The Shrewsbury and Telford Hospital NHS
NHS Trust

Looking to the Future

Securing the future of hospital services in Shrewsbury and Telford

Trust Board
25 August 2011

Purpose

The overarching objective for the reconfiguration of hospital services is to secure high quality, safe and sustainable local hospital services.

‘Keeping It In The County’:

- Making sure we continue to provide 24 hour acute surgery
- Making sure the range of inpatient children’s services are maintained
- Planning to move out of the deteriorating Maternity building

What does this mean for our communities?

- **Most services for most patients will remain the same:**
  - A&E service at both hospitals
  - Most outpatients and diagnostics unchanged
  - Most day case procedures unchanged
  - Children's Assessment Unit at both hospitals (24 hrs at PRH; 13 hrs at RSH)
  - Midwife Led Unit at both hospitals
  - Emergency medical patients & emergency surgery at both hospitals (e.g. heart attacks, serious chest infections, road traffic accidents)
- **Improved facilities for patients**
  - Improved facilities for cancer patients at RSH
  - Surgery concentrated at RSH
  - Head and Neck inpatients at PRH
  - Safe and sustainable maternity and children's services by moving to new modern facilities at PRH

The Treasury's Five Case Model of the OBC

The **Strategic Case** – describes the case for change, why the proposal is necessary and how it fits with local and national strategies

The **Economic Case** – asks whether the preferred solution meets future service requirements and offers best value for money

The **Commercial Case** – tests the likely attractiveness of the proposal to developers and outlines the approach of using P21+ best practice framework

The **Financial Case** – asks whether the financial implication of the proposed investment is affordable and confirms the funding arrangements

The **Management Case** – highlights implementation issues and demonstrates the Trusts capability of delivery

Strategic context - changes in the demographics

Service	*% change 2011-2016*	*% change 2011-2021*
0-14 years	**0**	**+3**
15-44 years	**-4**	**-5**
45-64	**+3**	**+3**
65-79	**+18**	**+27**
80+	**+18**	**+44**
Total	**+3**	**+6**

Capacity modelling across the Trust

- In general the Trust is committed to a move towards to the upper quartile benchmark length of stay – this is necessary as part of ‘normal’ business to ensure viability
- Impact of demography without any actions would mean an additional 186 beds in 10 years time
- For the affected services within the reconfiguration, improved efficiency has been appropriately factored into the future capacity requirements
- This is to ensure we do not ‘over build’ – an important issue for the tax payer
- Current occupancy is 97% - modelled a move to 90% (80% maternity and paediatrics)

Getting the size right – agreed productivity improvements

Service	*Current Inpatient beds*	*OBC Proposed Inpatient beds*	*Net Change*
General Surgery	**105**	**91**	**-14**
Urology	**26**	**15**	**-11**
Head & Neck	**20**	**10**	**-10**
Gynaecology	**18**	**16**	**-2**
Paediatrics	**50**	**36**	**-14**
Obstetrics	**41**	**41**	**-**
Neonatology	**22**	**22**	**-**
			-51

*Based on moving towards upper quartile LOS

NB Page 81, Table 33 (zero change in OB)

Maternity & Neonatology service brief

	Service Assumptions	Current Capacity	PRH Capacity and Facility Requirements	RSH Capacity and Facility Requirements
Consultant Obstetric Unit	• Assume 5,500 deliveries across the health economy • Sensitivity analysis re increase to 6,500 suggested this could be accommodated through LoS and model of care changes • 25% midwife led deliveries • LDR model of care	• 41 antenatal / postnatal beds • 11 delivery rooms	• 41 antenatal / postnatal beds – flexible design and use, incl. 4 transitional care • Option to use vacant MLU beds as postnatal overspill at times of peak demand • 11 delivery rooms, incl. 1 high dependency room • 2 maternity theatres • Bereavement room separate from main obstetric area	
Antenatal Clinic and MLU	• Antenatal clinics to continue on both sites, though some increase at PRH • MLU at PRH needs to be physically distinct from obstetric unit	• Antenatal clinic • 24 antenatal / postnatal beds • 8 MLU delivery rooms • PANDA and WANDA	• Antenatal Clinic • 8 MLU A/N & P/N beds • 3 MLU delivery rooms • 4 bed WANDA unit	• Antenatal clinic • 8 MLU A/N & P/N beds • 3 MLU delivery rooms • PANDA • MLU, PANDA and antenatal clinic to be relocated
Neonatology	• No change in total cots; proportion of ITU/HDU may vary in the future • Transitional care is part of postnatal bed complement,	• 3 level 3 cots • 3 level 2 cots • 16 SCBU cots	• 3 level 3 cots • 3 level 2 cots • 16 SCBU cots	

Getting the workforce right in Paediatrics – safe and sustainable new ways of working

- Clinically led discussions
- RCPCH involvement
- Adjacencies with paediatrics and emergency care
- Increased consultant availability at peak times
- Introduction of Advanced Paediatric Nurse Practitioner role
- Need to ensure staffing levels right for a much bigger PRH unit, plus a 13 hour PAU at RSH, plus separating out staffing for paediatric oncology
- Ensure there are three consultant rotas – one each for PRH and RSH (in support of A&E & PAU) and NNICU

Getting the workforce right in Paediatrics – safe and sustainable new ways of working

Service - Paediatrics	*2012/13 wte*	*£000*	*2013/14 wte*	*£000*
Consultants			**0.4**	**45**
Reduction in junior doctor banding		**(25)**		**(25)**
Reduction Assoc Specialists PAs			**(0.6)**	**(45)**
SHOs			**(2.0)**	**(88)**
Paediatric Nurse Practitioners	**4.0**	**258**		
Qualified nurses			**4.19**	**263**
Unqualified nurses			**1.8**	**15**
Total	**4.0**	**233**	**3.79**	**165**

The economic case – appraisal of the options

- At PRH – 4 shortlisted options
- At RSH – 3 shortlisted options
- Non-financial appraisal against 7 objectives:
  - Improve quality of services
  - Develop existing services and enable provision of new services
  - Improve the environment and patient experience
  - Improve safety of patients, visitors and staff
  - Ensure viability and sustainability of clinical services
  - Create flexibility for the future
  - Practicality and ease of implementation
- Scoring and sensitivity testing

PRH – Option 4

- New build:
  - Antenatal obstetric inpatient beds
  - Delivery suite
  - Neonatal Unit (NICU, SCBU)
  - Two obstetric theatres and support accommodation
  - Parents accommodation
  - Transitional care beds obstetric beds
  - Paediatric oncology
  - Some paediatric inpatient beds (including adolescents bays)
  - Paediatric outpatients
- Reuse and Refurbishment:
  - Postnatal obstetric inpatient beds
  - Paediatric inpatient beds (existing template)
  - PAU
  - Inpatient head and neck beds (ward 8)
  - Inpatient gynaecology beds
  - Gynaecology assessment and Colposcopy
  - All non-clinical support (e.g. relatives overnight, administrative centre, teaching space)
- Additional car parking and detailed transport planning

Dominant nucleus style of PRH to be extended

PRH Option 4 site plan

Proposed development at PRH:

The proposed plans would see the majority of consultant-led maternity and neonatal services located next to the existing children's ward at the Princess Royal Hospital.

The Wrekin Maternity Unit and clinics would stay where they are.

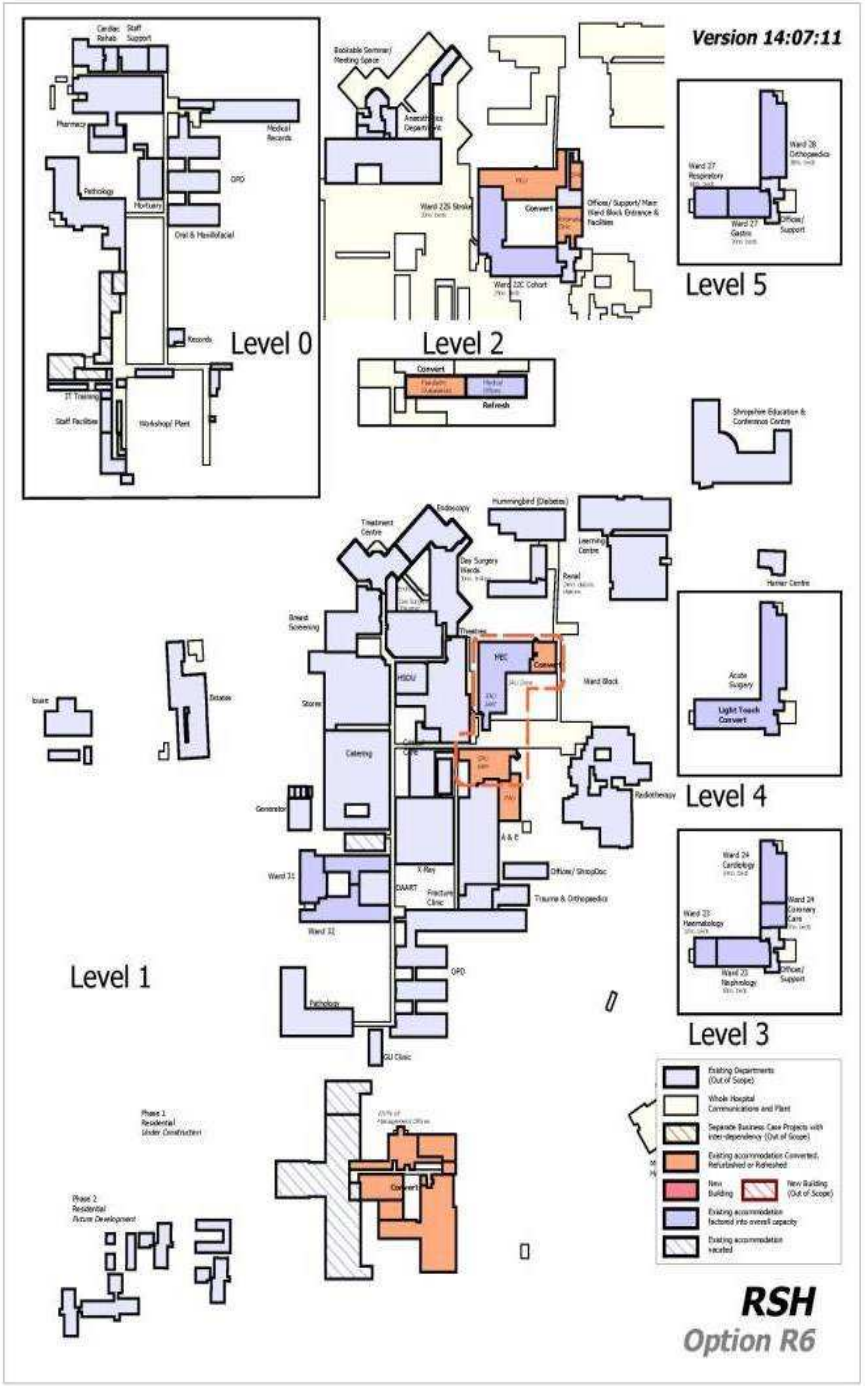
This will allow for some of the building to be used for overnight stay accommodation for relatives

RSH – Option 6

- Relocation and refurbishment:
  - Acute surgery consolidation on Level 4 Ward Block
  - SAU and MAU reconfigured to provide an Integrated Assessment Zone utilising adult Head and Neck Ward
  - Midwifery-led Unit and antenatal clinic, EPAS and PANDA relocated ground floor Ward Block
  - PAU located adjacent to A&E in vacated paediatric Head and Neck
  - Administrative staff relocated from Admin Corridor Outpatients Block, HR Houses at PRH and off site at Douglas Court to maternity block
  - Paediatric outpatients relocated to current Admin Corridor Outpatients Block

RSH Site - no material external changes

RSH option site plan



LOOKING TO THE FUTURE

Keeping you up to date on work to secure the future of hospital services in Shrewsbury and Telford

The commercial case - procurement strategy

- NHS best practice – ProCure 21+
- P21+ offers best value in terms of capital and revenue costs through improved efficiency and elimination of waste
- Reduces many risks to the project costs and timetable
- Removes much of the adversarial nature of the design/ construction management process

Desciption	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*
Appoint Technical Advisory Team	*					
Trust Board approval		*				
OBC submission to SHA			*			
P21+ information pack		*	*			
OBC approval			*			
Scheme registration				*		
EOI/short listing/open day					*	
Final selection/execution of plan						*

The financial case – the capital costs of preferred options

	2012/13 (£000)	2013/14 (£000)	2014/15 (£000)	Total
Option				
Capital – P4	**11,785**	**11,380**	**5,534**	**28,699**
Capital – R6	**2,633**	**2,454**	**1,174**	**6,261**
Total	**14,418**	**13,834**	**6,708**	**34,960**
Funded by:				
External Loan (DH)	**14,418**	**13,834**	**6,708**	**34,960**
Total	**13,834**	**13,834**	**6,708**	**34,960**

The financial case

- The impact on the Trust of additional revenue cost is £1.5million in 2014 rising to £1.6million in 2021
- This will be handled through the Trust's Cost Improvement Plan
- There are 8 prioritised CIP schemes for 2012/13, including
  - Capacity management
  - Medical workforce – locums
  - Nursing workforce – agency
  - Admin and clerical review
  - Robust programme management

- Reconciliation of £1.5million versus 'do-nothing' cost pressure of £2.4 to £3.2 million per annum

The financial case – comparing P4 with 'do nothing'

- Must continue to act to ensure safety & sustainability (OB & Paed)
- Cost not the only issue – risk that prospectively do nothing will fail to deliver the additional numbers of key staff that would be required

	Reconfiguration Option P4 £000		*Do nothing £000*	
	2014	2021	2014	2021
Increased capital cost	**1936**	**2011**	**-**	**700**
Increased staffing cost	**187**	**187**	**2400**	**2400**
Increased income	**(300)**	**(300)**	**-**	**-**
Non pay savings	**(399)**	**(399)**	**-**	**-**
Additional revenue cost	**1524**	**1612**	**2400**	**3140**

The management case – programme governance

- Sound programme structure in place (OGC assurance)
  - Programme Director, Programme Manager and Professional Team
  - Full Professional Team appointed and in place (Architects, Town Planners, Engineers M&E, Structural, Fire Safety and Environmental)
  - Surveys all in progress
  - Robust risk management
  - Benefits realisation
  - Strong clinical leadership
  - Strong clinical and staff engagement
  - Comprehensive on-going assurance

- Phase 2:
  - If OBC approved we will need to appoint a Project Delivery Director
  - Strengthen the Programme Team to manage the wider implementation and change programme
  - Resource communication, engagement and ongoing assurance plan

A reminder of the Assurance Framework

The processes	The Outcome
•Local Assurance Panel	√
•Office of Government Commerce	√
•National Clinical Advisory Team	√
•Joint Health Overview and Scrutiny Committee	√
•Clinical Assurance Group	√
•Equality Impact Assessment	√

Progress on further assurance

- Transport and Travel - a coordinated approach
  - WMAS/WAS (focus on minimising the impact of additional travel time)
    - Memorandum of understanding
    - Network of First Responders
    - Community Paramedics
    - BT – postcode not landline
    - Triage, protocols and operational procedures
  - Working with parents
    - Listening to concerns – drop off points and signposts
    - Individual plans for each child and family
    - Simplifying access to transport for routine appointments in/out of county
    - Door to needle time
  - Trust travel review
    - Additional car parking at PRH
    - Shuttle bus development
    - Series of options to reduce congestion on both sites and car usage of staff

Progress on further assurance

- Involvement, Engagement and Communication

  - Our patients – Network of Focus Groups
    - Real opportunity to improve things now and in the future
    - Simplify processes
    - Getting the ‘feel’ right
    - Acknowledging different needs of those with long term care needs and those accessing briefly

  - The public
    - Public briefing sessions – Q&A with clinical and Trust leaders
    - Looking To The Future newsletter
    - Website – Frequently Asked Questions

Progress on further assurance

- Involvement, Engagement and Communication

  - Our staff
    - Clinical Working Groups – pathways, risk mitigation, OBC
    - Specialty meetings and discussions
    - Staff briefings
    - CEO bulletin and conversations

  - Our partners and stakeholders
    - Members of working and strategic groups
    - Regular updates – formal and informal
    - Clinical Assurance Group
    - Strategic Forum
    - Travel and Transport Group

Now to March 2012

- Check and develop a greater level of detail about our plans to go into a Full Business Case – by March 2012
- Work with our focus groups to get this detail right
- Continue to talk to patients, the public and local communities about the changes – programme in place
- Continue to work with clinicians, WMAS, WAS, councillors, GPs and the PCTs to respond to concerns about transfers and transport
- Work with staff and staff side representatives to get the management of change process right
- Review our structures and begin to plan for implementation and construction from April 2012
- Continue to engage with the Joint HOSC and PCTs on the delivery of areas for further assurance through the HOSC work plan and assurance framework

Recommendations within the OBC

- The recommendation is
  - To approve the OBC and proceed with the development of the Full Business Case for the Future Configuration of Hospital Services
- This means supporting a capital loan request of £34.96m to enable:
  - A Women's and Children's Centre to be developed at PRH
  - Head and Neck inpatients to be consolidated at PRH
  - Paediatric outpatients, Paediatric Assessment Unit, Midwifery-Led Unit and Ante/Post-natal Care to be provided at RSH
  - Acute Surgery and Urology to be consolidated at RSH

OBC approval process

- HOSC meeting 23 August
- SaTH Trust Board 25 August
- SHA CRG 6 September
- PCT Boards 13 September
- SHA Board 27 September