APPENDIX 2

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

MANAGEMENT EXECUTIVE – June 2010

Division 3

NHS Breast Screening Programme Expansion of Service

EXECUTIVE RESPONSIBLE	Trish Rowson
AUTHORS (if different from above)	Dianne Lloyd, SDM for Diagnostics and Therapies Andrew Kent, Divisional General Manager, Division 3
CORPORATE OBJECTIVE	▪ Delivering high quality care for all by embracing technology and other enabling strategies. ▪ Delivering national and local targets and priorities, including financial balance. ▪ Improving engagement and partnership working to develop and deliver a coherent vision for health and social care.
BUSINESS PLAN OBJECTIVE NO(S)	▪ Continue to achieve national access targets for Cancer of 2 weeks from urgent referral to first outpatient appointment for all urgent suspect cancers and 1 month from diagnosis to treatment for all cancers ▪ Support the delivery of the Cancer Reform Strategy in the prevention, early diagnosis, improved patient experience and use of appropriate care settings for cancer patients
EXECUTIVE SUMMARY	The Cancer Reform Strategy (CRS) requires all breast screening services to have at least one digital mammography x-ray unit in place by the end of 2010 and to be meeting the round length standard of 90% of women being screened within 36 months. This is a pre-requisite before services can apply for nationally held revenue to enable them to extend their screening service from women aged 50-70 years to those aged 47-73 years. This age extension is a Tier 1 Vital Sign. The Operating Framework for 2010/11 specifies that 8% of the extended age range will have been invited for screening by the end of March 2011. For Shropshire, this is approx. 1750 additional women. Two previous papers have been considered by the ME highlighting the CRS requirement regarding the extension of the breast screening service by 2012 indicating significant capital investment is required. There is no central capital funding. In February 2010 the Capital Planning Group have approved a phased approach to implementation.

	The purpose of this paper is to update the ME on the options for SaTH as a provider of the Shropshire Breast Screening Service (SBSS) so that the strategy for expansion of the service can be implemented. Of the options detailed in this paper, Option 3 is the preferred option.
KEY FACTS	▪ The extension of the age range to women aged 47 – 73 years will be implemented by 2012 in line with the CRS. ▪ Application for expansion of local services must be supported by the Quality Assurance Reference Centre (QARC) before an application can be made to the National Office. ▪ Expansion is conditional upon certain criteria being met, including availability of digital mammography equipment in the Assessment Centre by 2010. ▪ Screening in the extended age range must begin in 2010/11. For Shropshire, by Quarter 4 end, approx. 1750 additional women must have been invited for screening therefore digital equipment must be available by December 2010. ▪ National funding is available to support the expansion there will be new income of £126k p.a. ▪ Indicative capital investment of £1.8M is required between now and 2012 plus ongoing supportive revenue costs in the region of £117k. excluding finance costs of £251k ▪ In order to meet the age expansion requirement for 2010-11, the first piece of digital equipment must be ordered imminently.
RECOMMENDATION(S)	The Management Executive is recommended to approve Option 3's capital and revenue requirements.

The Shrewsbury and Telford Hospital NHS
NHS Trust

Division 3

NHS Breast Screening Programme Expansion of Service

1. Strategic Background

1.1 The Cancer Reform Strategy (Dec 2007) made 4 commitments on breast cancer screening:

1. To extend the Breast Screening Programme (NHS BSP) to women aged 47 – 73 by 2012 (currently 50-70 years). Completion of the age range expansion is a Tier 1 Vital Sign.
2. To move from analogue to digital mammography, with at least 1 digital x-ray set in each Assessment Centre by December 2010 therefore the first piece of equipment must be ordered in May.
3. To transfer the management of the surveillance of women at high risk of breast cancer (previous family history) into the NHSBP by 2009 – this remains outstanding pending the move to digital mammography
4. To improve screening uptake in deprived and BME communities.

Revenue funding for extension of local breast screening services is available from the NHS Cancer Screening Programme on the basis of £12,000 per 1,000 eligible women in the 47 to 49 age range in the first instance. This will come into SaTH via the SHA. Applications to the National Office for extension of local services must be supported by the QARC. In order to apply to extend the service, providers must demonstrate they meet the following criteria before centrally held funding will be released:

1. Meet the NHS BSP minimum standard for round length i.e. 90% within 36 months
2. Have at least one digital mammography unit in place in the Assessment Centre
3. Meet the NHSBSP minimum standard for screen to assessment – i.e. 90% within 3 weeks.
4. All film readers must be reading at least 5000 cases per year.
5. Meet the NHSBSP minimum standard for repeat imaging i.e. <3% women recalled for repeat imaging due to poor imaging technique/ equipment faults.

1.2 Current position

1.2.1 Shropshire Breast Screening Service (SBSS) does not meet all QARC recommendations and there is ongoing work to address these which is acceptable to QARC. Since July 2008 the SBSS has achieved the round length standard overall although latterly the service has slipped on this target (reaching an all time low of 49.3% in January 2010) The SBSS is the only service within the West Midlands currently not meeting this PCT target . The Lead Commissioning PCT (Shropshire County) has assured QARC that the round length will be met by September and as a result has funded an additional £76,000. The costs and income are reflected within the current 2010/11 budget setting.

1.2.3 All current equipment is conventional, the Trust having 5 mammography units in total: one on each of 2 mobile screening vans, 2 located at RSH Treatment Centre and 1 located at PRH, which is used to support the symptomatic breast service at PRH.

Commissioners have indicated that any proposed move away from the current model of provision would require consultation within the local population. It is envisaged therefore that the service will continue to be delivered using mobile screening equipment which visit sites within the community on rotation.

1.2.3 The population eligible for screening in Shropshire will rise by 34.7%, from 63,000 to approx. 84,875 and approx 10,500 of these are within the expanded 47 – 49 years age range. The number of women invited for screening per year will rise from 21,000 to 28,292 (an additional 7,292 per annum).

The Operating Framework for 2010/11 specifies that 8% of the extended age range must have been invited for screening by the end of March 2011. 8% is ¼ of one year of a three year screening round. For Shropshire, this means approx. 1750 additional women must have been invited for screening by March 31st 2011. In order to achieve this, letters inviting women for screening in the extended age range must have commenced distribution by 1st December 2010. This means once the service commences, an additional 140 women (approx) will need to be screened each week.

The extension of the age range will result in the detection of more cancers and this will have an impact on breast surgery. It is estimated that 30-40% more women will transfer from the asymptomatic to the symptomatic service for further assessment with a view to treatment.

1.2.4 In order to assess the potential impact of the changes in breast cancer screening on the symptomatic breast service provided within SaTH, a Breast Services Working Party (BSWP) was set up with membership from all key stakeholders. This group has looked at the current symptomatic service and highlighted inequalities for symptomatic patients depending not only on which site they attend, but also which day they attend. The extension of the age range will result in potentially an additional 100 women per year transferring from the BSS to the symptomatic service. These women will require the full care pathway, with the majority requiring surgery and follow-up appointments. Information from Mede Finance indicates the new to follow-up ratio is 1:1.5. The impact upon the symptomatic service therefore needs to be addressed in parallel with changes within breast screening in order to ensure there is sufficient capacity to meet the cancer standards.

1.2.5 The current Director of the SBSS, Consultant Radiologist, Dr. J.A. Fielding has retired from his post (end of April 2010). This role is a requirement within the NHS BSP, providing both clinical leadership and expertise within the service. It is therefore essential that this post is replaced. The BSWP has agreed that the scope of this role needs to be expanded flexibly to support both asymptomatic and symptomatic services at PRH. Recruitment to this key post will be in place by September.

2. Capital to support expansion.

Department of Health advice publication, 29th January 2009 set out the expectation for how PCTs and Trusts will manage the investment and states that there will be no central funding for the purchase of digital equipment or links to PACS. It also points out that the transitional costs of running both conventional and digital systems in parallel are high, therefore full conversion to digital is the more cost-effective option.

A national framework contract is in place and NHS Supply Chain are assisting in the purchase of x-ray equipment. PASA are assisting with the purchase of mobile trailers. The capital costs and cost of integrating PACS given in this paper are indicative at this stage.

The issues to be considered in converting from conventional to digital technology include:

1. Installation of digital mammography equipment.
2. Interfacing digital mammography equipment with existing IT infrastructure to ensure accurate data transfer of patient demographics.
3. Storage, retrieval and display of the digital images that facilitates flow.

In December 2009, the Management Executive approved in principle, the paper entitled Diagnostics Services Priorities for Capital Investment 2010 – 2013 and this included the conversion to digital mammography equipment in line with the NHS BSP. As a result of other emergent service priorities, the option approved in principle means that digital equipment will be phased over 3 financial years.

On 11th February 2010, the Trust's Capital Planning Group approved an initial investment in 2010-11 of £466k to support installation of a static digital unit and necessary software / links to PACS in the assessment centre at RSH.

3. Commissioning Issues

The current service is provided by SPCT and T&WPCT, with SPCT taking the lead commissioning role, including the scheduling of invitations to screening. SPCT have confirmed their ongoing commitment to commission the service from SaTH at the Cancer LIT meeting on 1st April 2010. From 2010/11, the BSS contract will be included within the main hospital contract and negotiated alongside all other services.

The outstanding revenue shortfall of £76K present in the budget for 2009-10 has been met on a recurring basis (contribution of £50k from SC PCT and £26k from T&W PCT) and is now within SaTH's Financial Plan for 2010-11 as additional income for the service. During the past financial year, only bank hours were worked against this shortfall in funding.

4. OPTIONS

In order to meet the NHS BSP requirements to extend local services, the SBSS must commence inviting the extended age range in December 2010, and must therefore have at least 1 digital mammography unit by December 2010. Conversion to digital equipment must be completed by 2012. This paper details options to achieve this. Successful migration to a digital system is complex and requires a full and detailed consideration of workflow issues.

4.1 The options for transferring to digital technology are:

1	Do nothing.
2	Do minimal. Phased digital installation replacing current equipment chronologically at the end of its useful life, therefore running digital and analogue units in parallel.
3	Phased digital installation over 3 years, RSH fixed site first commencing 2010, therefore running digital and analogue units in parallel.
4	Replace all mammography equipment in 2010/11

4.2 Scoring of Options against benefit criteria

		Option 1		*Option 2*		*Option 3*		*Option 4*	
Benefit Criteria	Weight	Score	Weighted score	Score	Weighted score	Score	Weighted score	Score	Weighted score
Clinical Quality	25	0	0	0	0	4	100	5	125
Access	20	0	0	1	20	4	80	5	100
Efficiency/Patient Flow	25	1	25	1	25	3	75	5	125
Flexibility	10	1	10	1	10	4	40	5	50
Environment	15	1	15	1	15	4	60	5	75
Staff Recruitment/Retention	5	0	0	1	5	5	25	4	20
Total	**100**		**50**		**75**		**380**		**495**

4.3 Summary of investment options

4.3.1 Option 1

For SaTH is to meet the requirements of the NHS BSP by 2012, a strategy to transfer to digital technology must be approved. Of the 4 options detailed to achieve conversion to digital technology, Option 1 - to do nothing requires no immediate capital investment and no effort, but is not viable from the perspectives of clinical quality, effect on recruitment and retention of staff, access targets or potential impact on other SaTH services. Even if the Trust were not to provide the SBSS in the future, it will still need to invest in digital mammography equipment for symptomatic patients, as existing equipment will become quickly obsolete with the proven clinical benefits of digital technology to SaTH breast patients. Patients in the younger age group may choose to attend neighbouring Trusts where digital equipment is available.

4.3.2 Option 2

To replace equipment in chronological order, means that the older of the two mobile units, mobile 1, would be replaced and fitted with the first digital mammography unit. This van was already due for replacement in the current financial year. In addition, the tractor unit for this van is obsolete and the MOT has expired. It would appear sensible from a governance perspective, therefore, to replace this van first and install the first digital equipment on it. However, this option carries many disadvantages. The CRS requirement is that there must be a digital unit available in each Assessment Unit by 2010 (CRS requirement for women in the 47 – 49 years age group). The reason for this is to enable women in the younger age group to be assessed on digital equipment. If digital equipment is only available on a mobile van, this equipment would not be available for the assessment clinics that take place at RSH three times per week.

In order to comply with the NHSBSP requirement for expansion, the first digital equipment must therefore be installed in the RSH Assessment Centre. For this reason, Option 2 is not considered further.

4.3.3 Option 3

To implement a phased digital installation, RSH Assessment Centre first, followed by both mobile units and the other static unit at RSH, followed finally by the static unit at PRH. Phasing the implementation in this way would mean that during the transitional period, parallel systems would have to be in kept in place and managed appropriately. However, this approach would make commissioning the equipment

more manageable and allow more time for problem solving, thereby ensuring minimum disruption to service delivery. This option will provide the necessary conditions for the expansion of the SBSS and meet NHSBSP quality standards, and is also more manageable and affordable than Option 4.

4.3.4 Option 4

To replace all equipment at the same time carries the highest financial burden and potential service risk. This could potentially have a major disruptive impact on the service. The advantage of this approach is that the transitional period would be short and conventional and digital systems would not run in parallel, providing that the implementation of the digital system and integration with PACS goes smoothly. It is however, unlikely that the transition will be problem-free and there is a relatively high risk that the project team could potentially be overwhelmed trying to commission several pieces of new equipment with new technology, at the same time as implementing a new PACS and all at the same time having to maintain the BSS standards. For these reasons this would not be the preferred choice.

5. RISK ASSESSMENT AND MANAGEMENT - PREFERRED OPTION

The option that will achieve best fit in terms of non-financial and financial objectives is Option 3 and therefore the only option considered here.

	PLANS FOR MANAGEMENT OF RISK
1	**Mobile Vans:** The older of the 2 mobile vans is a moderate-high risk due to its age and poor state and needs to be replaced as soon as it is feasible to do so. The main risk is that the tractor unit will fail, leaving the van at the periphery of the county where it is least accessible. This means that the next cohort of women to be screened will be required to travel much further for screening. The useful life of the equipment on board the van will be prolonged by revising the site schedule, so that it returns to PRH and then remains there until it is replaced. This means that the van will be sited in a central location so that it is accessible to more women and the impact of longer travel time minimised. This could not continue indefinitely because the other, larger, van cannot be accommodated at all community locations.
2	**PACS:** The preferred option is to interface digital mammography units with the SaTH PACS. The implementation of this will incur a cost which the suppliers cannot quantify until the manufacturer of the mammography equipment to be interfaced is known following the formal procurement exercise. In addition, the current managed service contract for PACS is due for renewal in December 2012 and at this point, the Trust will be considering options for replacing both the PACS and RIS. The cost of a separate PACS for archiving and retrieval of digital mammography from 2010 has therefore been included in the financial appraisal.
3	**The existing analogue processors** will be in use for longer than intended therefore increasing the risk of failure prior to replacement with digital technology. There is a growing second hand market as other Trusts move to digital equipment therefore this may work to our advantage. Alternatively, a 'half-way house' move to digital technology by leasing computed recording equipment from the PACS supplier could be considered. However indicative costs suggest this could be approx. £41k per quarter with an additional annual service cost for the equipment of £67k. Therefore dependant upon the timing of a potential processor failure and its nature it may be more cost effective to bring forward the move to full digital equipment to replace the unit that has failed.

6. SERVICE RE-DESIGN TO SUPPORT THE PREFERRED OPTION

6.1 There are currently 3 patient clinics for the symptomatic service seeing 25 new and 3 follow up patients per clinic, 80% of which require imaging. Radiology support is not equitable across these 3 clinics, particularly affected is the Wednesday afternoon clinic which extends into the evening up to 10pm. There is currently no cover for Consultant annual leave and on-call. This means that meeting the 2 week cancer wait is a continual challenge and patients are receiving an inequitable service depending upon which day they attend as the concept of a 'one-stop' service is not available to all.

6.2 The aim is to provide a one-stop symptomatic service for all patients allowing them access to imaging and core biopsies if necessary during the same appointment. In the new model these clinics would accommodate 20 new patients each and reduce the number of repeated attendances required – currently some patients are attending 2 or 3 times to access the same service others are able to access in 1 visit. One-stop clinics cannot accommodate as many patients as traditional clinics as capacity has to be available to see patients at the end of the clinic with the results of their tests.

For this reason the current demand and initial implementation of the age extension will require another clinic during 2010-11. The initial aim is to hold an additional symptomatic clinic on a Wednesday morning with effect from September which could also focus on women with family histories of breast cancer as required by the CRS. All clinics must be adequately supported by Radiology Consultants and Radiography staff who will work to cover each others absences via flexible job plans.

6.4 A future aspirational proposal would be to site all breast services in one location on one site which would achieve fully streamlined patient pathways supported by medical and radiography workforce planning. Unifying the screening and symptomatic services into one location is ultimately the preferred strategic direction as per other units throughout the country. Housing the Radiology Consultants, Radiographers, Surgical Consultants and staff plus breast care nurses in one site would enable rationalisation of care pathways and reduced waste e.g. full implementation of a one-stop approach to reduce the number of patient appointments. This would require further consultation with the lead commissioning PCT, public consultation and be subject to a further business case.

6.5 The option of no longer providing the screening service has been explored with Regional Deputy Director of Breast Screening at QARC. Splitting the screening and symptomatic services is not an option with a successful national precedent – all services that have done this have subsequently lost the symptomatic service as the two are inextricably linked in terms of staffing and skills i.e. the symptomatic service would still require on-site digital screening as the equipment is shared between the screening and symptomatic services and Consultant Radiologist support would still be required at the one-stop symptomatic clinics for the 2 week wait referrals (approx. 5,000 p.a.). If such support is not available on-site then it has been found that services simply cannot function and the new host Trust for the screening service has had to take over the symptomatic service within a year to 18 months. It is highly unlikely that the Lead Commissioning PCT would wish use separate providers for the screening and symptomatic services due to the quality issues and resource inefficiencies.

6.6 There were 352 new breast cancers diagnosed last year, 50% of these via the screening service. It has been recognised nationally that the quality assurance framework within breast screening has had a positive effect on the quality of the symptomatic service when both services are delivered by a single team. In light of this, there is a national 'push' to align symptomatic services with breast screening. This is documented in the Cancer Reform Strategy vision document. Within the West Midlands there is only 1 service with separate screening and symptomatic providers and they will shortly go through public consultation in order to merge the services.

6.7 Recognition of the quality of the breast screening programme is shown through the decision to change the provision of family history surveillance from symptomatic services to the breast screening programme.

The inclusion of family history and the extension of the screening eligible age range will result in changes in the proportion of cancers diagnosed through the different pathways; this will mean fewer cancers being diagnosed through the symptomatic service. Therefore no longer providing the screening service would have significant implications upon symptomatic activity, income and medical staffing levels e.g. 90% of one of the Consultant Surgeons caseloads derives from screening, recruitment and retention of Consultant Radiologists would become extremely challenging if screening were to be excluded from job plans.

6.8 The recommendation from QARC is for Trusts to provide both screening and symptomatic services or not to provide any such services at all. The breast screening service in Shropshire is very well attended (over 20,000 women per year) which is a testament to the service offered and reflects the importance of the service to the population served. Nationally breast screening is known to be a highly emotive topic - relatively minor changes in service provision in other Trusts, such as changes in mobile screening locations, has resulted in letters to local politicians and high profile media articles.

7. INCOME AND EXPENDITURE ANALYSIS

7.1 Income and Expenditure Trends

The analysis below shows the historic and future income and expenditure for the Breast Screening Service.

The 2010/11 Plan is the budget setting plan before the impact of the extended age range.

The additional income and expenditure within the 2010/11 current plan reflect both the PCT's funding and the Trust expenditure required to improve the current round length standard to the required level.

The impact of the extended age range to income and expenditure position is fully illustrated within the movement between the 2010/11 position and the 2011/12.

The figures below indicate the historic and current EBITDA and therefore excluded the impact of the significant change to the capital charges costs.

	2007/08		2008/09		2009/10		2010/11		2011/12	
	WTE Worked	£,000 Actual	WTE Worked	£,000 Actual	WTE Worked	£,000 Actual	WTE Plan	£,000 Plan	WTE Plan	£,000 Plan
Total Income		**864**		**884**		**894**		**970**		**1096**
Pay Expenditure										
Consultant	0.9	(123)	1.2	(156)	1.2	(175)	1.2	(174)	1.2	(174)
Unqualified Nurse Band 2	1.2	(4)	1.2	(20)	1.0	(17)	1.0	(17)	2.2	(39)
PAMs Band 8A							1.0	(13)	1.0	(32)
PAMs Band 7	0.7	(41)	0.8	(35)		(16)			1.0	(43)
PAMs Band 6	5.7	(189)	6.4	(235)	5.9	(245)	7.1	(276)	7.1	(275)
PAMs Band 5		(2)								
PAMs Band 4									1.0	(24)
PAMs Band 3	0.9	(1)	1.0	(19)	1.0	(20)	1.0	(21)	1.0	(21)
Admin & Clerical Band 4	1.0	(7)	1.0	(23)	1.0	(24)	1.0	(25)	1.0	(25)
Admin & Clerical Band 3	0.6	(2)	0.6	(10)	0.6	(10)	0.6	(11)	1.6	(32)
Admin & Clerical Band 2			0.4	(1)	0.4	(7)	0.4	(6)	0.4	(6)
Pathology Band 6 BMS									0.2	(8)
Bank Nurse Usage					0.7					
Agency Admin		(2)		(4)						
Pay Awards								12		12
Total Pay	**11.1**	**(373)**	**12.5**	**(503)**	**11.6**	**(515)**	**13.1**	**(531)**	**17.5**	**(668)**
Non Pay		(202)		(214)		(200)		(211)		(208)
Total Pay and Non Pay		**(575)**		**(717)**		**(714)**		**(743)**		**(876)**
EBITDA		**290**		**167**		**180**		**227**		**220**

7.2 Preffered Option - Workforce and Pay Requirements

The table below details the additional staffing required to provide the extended age range service.

Additional Staffing Requirement - Full Year Recurring Impact

	WTE	£'000
Regrading of Band 6 Radiograher to Band 7 (Film Reader)		6
Band 6 Radiogragher	1.0	36
Assistant Practioner Band 4	1.0	24
Band 2 Radiographer Assistant	1.2	22
Admin and Clerical Support	1.0	21
Pathology Band 6 BMS	0.2	8
Total Staffing	**4.4**	**117**

It is anticipated that cost will be incurred from late 2010, and the estimated costs and change to the current 2010/11pay expenditure plan is circa **£20,000,** against an expected income stream of **£21,000**

The additional movements between the 2010/11 current plan and the 2011/12 proposal over and above the £117k above, relates to the full year effect of a Band 8a Radiographer post (£20k)

7.3 Income

The additional income from the PCT (£76k) which has come into the Trust on 1st April 2010 has been included within the 2010/11 plan along with the staffing requirements to meet the required improvement to the round length target.

The effect to income in 2011/12 due to the extended age range is expected to be an £126,000 per year. As mentioned above as this scheme starts during Quarter 4 2010/11 we are expecting an additional £21,000 in 2010/11, over an above the current income plan.

7.4 Activity

Below shows the current and historic levels of activity and the 2011/12 shows the impact of the extended age range.

Activity	2007/08	2008/09	2009/10	2010/11	2011/12
Total Eligible Women	63,000	63,000	63,000	63,000	84,875
Women Invited Per year	24,000	22,000	21,000	22,750	28,292
Women Screened	18,990	17,559	17,430	18,883	23,482

Unit Prices					
Income Per Eligible Woman	£14	£14	£14	£15	£13
Income per Woman Invited	£36	£40	£43	£43	£39
Income per Woman Screened	£46	£50	£51	£51	£47
Expenditure per Eligible Woman	-£9	-£11	-£11	-£12	-£10
Expenditure per Woman Invited	-£24	-£33	-£34	-£33	-£31
Expenditure per Woman Screened	-£30	-£41	-£41	-£39	-£37

7.5 Non-pay requirements:

Additional costs for Immunopathology testing (assuming 100 additional cases) £12,000 for ER/PR and other tumour markers as required.

There will be some savings from films during the 3 year transition to digital equipment, estimated at approximately £15,000

7.6 Finance Costs:

Capital Charges are applicable for the new equipment.

The full impact of these are £251.4k although as the capital purchase is phased over the next few years.

8 PREFERRED OPTION CAPITAL PHASING

Option 3 – Phase Digital Mammography over 3 years

The table below summarises the capital investment requirement for the preferred option and assumes two site working therefore if the service were to centralise on 1 site the equipment requirements for 2012/13 would be reduced (either another static unit or another mobile van).

	2010/11 £'000	2011/12 £'000	2012/13 £'000	Total £'000
Static Unit	226.0	226.0	226.0	678.0
Mobile Van inc sat trans		180.0		180.0
Mobile Van inc sat trans			180.0	180.0
Mobile mammo			172.0	172.0
Mobile mammo		172.0		172.0
Digital Stereo	40.0		40.0	80.0
Mammo PACS	200.0	200.0		400.0
Total	**466.0**	**778.0**	**618.0**	**1,862.0**

9 PREFERRED OPTION CASHFLOW

The following table summarises the changes to the cash flow for the three years for the preffered option.

	2010-11 £'000	2011-12 £'000	2012-13 £'000
Capital	(466.0)	(778.0)	(618.0)
Income	21.0	126.0	126.0
Pay	(20.0)	(117.0)	(117.0)
Non Pay		3.0	3.0
Net Cashflow	**(465.0)**	**(766.0)**	**(606.0)**

It shows a net cash outflow in each year, the key feature in this is the capital investment outflow. With the capital excluded a net inflow is noted.

10. DIVISIONAL/CORPORATE INVESTMENT SIGN-OFF

SUPPORT COSTS APPROVAL	Designation	Name	Date
Division 1	Divisional Director/Manager		
Division 2	Divisional Director/Manager		
Division 3	Divisional Director/Manager	Andrew Kent	
Facilities & Estates	Head of Estates/Facilities		
HR	Head of HR		
Strategy/Business Development	Director of Strategy		
Finance & Contracting	Director of Finance		

11. CONCLUSION/ RECOMMENDATION AND AUTHORISATION

RECOMMENDATION:

The Management Executive is asked to **approve** Option 3's capital requirements phased over 3 years and the revenue requirements of the age expansion.

In order to meet the age expansion requirement for 2010-11, the first piece of digital equipment must be ordered imminently.

AUTHORISATION

Signed: ..... Date: .....

Designation: CHIEF EXECUTIVE .....