

**BETTER HEALTHCARE CLOSER TO HOME**  
**REPORT TO JOINT OVERVIEW AND SCRUTINY COMMITTEE**  
**SEPTEMBER 2007**

**Executive Summary**

This report updates the JOSC in respect of the Better Healthcare Closer to Home programme's proposals for the general hospital in the borough of Sutton, the development of local care centres, and the position with Epsom hospital.

The programme looked at three options for the development of a general hospital: an entirely new built hospital on either the Sutton or St Helier hospital sites, or a combination of refurbishment and new build at St Helier.

The new build options have been assessed as unaffordable with no prospect of closing the affordability gap. The refurbishment and new build option which has been explored is not fully affordable but we believe that with further work it may be possible to come up with an amended proposal that makes clinical sense and addresses the affordability gap. We are therefore pursuing this option with a plan for staged investment at St Helier

Our general hospital modelling has made a number of assumptions about Epsom and renal activity which are subject to further review. There is also a need to do further work on the options for the future configuration of women and children's services between Epsom and St Helier

Surrey PCT will be joining the consultation on London's health services "Healthcare for London: A Framework for Action" to ensure that the interests of Epsom residents are considered.

The local care centre proposals for the Nelson, Wilson, Wallington and St Helier have been further developed and NHS London has agreed that we can submit an outline business case for their development, which is expected in early 2008. In addition, following stakeholder feedback in the summer, we are exploring the feasibility of a primary/local care facility on the Sutton Hospital site. A business case for further development of St Helier will also be produced for submission in 2008, once the further work described in paragraph four has been done.

## 1. Introduction

The last report to JOSOC was in June 2007. That report contained a full account of the background and history of the project, which will not be repeated here. This report will set out the position that has been reached on the key elements of the programme:

- Following the decision in February of this year not to proceed with the development of a critical care hospital, progress that has been made on the recommendation that a general hospital should be developed in the borough of Sutton:
- the future of Epsom hospital;
- the development of local care centres (LCCs) in Sutton and Merton;
- the development of an intermediate care facility in Sutton.

It will also comment on the wider strategic programmes taking place in Surrey and London and their relationship with BHCH.

## 2. General Hospital Location

In June we reported that three options were being looked at for the establishment of a general hospital in the borough of Sutton: a new hospital on the Sutton hospital site (option B), a new build on the St Helier site (option A1) and a mixed new build and refurbishment of the St Helier site (option A3).

The option of refurbishing buildings at Sutton hospital to create a general hospital was discounted as impracticable.

Tribal Consulting was engaged to scope the size and cost the hospital requirement, working from PCT commissioning plans and the clinical model the BHCH clinical group produced. Tribal then assessed the affordability of these options under the NHS capital regime. The Tribal report is attached to this paper.

The modelling was based on an assumed reconfiguration of flows from Epsom hospital based on earlier BHCH work. The status of this assumption, and the impact should this work not transfer, is discussed later.

The Tribal report reaches clear conclusions. An entirely new hospital at either the St Helier or Sutton sites would cost in the region of £320-£340 million, and would now be unaffordable under the NHS capital regime through a Private Finance Initiative (PFI) scheme or under borrowing rules.

### 2.1 A1 and B- new build at St Helier or Sutton using PFI

The capital affordability gap of these options is over £139m for each using the most optimistic financial projections. The gap amounts to over a third of the

projected capital costs. Using more pessimistic financial projections, the affordability gap increases to over £200m, this is more than 50% of the projected capital costs of these options.

## 2.2 Option B under publicly (loan) funded model at Sutton

This option explored the potential for the Royal Marsden Hospital Trust to use its foundation trust freedoms to raise a loan under its prudential borrowing limit (PBL). The assessment of the level of PBL required, concluded that the Marsden would need to cover between £222m and £265m of borrowing, on top of ESH using all of its maximum potential PBL of £68m, all of its internal funds of £29m as well as £35m of funding from the PCT for the LCC element.

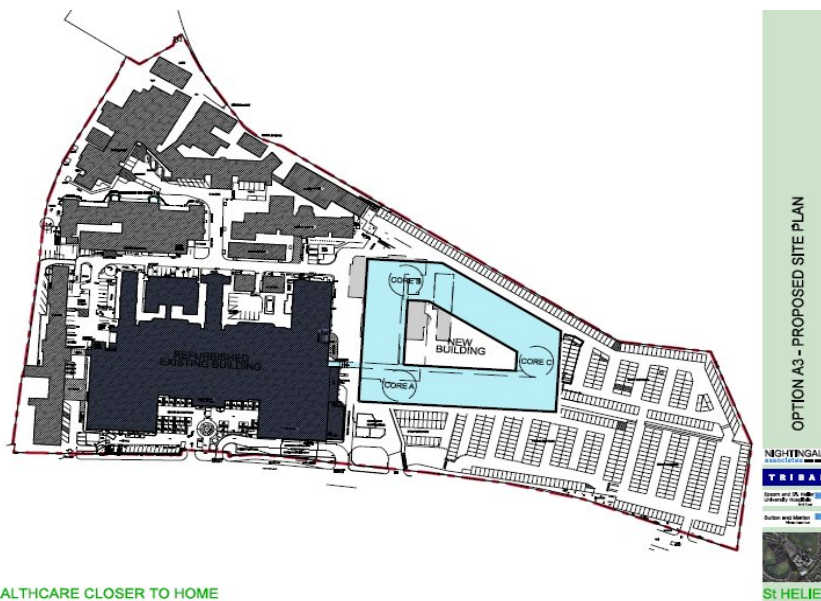
The Marsden does not have sufficient PBL available to support this scheme. The scale of PBL required would be three to five times that which was available.

We have concluded that the gap in the affordability of these options is such that there is no point in commissioning further work to develop these options.

## 2.3 Option A3 partial rebuild and refurbishment option of St Helier

This option is based on the building of a new triangular block on the site of Fergusson House which would be demolished. However this plan in its entirety is unaffordable and it would need to be revised to bring down costs. It does indicate the potential for new build and refurbishment on the St Helier site.

### Option A3 Site Plan



As modeled, this development would have five floors.

- Ground floor – Children’s unit and part LCC
- Floor 1 – Maternity unit and part LCC
- Floor 2 – Maternity and inpatient wards
- Floor 3 – Three 32 bed Inpatient wards
- Floor 4 – Three 32 bed Inpatient wards

This would allow the majority of patient accommodation to be in the new building. Clinical support accommodation, such as theatres, critical care and x-ray would be in the existing building. This arrangement would allow the worst accommodation, located to the rear of the site, to be released from use, so a strategy of retrenchment from the worst accommodation would be put in place.

The cost of this option has been estimated as £170m:

- Ward element £120m
- LCC element £35m
- Backlog maintenance £15m

However the sum available to support this is a maximum of £143m, depending on a number of assumptions.

We have assumed:

1. land sales of £30.8m from sales of the Sutton site and part of the Epsom site.
2. All of the Trust’s operational capital of £9.2m is invested in the project (i.e. none is invested in Epsom)
3. That £35m is available to PCT through a Business Case for the LCC element
4. That Epsom and St Helier Trust raises its maximum permitted loan under its Prudential Borrowing Limit of £68m. The Trust would have to have achieved its recovery plan and be on a sound financial footing to service this debt.

Each of these assumptions will require further testing.

£143m would only fund part of the new building and therefore more work will be done to develop this option.

## **2.4 Impact of Epsom Activity**

The table below shows the activity projected to be undertaken in the new General Hospital at St Helier that is currently undertaken at Epsom Hospital. This work is based on the previous assumption that Epsom would become a major local care hospital. If the nature of Epsom hospital did not change and this activity did not materialize, then this would have an effect on the size and

cost of the facilities required on the St Helier site: 113 fewer beds would be required.

<b>Admission Type</b>	<b>General Hospital Activity</b>
A&E Major	4,382
A&E Standard	1,378
Day Case	781
Elective	1,795
Non Elective	6,079
<b>Total</b>	<b>14,415</b>

Table1: Activity Potentially Transferred from Epsom Hospital

## **2.5 Renal**

Surrey PCT's commissioning intentions indicated that they wish to repatriate a proportion of renal activity at some future date. This will be subject to formal consultation at a later date. Although there are presently no detailed plans setting out the precise levels of activity that might be repatriated, for the purposes of Tribal's assessment, it was assumed that the level of renal activity commissioned by Surrey PCTs would fall by 80% so income would fall by £9.4m.

Sutton and Merton PCT, working with the south west London Extended Renal Network and other PCTs in south west London, is considering how to commission services and ensure the configuration of renal inpatient services is fit for purpose. This work follows the guidance contained in the Renal National Service Framework (NSF) published in 2004. As a result commissioning proposals are being considered regarding the disposition of specialist renal services which may impact on the services at St Helier.

## **2.6 Mental Health**

We have also established there is sufficient space to develop a new inpatient mental health facility on the St Helier site. This is an option which forms part of a wider assessment being undertaken by SWL & St George's Mental Health Trust for the location of mental health services in Sutton and Merton. The Trust will want to consider with stakeholders the consultation and engagement implications of this proposal, should it be pursued. It falls to the mental health trust to develop the business case for this development, should this option be pursued, working with PCT commissioners.

## **2.7 Women and Children's Services**

In parallel with the work being taken forward on the London NHS consultation "A Framework for Action", Surrey PCT, Sutton and Merton PCT and Epsom and St Helier NHS Trust have agreed to work together to develop options for changes to maternity and paediatrics on the Epsom and St Helier sites, in an open and transparent way with staff, patients, members of the public and other stakeholders. This is on order to ensure the long-term safety and sustainability of the services.

The timing of any consultation on women and children's services will be determined by the speed at which it is possible to develop robust proposals and the urgency on clinical grounds of the case for any change. The London "Framework for Action" consultation will be going on during this process, but it is not intended that this should stop consultations for which there is an urgent clinical case.

## **2.8 Next Steps on General Hospital Development**

We have discounted the new build options, and the programme board has committed itself to developing the right solution for improving St Helier hospital as a general hospital with an A&E department.

The improvements will need to be phased and will have a number of elements.

The Trust is planning to spend £1.45m from its operational capital allocation to upgrade women and children's services. This work is to bring the existing accommodation up to a reasonable standard and does not pre-judge the outcome of any consultation about the service. These parts of the estate are in particularly poor condition and it is an urgent requirement to improve them. Work will begin in January 2008.

This work will provide:

- general refurbishment of the unit, including upgrading of delivery rooms to include new lighting, flooring, washing and toilet facilities where necessary;
- development of a high dependency unit and recovery area;
- development of a four room midwifery led birthing unit including three birthing pools;
- development of transitional care area on the maternity ward to ensure the mothers and their babies are not separated unnecessarily if the baby needs further treatment;
- additional cot space for the neonatal unit and creation of an isolation room.

St Helier has always been earmarked as a site for a local care centre and this will now proceed to business case stage.

The third element is the assessment of the size and affordability of a new ward block based on the A3 option. This would need to be within the affordability envelope we have established, and so would be a smaller building. Its detailed content is also dependent on further work on the future service content of Epsom Hospital and therefore flows from Surrey. Consultants have been commissioned to undertake this work with the view of submitting a business case to NHS London in 2008.

### 3. Epsom Hospital

In the June report to JOSC we described the future of Epsom as a large local care centre, based on previous BHCH work. It was acknowledged however that Surrey PCT was embarking on reconfiguration programme (Fit for the Future) which would determine future service provision in Surrey.

As a result of the Fit for the Future acute commissioning intentions, Surrey PCT will not be formally consulting, at this point, on any changes at Epsom hospital.

In addition, at its recent board meeting, Surrey PCT took the decision to join the forthcoming London-wide consultation on Professor Sir Ara Darzi's report Healthcare for London: A Framework for Action which is expected to begin this November. The board took that decision to ensure that the views of Surrey residents, in particular those around the Epsom area, are heard in regard to London's healthcare services.

While questions remain about patient flows from Epsom the final size and content of both sites will remain uncertain. We are therefore modelling St Helier with and without the possible patient transfers from Epsom.

### 4. Local Care Centres

The table below gives an indication of the range of services that will be provided in Local Care Centres in Sutton and Merton:

	St Helier	Wilson	Nelson	Wallington
GP practices			2 GP practices	2 GP practices
Urgent care services	Urgent care services provided by primary care working with A&E staff			

Outpatients	85,000 pa	33,000 pa	30,000 pa	30,000 pa
Day case surgery	11,000pa			
Imaging	√	√	√	√
Community health services	√	√	√	√
Access to Pathology	√	√	√	√
Other primary care services	√	√	√	√
Accommodation for LSP partners including social care and the voluntary sector	√	√	√	√
Community mental health services	√	√	√	√

Table 2: Activity in Local care Centres

#### 4.1 Sutton

In the borough of Sutton plans are being developed for Local Care Centres at St. Helier, as part of option A3, and at Wallington.

A project initiation document is being developed for the St. Helier Local Care Centre describing the scope of the work and team membership. The centre is intended to provide a focal point for the Local Care centre network and will include services and facilities that cannot be distributed to the smaller centres. The project will have links to the hospital redevelopment project. The local Care Centre is expected to provide about 85,000 out patient appointments.

The Wallington Local Care Centre is being developed in two phases. Phase 1 of the scheme has been agreed by Sutton & Merton PCT and involves the redevelopment of the Shotfield Health Centre. The proposed building, for which planning consent is expected in December 2007, will have sufficient additional space for out of hospital services. An adjacent office block has been identified for locating back office functions and community team bases. The Wallington site is 75 m from the main shopping area and bus stops and is an excellent town centre site serving all of the eastern part of the borough. The Wallington site has 13 GP's and will handle about 30,000 outpatient appointments.

To deliver the Wallington LCC representatives from local patient and other interest groups will be invited to join the professionals who currently form the Shotfield reprovision team.

We also want to explore the feasibility of developing new community and primary care services on the Sutton site, in conjunction with the Royal Marsden Hospital.

### Intermediate Care Centre

The programme supports the development of Intermediate and Post Acute Care facilities which include community beds, rehabilitation day services and team bases for the home treatment teams. The site currently under consideration is Carshalton War Memorial Hospital. The size and location of these intermediate care services forms part of the business case. The service will be supervised by General Practice with consultant support. The units will provide nursing and rehabilitation services to enable people to return to high levels of independent living.

Membership of the Project Group includes voluntary service representation. The development has also been presented at area forums and local interest groups.

### 4.2 Merton

In the borough of Merton plans are being developed for Local Care Centres at the Wilson Hospital and the Nelson Hospital. The development of these sites will include joint working with Epsom and St Helier and St George's Hospital to confirm outpatient activity.

As a precursor to design work at the Nelson Hospital LCC discussions are taking place to agree functional relationships between services proposed, for example to plan the close relationship of outpatients to diagnostics. Merton Locality Executive Committee is reviewing the proposed services in relation to size and content and will recommend whether further services can go on the site. The 2 GP Practices (Cannon Hill and Church Lane) are exploring modern models of primary care working which will impact on building design and have undertaken a site visit to a Putney joint GP Practice centre.

Membership of Nelson Site Focus Group (Nelson Project Group) includes voluntary services, a member of the SMPCT PPI Forum, a Merton councillor and the chair of the Nelson Community Reference group (NCRG). The NCRG includes the League of Friends, local councillors and local residents with an interest in the site. The NCRG, have undertaken a survey of local organisations with an interest in being sited at the Nelson Hospital.

A similar exercise is underway to agree the functional relationship between services proposed for the Wilson Hospital LCC. This site will not have a GP Practice but a Practice Based Commissioning Consulting area with access to diagnostics and a treatment room. Likewise Merton Locality Executive Committee is also reviewing the proposed services in relation to size and content and will recommend whether further services should go on the site. London Borough of Merton is starting a Consultation September/October 2007 in relation to a draft planning brief for the Cricket Green Conservation area, which includes the Wilson Hospital.

Membership of the Wilson Site Focus Group includes voluntary service representation, the Chair of the SMPCT PPI Forum and the Chair of the Wilson Reference Group.

#### Wilson Hospital Intermediate and Post acute Care bed unit

It is proposed to place Intermediate and post acute care beds on this site including an Older People's Assessment and Rehabilitation Service. The London Borough of Merton is looking at options for commissioning an independent living centre, and one of these options is siting it at the Wilson Hospital.

The work on the nature and type of beds, and how they will work to provide alternatives to admission to acute hospitals is being undertaken across Sutton and Merton PCT, and lessons from the Carshalton War Memorial project are being shared with the Merton project. Joint working with St George's Hospital and Epsom and St Helier is also in progress to inform the planning process for this unit.

## **5. Engagement and Communication**

The Better Healthcare Closer to Home Programme is committed to continuing to engage and communicate with stakeholders around developing and progressing the programme. A communications and engagement strategy was designed in May this year based on information from the following sources:

- The engagement discussion report that was submitted as part of The BHCH Review
- The Joint Overview and Scrutiny Committee response to The BHCH Review
- The Gateway Review report
- Programme office meetings with PPI Chairs.

This strategy includes identifying key audiences and their concerns, a programme of one to one, and larger stakeholder meetings so people are able to feedback their concerns and questions, and the capture of preliminary discussions with the PPI Forum chairs about the approach to any future engagement/consultation activities.

In addition the following communication mechanisms have been updated and put in place:

- BHCH interactive website updated and maintained.
- Public query phone line for BHCH re-established
- Freepost address for BHCH written queries re-established.
- Writing and distribution of regular E-newsletters with feedback options
- Maintenance and growth of stakeholder database of 3,000 individuals and groups.
- A media protocol has been established to make sure the press coverage is as accurate for local people as possible. This includes a proactive/rebuttal programme and monitoring coverage for accuracy.
- Protocol established for responding to the public and stakeholders - all phone calls/letters/emails from the public will be logged and answered within 7 working days.
- Regular liaison with Surrey PCT "Fit For the Future" and Healthcare for London communications team around clear communication issued to public/stakeholders.

The PPI Forum Chairs recommended that public information and engagement should take place around the *geographical* areas where the local care centres and general hospital would be situated. They also suggested that this activity should take place with local community groups, key disease groups and hard to reach groups.

Once the outline business cases for the local care centres are approved the PPI (&/or their successor LINK) work programme will be increased and extended. Where community reference groups have not been already established for local care centres, this work will be completed, and activities to engage and inform the wider community will be initiated with advice from the PPI Forum and local representatives. The PPI Chairs were convinced that talking about the individual patient experience or patient case studies, with these groups would be most effective way to communicate. This will form the basis of the engagement work in the future.

The local care centres in Sutton and Merton have previously been subject to consultation . Further stakeholder engagement and scrutiny is required in their development but we are not proposing to consult formally on their establishment.

It has been established that any changes to women and children's services will require consultation. It may be that other changes we propose will require consultation, and this will need dialogue with the JO SC. In the meantime we will continue to engage widely as we develop our plans and speak frequently with the JO SC.

## **6. Business Case Position and Timetable**

NHS London has agreed that the development of the Local Care Centres can proceed directly to outline business case (OBC) stage and need not be tied to the timetable for the development of the general hospital. This will enable us to proceed directly to a definitive position on LCCs and ensure the LCC structure is in place before changes are made to general hospital services.

Although the precise requirements for a business case document have yet to be agreed, it is likely that this will follow the traditional OBC format which typically include analyses of:

- the case for change;
- objectives and constraints;
- options and option identification;
- activity projections;
- financial impact;
- non financial assessment;
- risk;
- the preferred solution.

We expect to submit a LCC business case to NHS London in early 2008. Capital projects of this size generally take two to three years before they are open and operational, after approval of the business case.

We shall also be developing proposals for the new ward block at St Helier to OBC standard over the remainder of 2007 with a view to submission to NHS London in 2008. However, the question of the distribution of services between sites, particularly women and children's services, will be open until any consultations required are concluded.

Mark Easton  
Programme Director  
Better Healthcare Closer to Home  
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## Appendix 1

*Hospital Size*

## Bed Comparisons

Specialty Description	Epsom General Hospital 06-07	St.Helier Hospital 06-07	Combined 06-07	General Hospital 12-13	Intermediate Care Beds 12-13	Epsom LCC 12-13	Combined 12-13
Accident and Emergency	3	0	4	10	0	0	10
Cardiology	1	0	1	0	0	0	0
General Medicine	163	154	317	89	73	23	185
General Surgery	32	54	87	49	0	4	53
Geriatric medicine	52	49	101	50	0	8	58
Gynaecology	4	10	14	8	0	0	8
Haematology	2	9	10	6	0	0	6
Midwife Episode	2	1	3	2	0	-	2
Neonatal High Dependency	0	0	1	0	0	-	0
Nephrology	0	39	39	19	0	3	22
Obstetrics	20	20	40	31	0	-	31
Ophthalmology	0	1	1	0	0	0	0
Paediatrics	8	11	20	15	0	3	18
Special Care Babies	6	4	10	6	0	-	6
Transplantation Surgery		1	1	1	0	-	1
Trauma & Orthopaedic	30	45	75	24	17	5	46
Urology	6	7	13	7	0	1	8
<b>Total</b>	<b>331</b>	<b>406</b>	<b>736</b>	<b>317</b>	<b>90</b>	<b>46</b>	<b>454</b>

The table above shows the bed modelling that has been undertaken to plan a single general hospital with some services transferred from Epsom hospital. The number of beds would be fewer than currently provided because of:

- patients choosing other hospitals which are closer, particularly in Surrey;
- reductions in length of stay to meet best practice;
- the opening of 90 intermediate care beds.

Bed figures will continue to be refined as the programme continues.

## Appendix 2

### **Commentary on NHS Capital Regime**

The capital regime in the NHS has changed since the inception of the BHCH programme. The NHS has moved away from central bodies allocating capital to a position where capital is raised by local health bodies in the form of loans or private finance deals. In the case of major hospital developments this either operates in one of two ways.

- With PFI hospital trusts enter into contracts with the private sector to build and operate a new facility over a 30 year period, with the trust paying from its revenue a regular sum to the PFI developer known as a unitary payment.
- Loan arrangements are typically undertaken by trusts which have achieved foundation status. They are assigned a “prudential borrowing limit” which sets the maximum they can borrow. The loan is then serviced through the Trusts income.

Under either option a contribution can be made to a capital scheme from land sales.

It is a pre-condition of either arrangement that the organisation entering the arrangement is in good financial health and can demonstrate it can credibly take on the burden of debt or PFI. The amount an organisation can raise is broadly related to its income flow.

### **How Much Can a Trust Borrow Under the Prudential Borrowing Limit?**

1. For a non-Foundation Trust, the PBL calculation follows similar principles as FTs.
2. The PBL is based on the net relevant assets (NRA). The % of NRA allowable depends on the risk rating allocated to the trust.
3. The risk rating a trust is allocated depends on a number of key financial ratios:
  - EBITDA margin (Earnings Before Interest Taxation Dividends and Amortization)
  - EBITDA surplus
  - ROA (Return on Assets)
  - I&E surplus margin
  - Liquid ratio
4. The risk rating is then a weighted average of the above scores to give an overall score. Each overall score determines what % of NRA they are allowed to have as loans:

- 1 0%
- 2 10%
- 3 15%
- 4 25%
- 5 40%

5. For Epsom and St Helier, their 05/06 NRA from their annual accounts is £171,037k. With a risk rating of 3, that gives them a 15% PBL which equals £25,656k. If they could achieve a risk rating of 5 and the highest PBL of 40%, that would be £68,415k.