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
Putting Patients First

- Safe
- Compassionate
- Personal
- Integrated
- Respectful and Responsive
- 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
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

Lansley Four Tests
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
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
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
Current Financial and Workforce Position

- 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

  – 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

<table>
<thead>
<tr>
<th>Scheme A</th>
<th>Scheme B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£28m</strong></td>
<td><strong>£62m</strong></td>
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#### Additional Costs

<table>
<thead>
<tr>
<th>Item</th>
<th>Scheme A</th>
<th>Scheme B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Running Costs</td>
<td>945</td>
<td>2,214</td>
</tr>
<tr>
<td>Annual Depreciation Charge</td>
<td>1,141</td>
<td>2,480</td>
</tr>
<tr>
<td>PDC</td>
<td>80</td>
<td>174</td>
</tr>
<tr>
<td>Loan Interest</td>
<td>521</td>
<td>1,140</td>
</tr>
<tr>
<td><strong>Total Costs Year 1</strong></td>
<td><strong>2,687</strong></td>
<td><strong>6,008</strong></td>
</tr>
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</table>

#### Potential Savings

<table>
<thead>
<tr>
<th>Item</th>
<th>Scheme A</th>
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<tbody>
<tr>
<td>Paediatric Staff Rotas</td>
<td>200</td>
<td>560</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>Nil</td>
<td>560</td>
</tr>
<tr>
<td>Surgery</td>
<td>360</td>
<td></td>
</tr>
<tr>
<td><strong>Total Potential Savings</strong></td>
<td><strong>2,802</strong></td>
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Reduction in Occupancy Costs

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<tbody>
<tr>
<td>Depreciation *</td>
<td>351</td>
<td>351</td>
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<tr>
<td>PDC</td>
<td>221</td>
<td>221</td>
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<tr>
<td><strong>Total Potential Savings</strong></td>
<td><strong>2,802</strong></td>
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Less Inter site Transport **

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<tr>
<th>Item</th>
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<tbody>
<tr>
<td>Net Savings</td>
<td>2,402</td>
<td>2,802</td>
</tr>
<tr>
<td><strong>Financial Loss</strong></td>
<td><strong>285</strong></td>
<td><strong>3,206</strong></td>
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</tbody>
</table>

* Current depreciation from SaTH asset register

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

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</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Potential Savings</strong></td>
<td>2,230</td>
<td>2,230</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less Inter site Transport *</td>
<td>400</td>
<td></td>
</tr>
<tr>
<td>Net Savings</td>
<td>1,830</td>
<td>2,230</td>
</tr>
<tr>
<td><strong>Net savings which add to the EBITDA</strong></td>
<td><strong>886</strong></td>
<td><strong>16</strong></td>
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</tbody>
</table>

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

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<tr>
<td><strong>EBITDA</strong></td>
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<td>16</td>
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<tr>
<td><strong>FINANCE COSTS</strong></td>
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<td></td>
</tr>
<tr>
<td>Reduction in PDC</td>
<td>221</td>
<td>221</td>
</tr>
<tr>
<td>Increase in PDC</td>
<td>(80)</td>
<td>(174)</td>
</tr>
<tr>
<td>Interest</td>
<td>(521)</td>
<td>(1,140)</td>
</tr>
<tr>
<td><strong>Net Finance Costs</strong></td>
<td>(381)</td>
<td>(1,094)</td>
</tr>
<tr>
<td><strong>OPERATING CASH FLOW AFTER FINANCE COSTS</strong></td>
<td>505</td>
<td>(1,077)</td>
</tr>
<tr>
<td>Loan Repayment</td>
<td>(1,141)</td>
<td>(2,480)</td>
</tr>
<tr>
<td><strong>NET CASH OUTFLOW</strong></td>
<td>(636)</td>
<td>(3,557)</td>
</tr>
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Note: DH requirement to meet interest and capital repayment as I&E surplus (Capital Loan Rules)

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<td>601</td>
<td>1,314</td>
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<tr>
<td>Loan Repayment</td>
<td>1,141</td>
<td>2,480</td>
</tr>
<tr>
<td><strong>Total I&amp;E Surplus required (minimum)</strong></td>
<td>1,742</td>
<td>3,794</td>
</tr>
</tbody>
</table>
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”
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)
An example

- RSH Treatment Centre
- Risks and contingencies stripped out to make the scheme affordable
- 40% over budget
Are we comparing like with like?

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

Sec 4.1
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 it’s 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
Clinical Space

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

5,100 m²

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

5,800 m²
New Build vs. Refurbishment and Re-use

Sec 4.1
Clinical Space vs. Support Space

PRH

78%

22%

Clinical Space

Support Space

RSH

30%

70%

Clinical Space

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
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.
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.
Option 2: Moving Services Between Sites

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

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