patients suitable for a UTC include:

- Strains and sprains
- Suspected broken limbs
- Minor head injuries
- Cuts and grazes
- Bites and stings
- Minor scalds and burns
- Ear and throat infections
- Skin infections and rashes
- Eye problems
- Coughs and colds
- Feverish illness in adults
- Feverish illness in children
- Abdominal pain
- Vomiting and diarrhoea
- Emergency contraception

This is not an exhaustive list but it shows some of the minor illness and minor injuries which should be treated at a UTC and some of the most common reasons to visit a traditional A&E.[22]

UTCs have access to investigative facilities including x-rays, swabs, pregnancy tests and urine dipstick and culture, near patient blood testing, such as glucose, haemoglobin, d-dimer and electrolytes, electrocardiograms and near-patient troponin testing.[23] When applied to St Helier's role in the proposed model, the Trust has been clear that 85% of services will remain at the hospital.

Far from a "glorified walk-in", UTCs are important part of local healthcare that place patient care outcomes at the forefront of the NHS. Further, evidence suggests that waiting times in UTCs are lower than traditional A&Es because services can be focused to manage district care whilst acute care is tackled separately.[24]

Under the proposed model, St Helier will not be closing or becoming a "glorified walk-in". In fact, part of the £500million proposed for this scheme will be dedicated to upgrading the hospital.

ii) declaration of agreement with local health leaders that in the context of COVID-19 we need speedy investment into our local health services

Urgency of proposed model and COVID-19

Partway through the formal IHT consultation (8 January – 1 April 2020), cases of COVID-19 in the UK were first confirmed. Since then, as we know, the virus has spread into a global pandemic with significant impacts to healthcare in the UK, as well as other parts of our society.

The pandemic was mentioned by fewer than 2% of questionnaire respondents in their comments, despite it being headline news for much of February and March, and almost a third of all questionnaire responses being submitted after the UK Government had declared lockdown on 23rd March 2020.[25]

The consultation documentation, of course, did not include references to COVID-19 because they were written and published before the pandemic hit. However, since the close of the consultation, local health leaders have commented on the importance of the investment to helping tackle COVID-19 going forward.

Dr Andrew Murray, GP and Clinical Chair at NHS South West London CCG, commented recently: *"Covid-19 has shown that there's no time like the present to invest in our hospitals. Now more than ever we need to ensure the right healthcare services for local people and under our proposals we would gain a brand new specialist hospital and see an increase of around 15% in critical care beds while 50% of beds would be in single rooms for better infection control.*

"More work is being done to consider the impact of the pandemic on our clinical model and ensure it fully meets any future needs. This will be considered alongside everything else at next month's meeting – including the many thousands of consultation responses and a decision-making business case."

Surrey Downs Integrated Care Partnership Clinical Chair and GP Russell Hills also commented: *"This pandemic shows we cannot afford to delay improving and modernising our local health services for the benefit of both patients and staff – and the independent analysis of feedback shows there is clear support for this vital investment."*

Despite calls from a minority of consultation respondents calling for the proposals to be put on hold, it is clear from the CCGs that any delay to this project could be disastrous for local efforts to manage COVID-19 in the future.

The need for the proposed model to improve COVID-19 healthcare

The Improving Healthcare Together team has released their own review of the impact of COVID-19 on the clinical model, since the consultation closed. This paper provides a summary of the early lessons learned to date in respect of the pandemic, and in addition draws upon the experience and feedback of NHS staff working at Epsom and St Helier hospitals (ESTH) during the COVID-19 outbreak.

As is the care with every emergency care hospital in the country, ESTH have had to adapt and dedicate an unprecedented effort to manage COVID-19 over the past few months. Whilst this period has highlighted the very best of our local healthcare teams, it has also demonstrated the limitations of the current model with dealing with pandemic, including:

- COVID-19 required an increase in Level 3 ITU beds from 7 to 38. This was not possible at St Helier Hospital (the current Level 3 site) due to the layout of the hospital.

- Less than 20% of the beds at Epsom and St Helier are in single rooms. This was

insufficient to isolate an average of 50 suspected COVID-19 patients each day at the height of the recent peak, requiring these patients to be cohorted on wards – meaning patients cannot be effectively separated (especially in specialist clinical areas).

- Due to the limitations of the existing emergency departments, ESTH has struggled to create separate COVID-19 positive and COVID-19 negative spaces and has not been able to separate patient flows.

- The design of Epsom and St Helier Hospitals makes separate spaces for planned and emergency care very challenging in their current configuration (e.g. eye theatres at St Helier are in the same wing as the ITU).

It is clear from this review that the facilities at ESTH are not fit for purpose to manage healthcare during a viral pandemic. However, there are opportunities within the new proposed model in which can be employed to improve healthcare during any possible future pandemics:

- The case for change and need to consolidate major acute services is enhanced. COVID-19 demonstrated the difficulties in responding to this crisis with split-site services, inadequate estate and a stretched workforce. Consolidating major acute service would mean responding to any future crisis with more robust services, in purpose-built estate and with an enriched and enhanced workforce.

- More staff are needed in key areas. The shortcomings exposed, especially in ITU, demonstrate a need for more medical staff in each unit. This would be eased by consolidating services to create critical mass and greater staffing resilience, with greater scale enabling better staff-to-patient ratios.

- The district and out of hospital models need to work more closely together. COVID-19 demonstrated that the @Home service and Health and Care services can do more to support the district hospital model. In the PCBC, we expected this to be developed over the next five years – COVID-19 has accelerated a lot of this work and we are now working in a more integrated way.

- Planned spaces should, where possible, be separate from emergency spaces, to support separation of patients – and this would be supported by the split of the SECH from the district hospital sites (meaning we could offer COVID-protected environments). Emergency spaces should also be designed to enable segregation when necessary (e.g., segregating emergency departments in COVID and non-COVID spaces). Departments should, as much as possible, have dual access and egress routes.

- We need greater capacity and staffing resilience to support planned care. In future

pandemics, we would want to continue more planned care than during COVID-19. This requires better facilities and more resilient staffing, supported by consolidation. The greater separation of planned and emergency care offered by the clinical model would mean we are more able to offer COVID-protected planned care facilities in the future. Already, ESTH has demonstrated with their adaptive healthcare efforts during the COVID crisis that policies from the proposed model can be used to benefit patients during a pandemic:

- The crisis has forced all acute trusts to rethink outpatient care with virtual appointments. ESTH has found multiple ways of delivering clinics differently without face-to-face interaction; it is currently running 500 - 1000 virtual outpatient appointments a week.

- Patients can be discharged from acute care more quickly. The crisis has required record numbers of patients to be discharged. This has accelerated significant improvements in patient flow and length of stay, supported by our out of hospital system.

Impact of proposed model on associated COVID-19 conditions

As well as reacting to the COVID-19 pandemic, the new model will also support better preventative care and long-term care for issues that are related to the virus.

There is a proven link between diabetes and COVID-related deaths, with over a quarter of deaths reported in English hospitals occurred in patients with diabetes.[26] NHS England figures revealed that of the 22,332 people who died in hospital in England between 31 March and 12 May, 5,873 (26%) suffered from either type 1 or type 2 diabetes.[27]

A large part of the proposed model, therefore, is focused on tackling long-term conditions, such as diabetes. One such example is the rolling-out the concepts of the National Diabetes Prevention Programme, including a digital option, to other long-term conditions, such as cardiovascular disease, across South West London.

Likewise, a study by the Centres of Disease Control and Prevention found that those who suffer from asthma have a greater likelihood of being hospitalised with COVID-19.[28] As a respiratory condition, asthma can cause COVID symptoms to have a greater impact on patients. 5.4 million people in the UK are currently receiving treatment for asthma: 1.1 million children (1 in 11) and 4.3 million adults (1 in 12).[29] It’s a common condition which costs the NHS over £1billion a year to treat.

The number of people with multiple long-term conditions is increasing, meaning a greater focus on preventative and proactive support is required. Around 15 million people in England have a long-term condition, and across Surrey Downs, Sutton and Merton, a number of these conditions are particularly prevalent, including asthma (c. 5%) and diabetes (c. 5% for Surrey Downs and c. 6% for Sutton and Merton).[30]

The ageing population means the need for preventative and long-term health care is much greater, as older people are more likely to develop conditions such as diabetes. And, as is well known, the likelihood of dying from COVID-19 or related issue is much greater for those over the age of 65.

These local strategic priorities have clear alignment in seeking to reduce health inequalities

through increased access to local primary or community care, a focus on prevention, as well as targeted initiatives to manage patients with risk factors around diabetes or high blood pressure and supporting behaviour change. District hospitals will be at the centre of the networks of care and will provide effective joined up health and care to keep people well and recover after an acute episode of care.

Proposed changes to the business case

It is our understanding that, in response to feedback from the consultation, the IHT has decided to extend the planning horizon for the project to 2029/30. Extending the bed modelling to this date means 14 more beds than were included in the pre-consultation business case.

Further, in preparedness of potential future pandemic, the assumptions previously made in the pre consultation business case about critical care capacity and single room provision may need revisiting to create further capacity. Suggestions have been made about the possibility of increasing capacity in the district hospitals in an emergency pandemic situation.

We welcome the initial increase in bed capacity and support further discussions about how the model can support greater pandemic care. We will continue to work with the Trust on this issue as it is reviewed in the future.

Conclusion

In conclusion, I hope this letter has proven to be helpful in demonstrating the need for the IHT programme going forward and dispelling some of the attacks on the proposals.

At best, the aforementioned accusations in the first section of this letter were based on a misunderstanding. At worst they were a calculated political move, which threatens to risk investment in our local health services and consequently lead to the very closures they profess to be fighting against.

Years, even decades, have gone by with many attempts at potential reconfigurations and investments, and even more political campaigns fought over the hospitals.

This investment allows us to put those years of uncertainty to bed. To not only sustain the Epsom and St Helier NHS Trust, but to improve healthcare outcomes for local people. To deliver not only improvements in the existing buildings, but provide a new acute facility built for the modern age, capable of sustainably tackling the threat of another pandemic. In short, this will sure up the Trust's clinical and financial future.

Risking that future is not acceptable. If this programme does not proceed on the back of what has been demonstrated to be misinformed information, it is clear from conversations with the Trust and others, that the alternative is most likely to be a loss of investment and a loss of services – the very thing many claim to be fighting against.

As local MPs, we agree with the heads of the South West London and Surrey Heartlands that this investment in needed now more than ever. It's not about politics; it's about improving our local healthcare system and future-proofing against the impact of another pandemic.

I hope, therefore, that you will look favourable upon IHT's plans and allow Sutton, Merton and Surrey residents access to the improved healthcare facilities that they deserve.

Best wishes,

Elliot Colburn
Conservative Member of Parliament for Carshalton and Wallington

Crispin Blunt
Conservative Member of Parliament for Reigate

Stephen Hammond
Conservative Member of Parliament for Wimbledon

Paul Scully
Conservative Member of Parliament for Sutton and Cheam

[1] Improving Healthcare Together 2020-2030 pre-consultation Business Case, pg. 185

[2] Improving Healthcare Together 2020-2030 pre-consultation Business Case, pg. 59

[3] Improving Healthcare Together 2020-2030 Consultation Report Key Findings, pg. 8

[4] Improving Healthcare Together 2020-2030 pre-consultation Business Case, pg. 308

[5] Improving Healthcare Together 2020-2030 pre-consultation Business Case, pg. 244

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[12] http://www.euro.who.int/__data/assets/pdf_file/0019/101476/E93762.pdf

[13] Improving Healthcare Together 2020-2030 pre-consultation Business Case, pg. 231

[14] Improving Healthcare Together 2020-2030 Baseline Travel Analysis

[15] https://goo.gl/maps/CgQvqG1Yj7fxtQ7v8

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[18] https://goo.gl/maps/3j1n6iWYcYPAERS58

[19] Improving Healthcare Together 2020-2030 Consultation Report, para. 5.61

[20] Siassakos, D. et al. (2011) 'Attitudes Toward Safety and Teamwork in a Maternity Unit with Embedded Team Training'

[21] https://www.england.nhs.uk/urgent-emergency-care/urgent-treatment-centres/

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[24] https://www.cqc.org.uk/sites/default/files/20191023_uec18_statisticalrelease.pdf

[25] Improving Healthcare Together 2020-2030 Consultation Report, para. 1.34

[26] https://www.diabetes.org.uk/about_us/news/coronavirus-statistics

[27] https://www.theguardian.com/world/2020/may/14/one-in-four-people-who-died-in-uk-hospitals-with-covid-19-had-diabetes

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[29] https://www.asthma.org.uk/about/media/facts-and-statistics/

[30] Improving Healthcare Together 2020-2030 pre-consultation Business Case, pg. 46