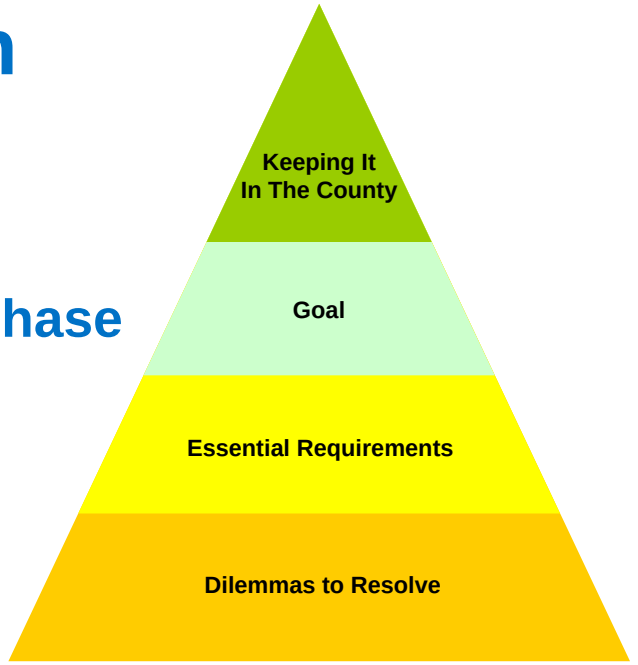
The Shrewsbury and Telford Hospital NHS
NHS Trust

Keeping it in the County

Securing the future of hospital services in Shropshire, Telford & Wrekin



Report on the "Assurance and Consultation" phase
24 March 2011

Compassionate

Personal

Safe

Putting Patients First

Respectful and Responsive

Integrated

Seamless

Closer to Home

Keeping it in the County

Securing the future of hospital services in Shropshire, Telford and Wrekin

What people like:

- Better buildings and facilities
- Proposed location reflects population trends
- Best use of limited resources
- Improved quality of service and better care
- Improved access to services – older people and stroke/urology
- Centres of excellence and specialist services
- Keeps skills and services in the County
- Potential to modernise hospital sites
- Consultants and other medical staff have been involved

What are the main concerns:

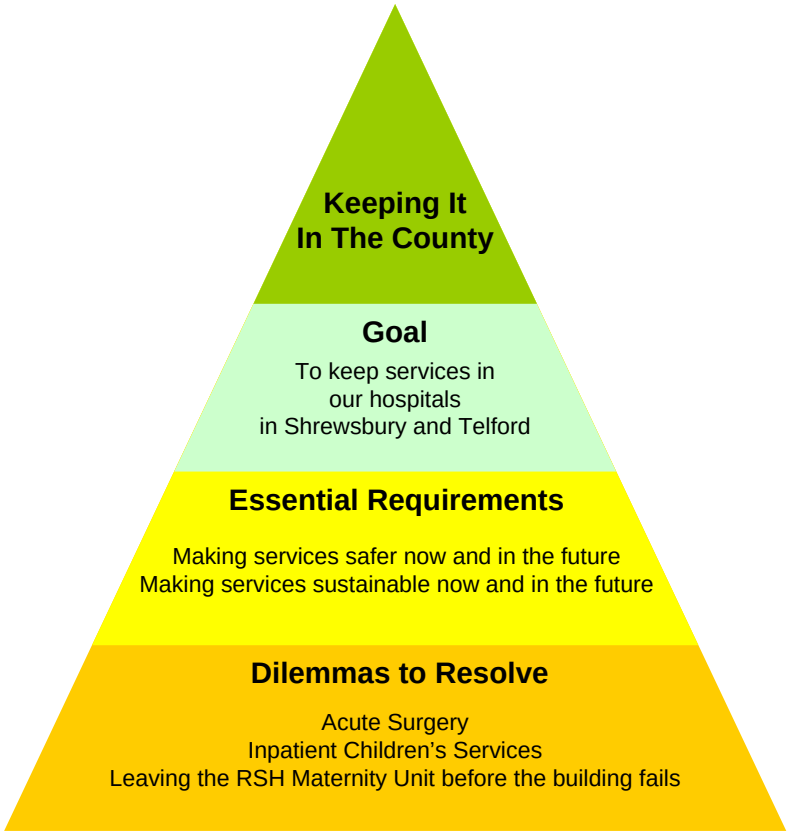
- Travel time, distance and transport
- Location of services

What reassurances did people want:

- Nothing to change
- Public transport and shuttle bus arrangements
- Reassurance on travel times
- Clear clinical pathways and arrangements in place to mitigate risks
- That clinicians support the proposals
- That there will be sufficient trained and qualified staff to ensure that the proposal are sustainable

The background

- One Goal
- Two Essential Requirements
- Three Dilemmas
- Three Reconfiguration Principles:
  - Keeping two vibrant, successful, well-balanced hospitals in the county
  - A commitment to having an A&E department at both sites
  - Access to acute surgery from both sites



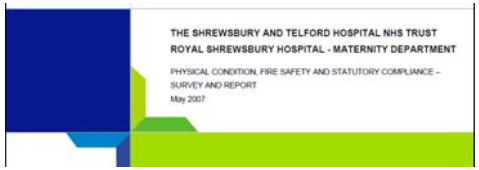
Other context

- Listening to Feedback
- Changing Legal/Financial Context
- “Burning Platform”
- Deteriorating Building
- A common issue

Financial failure: what will it mean for NHS providers

Achieving FT status as quickly as possible

Firstly, it is important to be absolutely clear that achievement of FT status is both vital, and urgent. Subject to the outcome of consultation and legislation, it will not be possible to remain an NHS Trust in the future. In bringing all Trusts to FT status we will not be lowering the bar. I recognise that some NHS Trusts will have difficulty in reaching FT status in their current form. If this is the case, plans need to take account of the alternative configurations which may be required.


THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
ROYAL SHREWSBURY HOSPITAL - MATERNITY DEPARTMENT
PHYSICAL CONDITION, FIRE SAFETY AND STATUTORY COMPLIANCE – SURVEY AND REPORT
May 2007


RECONFIGURING HOSPITAL SERVICES
Lessons from South East London
Keith Palmer

Keeping it in the County
Securing the future of hospital services in Shropshire, Telford and Wrekin

What were the options?

Option 1: Do nothing

Option 2: Move some services from RSH to PRH and some services from PRH to RSH

Option 3: Single Site

Option 4: Concentrate all major inpatient and emergency activity at one site, with planned activity at the other

Development and Assurance

During the development:

Clinical Problem Solving Workshops

Internal workshops

Building notes guidance / Healthcare Capital Investment Manual

Prior to consultation:

National Clinical Advisory Team

Local Assurance Panel

Office for Government Commerce

During consultation:

Local Assurance Panel

Joint Health Overview and Scrutiny Committee

Clinical Assurance Group / Clinical Pathways Groups

Equality Impact Assessment

Following consultation:

Joint Health Overview and Scrutiny Committee

Office for Government Commerce

Clinical Assurance Group

Clinical Pathways Groups

Outline Business Case

Full Business Case

Sec 2

Local Assurance Panel

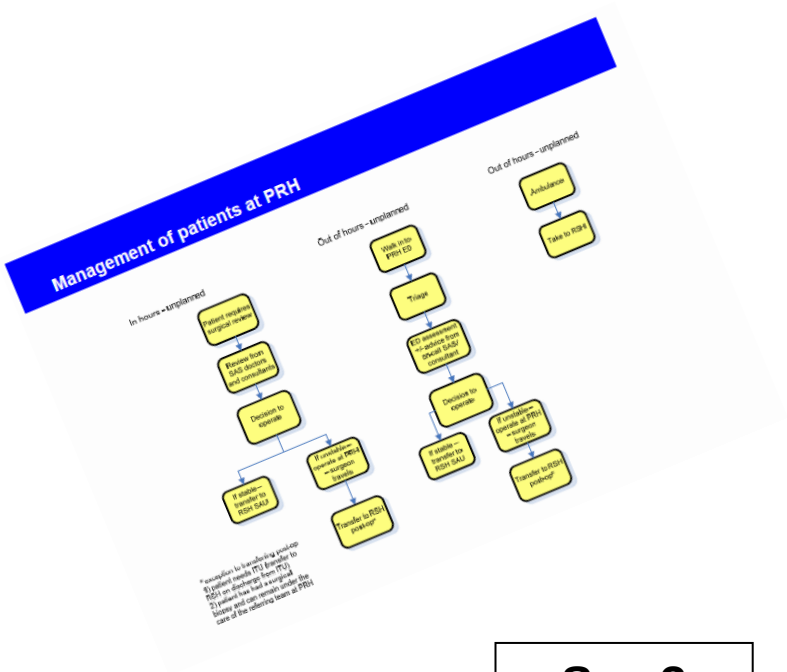
- Experts from relevant fields
- Local GPs, Directors of Public Health, Commissioning Directors, Links, all observed by HOSC
- Full assurance against the Lansley tests
  - Clinical evidence
  - GP commissioning support
  - Choice
  - Consultation
- NCAT, RCS, RCOG

Development and Assurance

- Broad assurance on the proposals, finding that the Lansley Tests were met
- Recommendations that would need to be taken forward into OBC, FBC and implementation
- Other valuable recommendations regardless of the decisions today
- Ongoing assurance in next phase

Current Clinical Pathway Position

- Identified high level clinical pathways
- Some areas of a priori disagreement
- This has been tested through the Local Assurance Panel – external chair, external paediatrician, external obstetrician, external nurse director from Alder Hey



Surgery

- Draft clinical pathways developed, influenced by feedback from public and clinicians, e.g.
  - Development of ITU at RSH is in the capital programme
  - Model for surgical opinion at PRH with 24/7 paediatric surgical team

- Local Assurance Panel fully assured

- Key recommendations assurances to address, e.g.
  - Continue to develop surgical model
  - Agree timetable for implementation given current clinical risks

Maternity/Gynaecology/Neonatology

- Draft clinical pathways developed, influenced by feedback from public and clinicians, e.g.
  - Discussions with ambulance services on emergency transfer
  - Visits to other sites
  - Pathways for women with abdominal pain
  - Maintain Early Pregnancy Advisory Service at both sites
- Local Assurance Panel assured on the majority of the pathway
- Key recommendations assurances to address, e.g.
  - Concerns about travel time and distance / cross-border issues
  - Risk assessment and transfer model – home / MLU / CLU
  - Reduce overall hospital transfer time

Children's Services

- Draft clinical pathways developed, influenced by feedback from public and clinicians, e.g.
  - Surgical support at PRH
  - Building on existing arrangements for out-of-area transfers of sick children (e.g. Birmingham, Alder Hey)
- Local Assurance Panel assured on the majority of the pathway
- Key recommendations assurances to address, e.g.
  - Rainbow Unit: engagement in designing the new services, and legacy issues
  - Concerns about travel time and distance / cross-border issues
  - Resume discussions on development of Hospital at Home
  - Continue to develop demand/capacity and workforce model for PAU at RSH

Sec 3.3

Other Services

- **Stroke:** Model for 24/7 stroke thrombolysis at both hospitals through a telemedicine solution

- **Urology:** Continue to review of urology services

Issues to address during implementation

- Travel and access, e.g.
  - Cross-border discussions underway on travel and access, involving ambulance services, hospitals and community services
  - Working closely with midwifery services in Powys
  - Inter-site travel (e.g. Shuttle Bus)
  - Training and support for staff involved in transfers

Q6/7, Q9, Q13, Q14/15/16

Issues to address during implementation

- Detailed shape of services (e.g. PAU, Stroke)
  - Hyper acute stroke services at both hospitals
  - Demand/capacity for PAU
- Hospital ⇔ Community, e.g.
  - Telehealthcare
  - Preventing avoidable admissions

Q4, Q5, Q6, Q13

Current Financial and Workforce Position

SOC

OBC

FBC

Procure

Build

Operate

- High level financial assessment at this stage
- Outline Business Case will follow after consultation
- Full Business Case later in the year – provides an opportunity to further test affordability and options appraisal before implementation
- Affordable at £28M – at the limits of affordability
- Not affordable for higher borrowing, e.g. £60M

Financial Summary

Assumptions and Definitions

- Running Costs – DH Estates and Facilities, Performance and Estates Analysis: Trust High level Performance Indicators 2009/10.
  - Occupancy costs £199 per m2. Includes Estates costs, lease costs, rates, energy and utilities and capital charges. Capital charges have been excluded from the calculated figures and classified as Finance costs.
- Capital expenditure has a direct link to the depreciation charge – ie cash spend on capital (CRL) is equal to the depreciation charge. Any change within the depreciation charge has been assumed to have an equal effect within capital expenditure.
- Loan interest has been calculated at the latest DH interest rate of 2%.
- Loan repayments have been calculated over a period of 25 years.
- PDC (Public Dividend Capital) dividend has been calculated at 3.5% ie return on capital employed.
- No benefit taken for reduced staff expense claims that may result from ‘cross-site’ travel solution.

Income and Expenditure Account

		Scheme A	*Scheme B*
		£28m	*£62m*
Additional Costs			
Running Costs		**945**	*2,214*
Annual Depreciation Charge		**1,141**	*2,480*
PDC		**80**	*174*
Loan Interest		**521**	*1,140*
Total Costs Year 1		**2,687**	*6,008*
Potential Savings			
Paediatric Staff Rotas	**200**		
Obstetrics	**Nil**		
Surgery	**360**		
		560	*560*
Reduction in Occupancy Costs		**1,670**	*1,670*
Depreciation *		**351**	*351*
PDC		**221**	*221*
Total Potential Savings		**2,802**	2,802
Less Inter site Transport **		**400**	*0*
Net Savings		**2,402**	*2,802*
Financial Loss		**285**	*3,206*

* Current depreciation from SaTH asset register

** There is potential for further savings relating to productivity gains in reduced staff travel time.

EBITDA Effect

		Scheme A	*Scheme B*
		£28m	*£62m*
Additional Costs			
Running costs		945	*2,214*
Potential Savings			
Paediatric Staff Rotas	200		
Obstetrics	Nil		
Surgery	360		
		560	*560*
Reduction in Occupancy Costs		1,670	*1,670*
Total Potential Savings		2,230	*2,230*
Less Inter site Transport *		400	
Net Savings		1,830	*2,230*
Net savings which add to the EBITDA		**886**	*16*

* There is potential for further savings relating to productivity gains in reduced staff travel time.

Cash Flow

	Scheme A £28m	*Scheme B £62m*
EBITDA	**886**	*16*
FINANCE COSTS		
Reduction in PDC	221	*221*
Increase in PDC	(80)	*(174)*
Interest	(521)	*(1,140)*
Net Finance Costs	**(381)**	*(1,094)*
OPERATING CASH FLOW AFTER FINANCE COSTS	**505**	**(1,077)**
Loan Repayment	(1,141)	*(2,480)*
NET CASH OUTFLOW	**(636)**	**(3,557)**

Note: DH requirement to meet interest and capital repayment as I&E surplus (Capital Loan Rules)

Interest & PDC	601	*1,314*
Loan Repayment	1,141	*2,480*
Total I&E Surplus required (minimum)	**1,742**	*3,794*

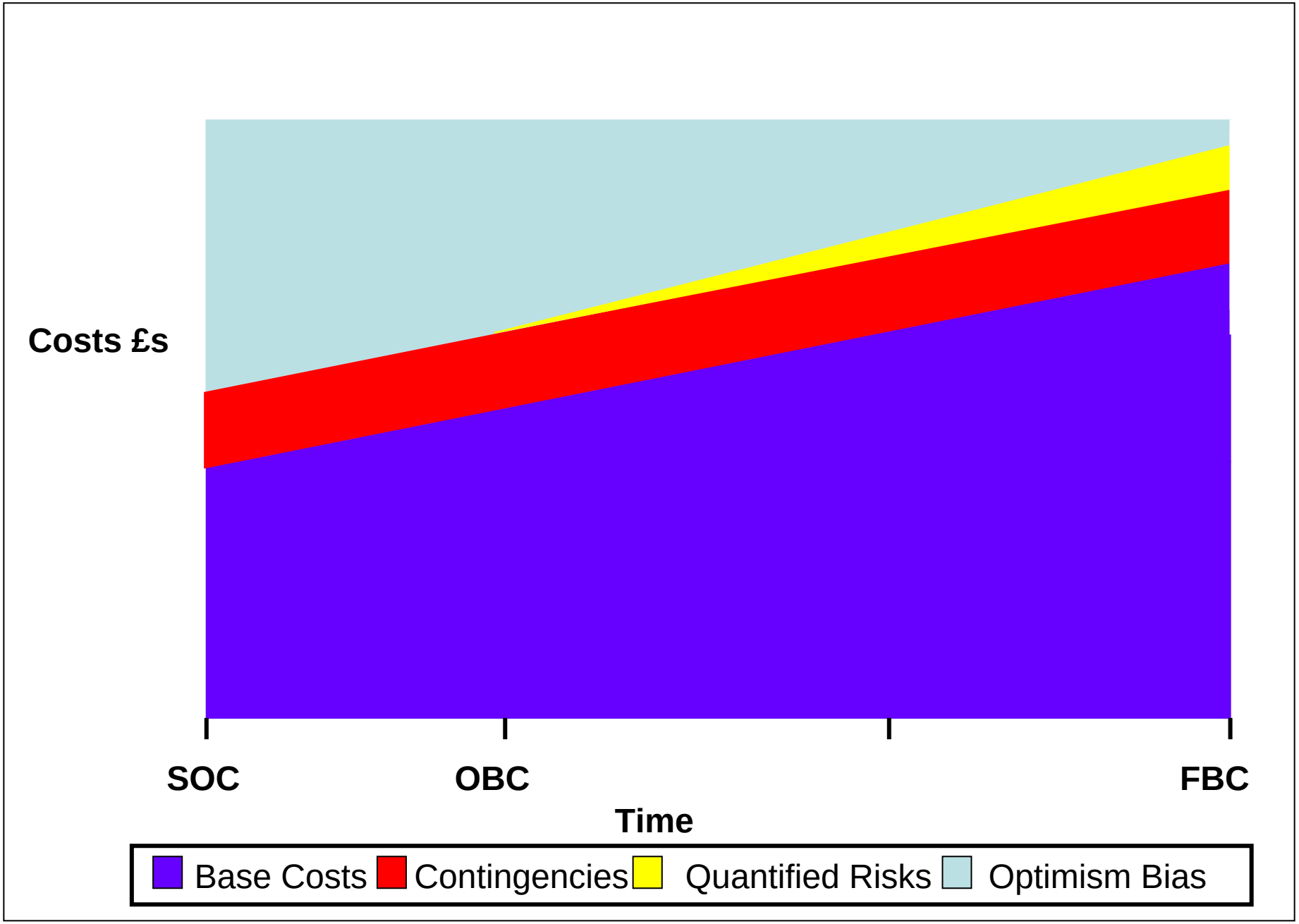
Are the capital costs estimates accurate?

- Yes
- Forecast vs. Outturn
- E.g. Optimism Bias
  - Scheme costs were historically underestimated by as much as 30–40% (initial costs were *optimistic*)
  - To counter this optimism the Treasury has developed a system that is *biased* against that optimism
  - Hence the term *"Optimism Bias*

Sec 4.1

NHS Estates

- Heavily prescribed
- Workbooks, schedules, calculators
- All evidence based using the most up to date NHS experience
- Mandatory for NHS Trusts to follow
- Regulated by the OGC who scrutinise every stage of capital development
- Independently compiled by cost advisers (Holbrow Brookes, members of the Royal Institute of Chartered Surveyors)



Holbrow Brookes

An example

- RSH Treatment Centre
- Risks and contingencies stripped out to make the scheme affordable
- **40% over budget**

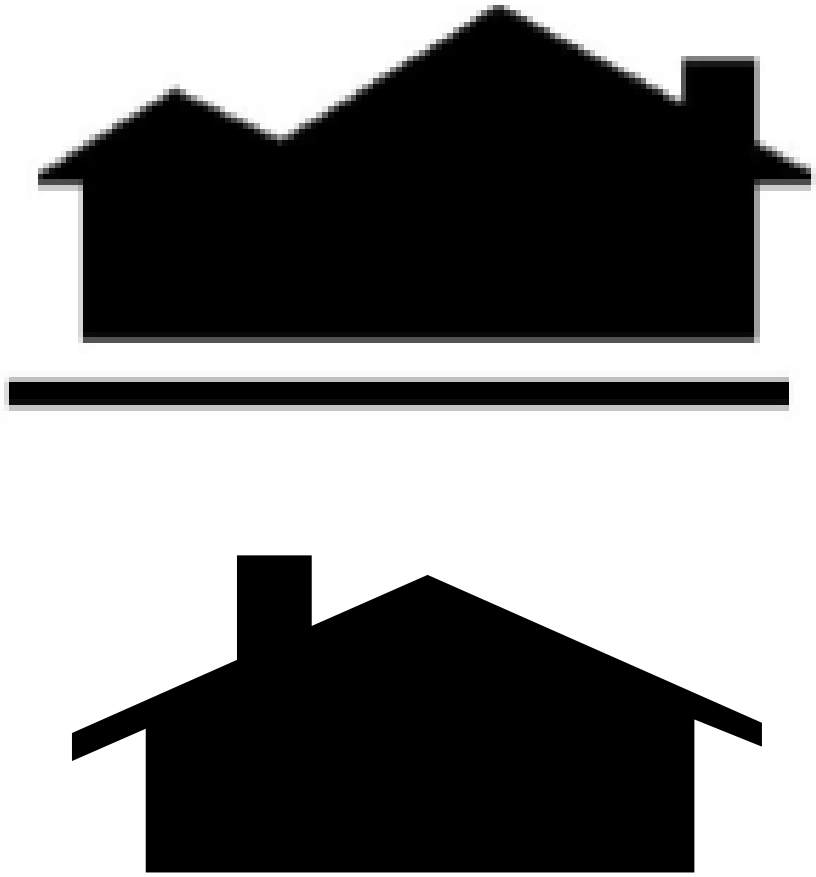
Sec 4.1

Are we comparing like with like?

- No
- It is a package not a menu.
- If one service moves this creates space for another.

Sec 4.1

Scheme Costs



- The two solutions are different
- RSH scheme is bigger because everything has to be replaced in one new building
- PRH is smaller because some services remain at RSH

The schemes are very different

- The RSH scheme is more costly because it will stand alone and it needs everything from foundation to roof
- RSH will need new boiler plant, lifts, engineering, water treatment
- RSH is a hotch potch of buildings without a central core
- PRH is cheaper because its only 62% new build, its smaller and the building already has plant, lifts, engineering, water treatment
- PRH is designed to be added to and/or adapted

Have we reviewed the £62m costs for RSH?

- Yes
- Some changes in planning assumptions (e.g. reduced MIPS and increased VAT)
- Best case scenario reduces RSH build costs marginally – but still not affordable

Sec 4.1

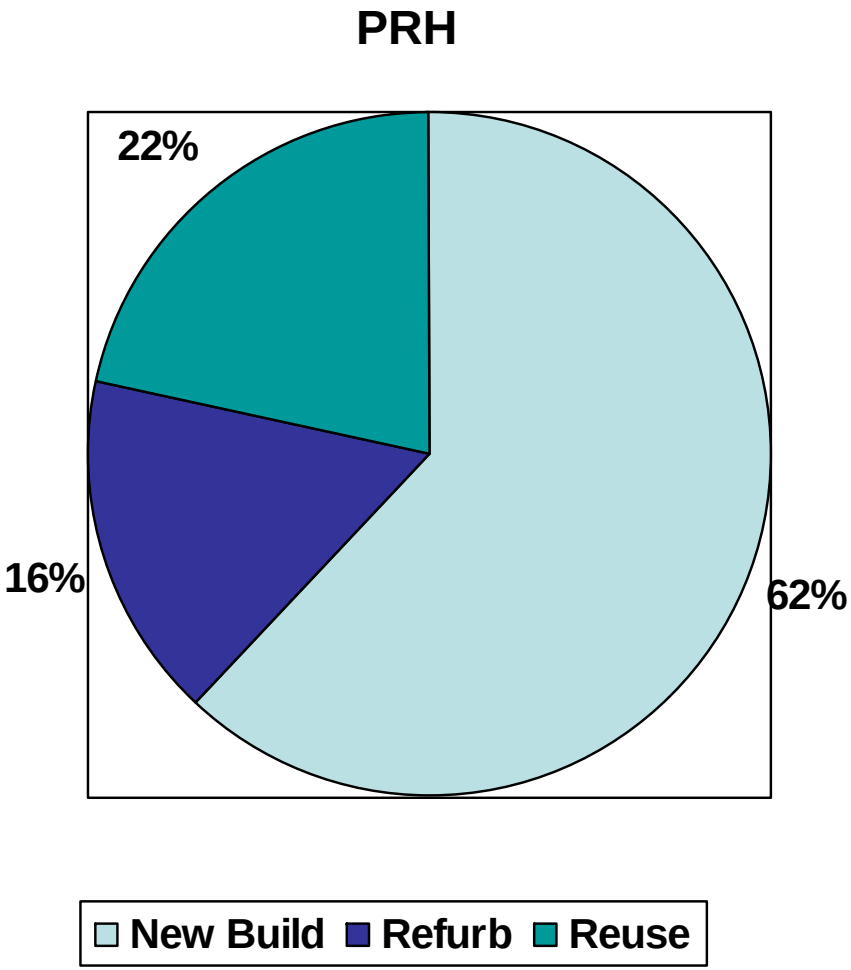
Clinical Space

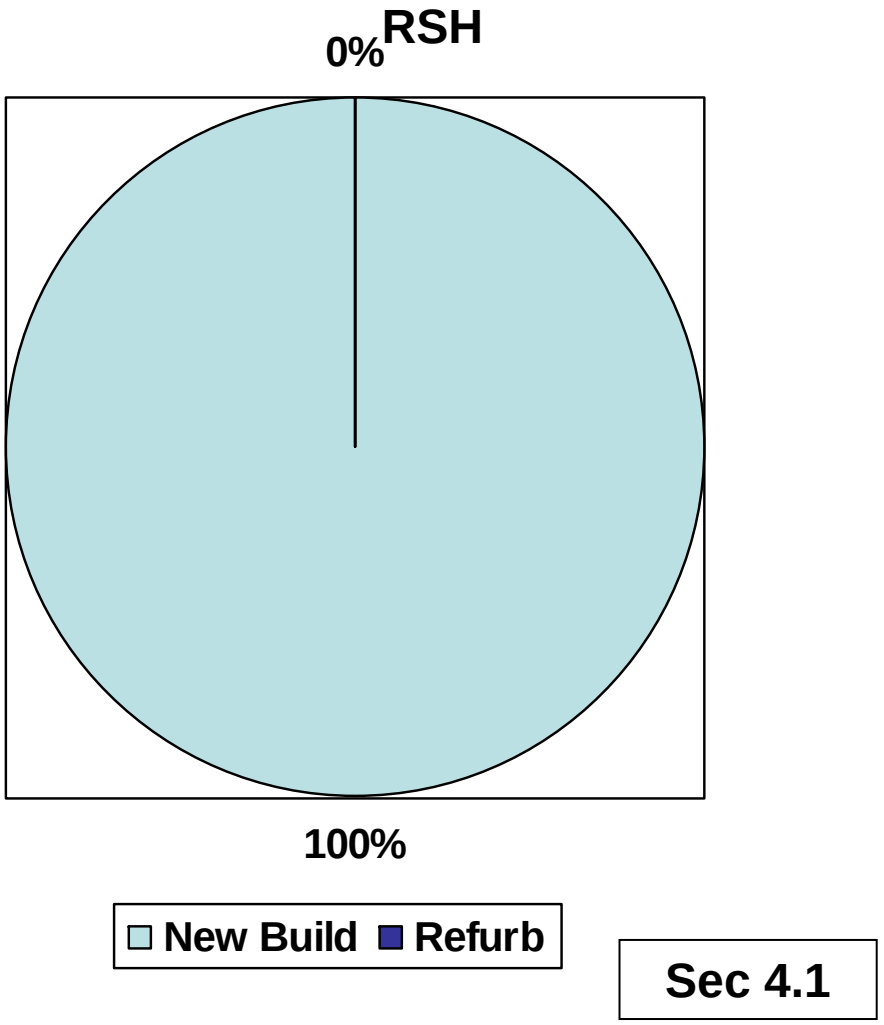
Clinical space for Delivery Suite, Theatres, Ante-Natal and Post-Natal beds, Neonatal Unit, Paeds Inpatients at **PRH**
5,100 m^2

Clinical space for Delivery Suite, Theatres, Ante-Natal and Post-Natal beds, Neonatal Unit, Paeds Inpatients at **RSH**
5,800 m2

Sec 4.1

New Build vs. Refurbishment and Re-use





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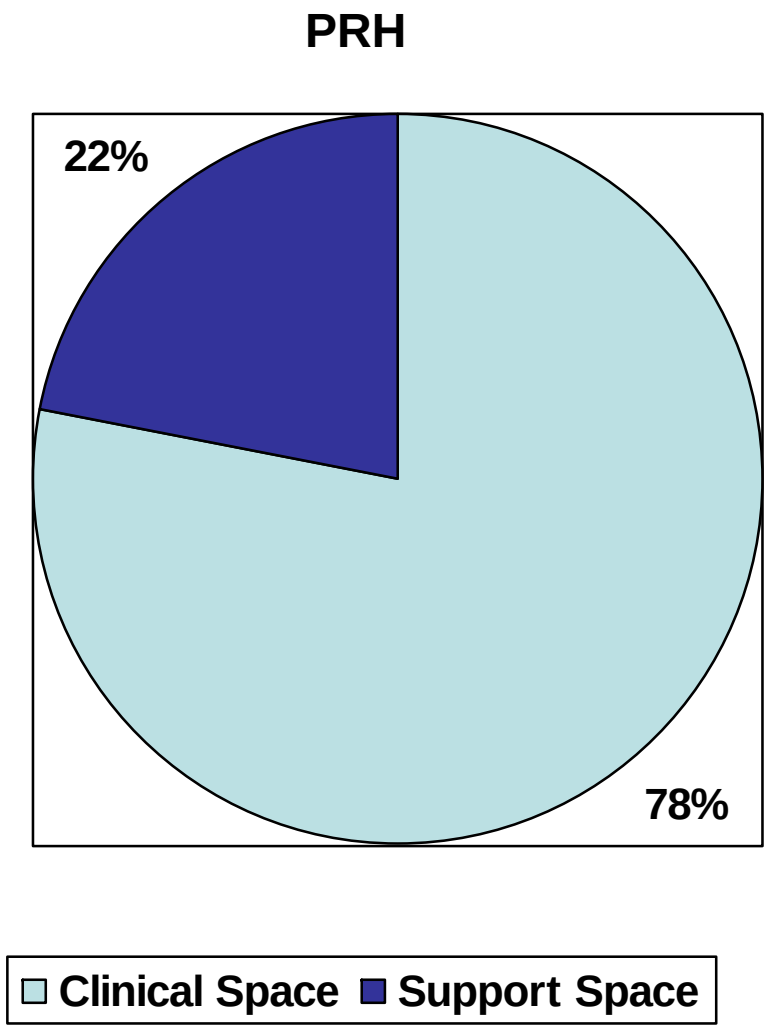
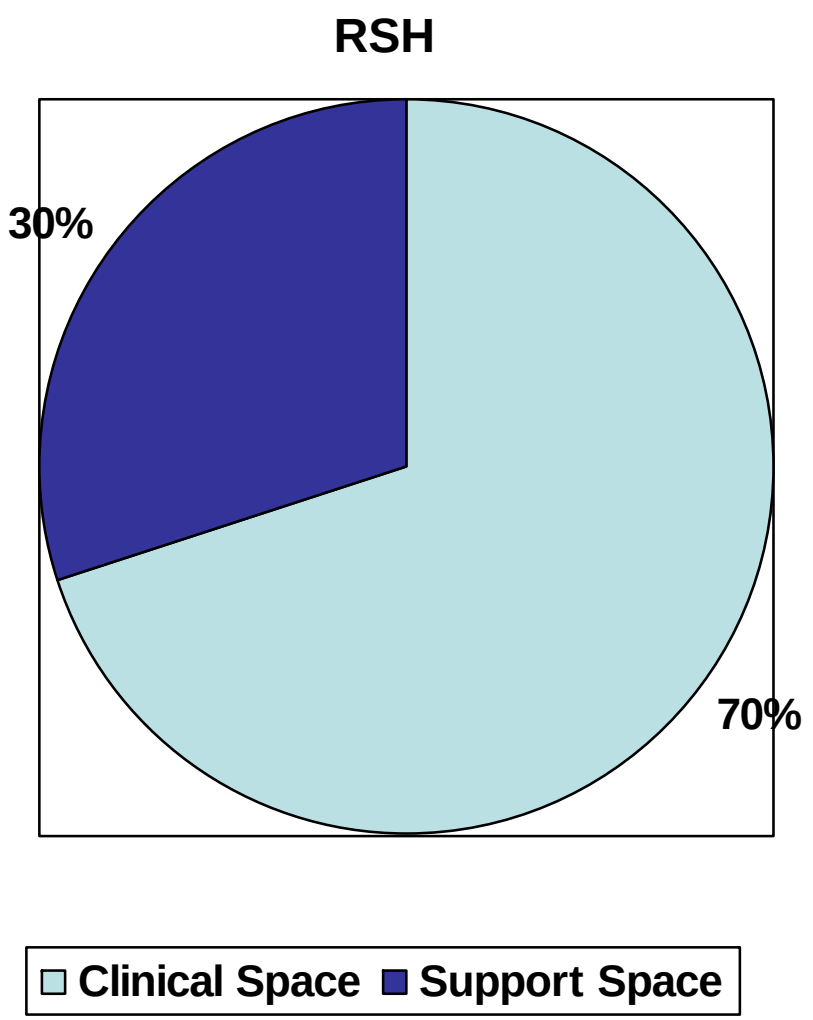
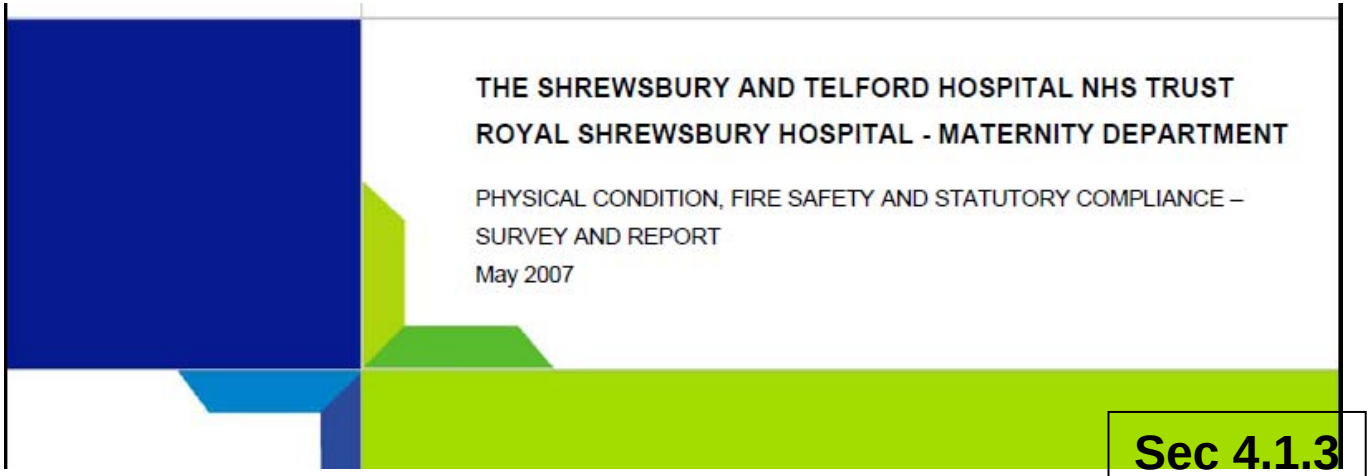
Clinical Space vs. Support Space





Updated Options Appraisal: Option 1: Do nothing

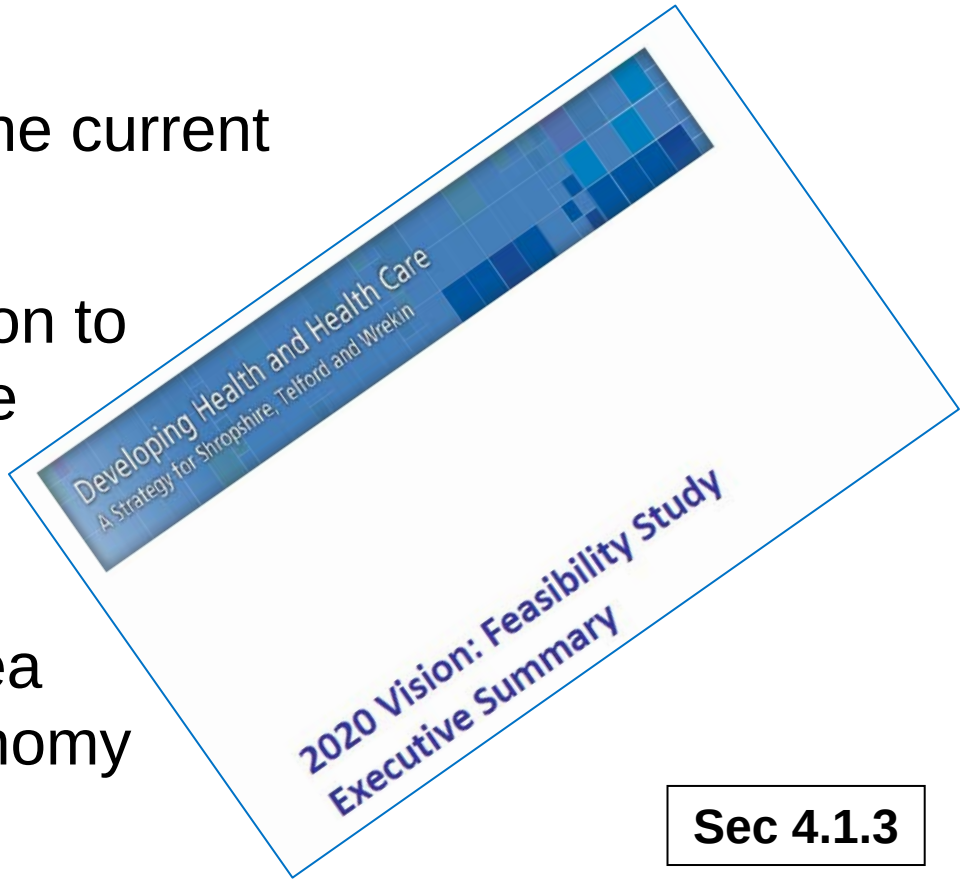
- Many people want services to stay where they are
- But, this does not address the dilemmas we face
- Specifically, it does not move services from the deteriorating women and children's building at the Royal Shrewsbury Hospital



Sec 4.1.3

Option 3: Single Site

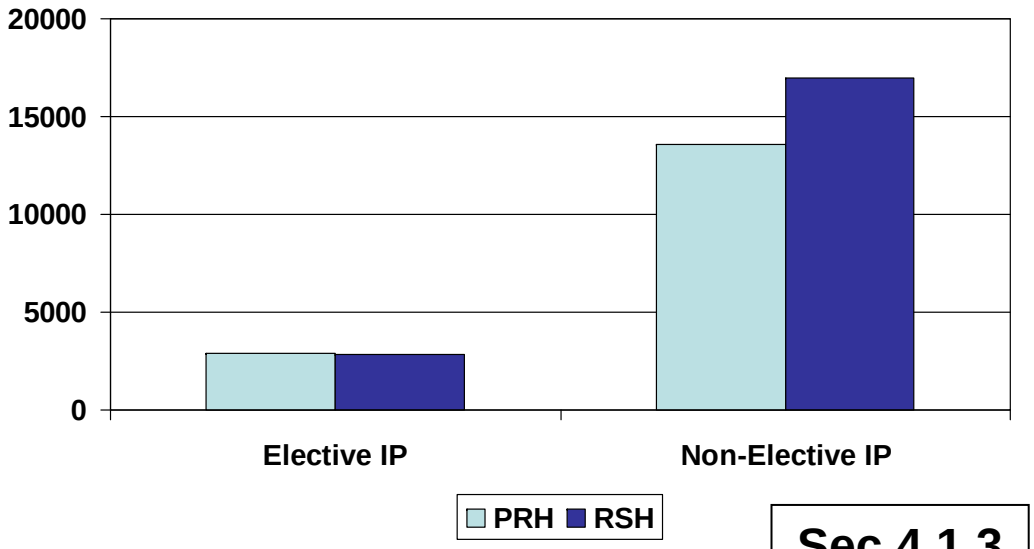
- It is preferred by our clinicians.
- Detailed long term costings were prepared by Provex and SHP in 2009.
- It is simply not affordable in the current economic climate.
- It cannot be our strategic vision to deliver a single site unless we are confident that it is affordable.
- We can come back to this idea in future if and when the economy improves.



Sec 4.1.3

Option 4: Hot vs. Cold

- Also would be preferred by clinicians.
- We have much more emergency work than planned work – and emergency inpatients tend to stay in hospital much longer than planned inpatients.
- This would lead to two hospitals of very different sizes.
- We need to model not just the bed moves (e.g. 280 additional beds at RSH) but also the impact this has on A&E, ITU and a wide range of other services.
- This is not affordable.



Sec 4.1.3

Option 2: Moving Services Between Sites

- Remains the preferred option
- Needs to be tested further through the development of an Outline Business Case

Timetable

Phase	Objective	Timescale	
Discussion and Design	Developing options	To Nov 2010	✓
Pre-Consultation Assurance	Assurance process PCT and Trust Boards	Nov to Dec 2010	✓
Assurance and Consultation	Public consultation process Assurance processes	Dec 2010 to Mar 2011	✓
Post-Consultation	Review and decisions following consultation	Mar to Apr 2011	
Planning for Implementation	Working with patients and carers to develop detailed pathways Detailed operational and financial planning Ensuring safe acute surgery	Apr 2011 to Apr 2012 Jun 2011 OBC Autumn 2011 FBC	
Implementation	Begin to put the new services in place	Phased approach from April 2012	

Moving Forward

- Develop outline business case (June) and full business case
- Comprehensive communication and engagement plan – engage patients and communities in further development of the pathways
- Focus on the key concerns raised during consultation – travel & access, rural health & cross-border issues

Questions