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Clinical Commissioning Group

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Transforming hospital estates and services

29 January 2019

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Agenda

Item	Speaker
Introduction	Dr Trevor Fernandes, GP Hemel Hempstead
Context • What has changed • Impact on our longlist	David Evans, Director of Commissioning Herts Valleys CCG
Case for change • Why we need to change • Healthcare in west Herts • Clinical principles	Dr Mike van der Watt, Medical Director Dr Anna Wood, Associate Medical Director West Herts Hospitals NHS Trust
Options evaluation process • Evaluation criteria and shortlist	Nick Kennell, Interim Director of Strategy West Herts Hospitals NHS Trust
Next steps and conclusion	David Evans, Director of Commissioning, Herts Valleys CCG Kathryn Magson, Chief Executive, Herts Valleys CCG Helen Brown, Acting CEO, West Herts Hospitals NHS Trust
Your questions	Facilitated by Dr Fernandes

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Introduction and context

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What has changed since our last update meeting

We are closer than ever to securing funding – national regulators continue to agree we need investment but they have **clearly told us**:-

- we need to develop a new proposal that is within the trust's turnover, **circa £350m**
- there is no access to private finance – investment will be **a loan** from public dividend capital (PDC)
- our proposal should be submitted **in early summer 2019**
- our proposal **will no longer** be a phased programme which relies on future funding for completion.

This means that affordability is a major constraint

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How has this affected our evaluation of options

We have:-

- worked with clinicians to agree clinical principles that underpin all options and have begun conversations about clinical priorities, given funding limits
- cost-assessed our longlist to rule out options **well above** turnover
- reconsidered all elements of all available options to understand what can be carried forward for evaluation.

Only options which meet the affordability criterion will be evaluated further

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The impact of working within the affordability threshold

- a new, single-site emergency and planned care hospital **is not a feasible option** because it far exceeds the affordability threshold
- **moving emergency care from Watford is not an option** because it exceeds the affordability threshold

The preferred option must **balance the needs** of:

- our **whole population** and the **different communities** we serve
- **all our services** - emergency, theatres, women's and children's services, planned surgery, planned medical care and diagnostics.

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Our case for change

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Why we need to change

1 

Medicine and healthcare is changing and so are we –

we are living longer and have different care needs

2 

Some of our hospital buildings no longer meet NHS standards and are not fit for purpose

3 

The way our hospital services are delivered is fragmented and at risk of becoming clinically unsustainable

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Our commitment to deliver services locally

- we are providing more care closer to home – with the aim of moving **40% of hospital trips to a community setting by 2024**
- GP practices will work with community, mental health, social care, pharmacy, hospital and voluntary services to provide more **personalised, coordinated and integrated** health and social care
- more **GP access through extended hours** and more minor illnesses and injuries to be treated in **local urgent treatment centres**
- improvements have and will be made to Watford General Hospital
  - a new **multi storey car park** opens next year
  - the new access road has **reduced congestion**
  - the site is **big enough** for major redevelopment, including **new build**

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Clinical principles for reconfiguration

1. The **wellbeing of our patients and staff** must be protected and enhanced in service re-design
2. Our future way of working should drive the **separation of HOT** functions (that focus on **emergency care**) and **COLD** functions (urgent and planned care)
3. Services with **critical interdependencies** must be co-located eg obstetrician-led births and acute paediatrics sited with critical care and emergency services
4. Clinical teams should be distinct and **not spread too thinly** to **avoid fragmentation** and duplication
5. **Technology and IT** must be incorporated into the design of our future models
6. The future system and buildings must be **flexible** to adapt to medical advances and the changing needs of patients.

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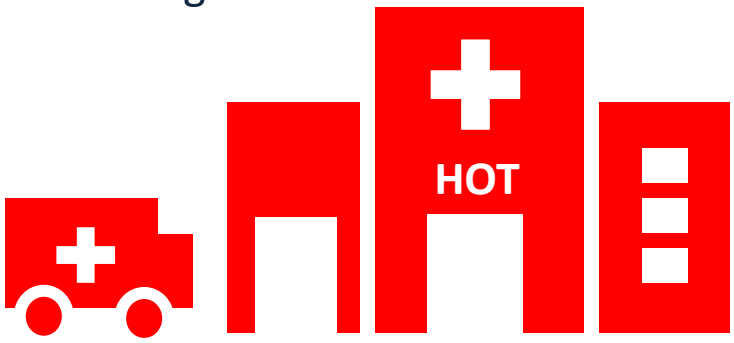
Our principles align with the NHS Long Term Plan

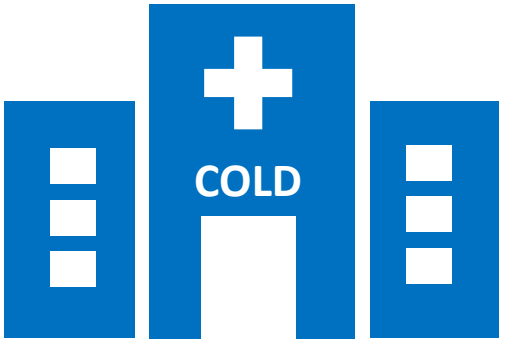
Emergency and specialist care

- allows improved trauma assessment
- patients have access to the right expertise at the right time

Planned care

- the risk of cancellations is reduced or removed because the beds are not needed for emergency cases





All sites have

- **A&E, inc. emergency surgery**
- **specialist inpatients**
- **ambulatory care**
- **critical care**
- **Women's & children's**

outpatients

midwifery-led care

urgent care

diagnostics

- **planned surgery & medicine**
- **older people's services**
- **cancer & long term conditions**
- **urgent care**
- **'one stop shops'**

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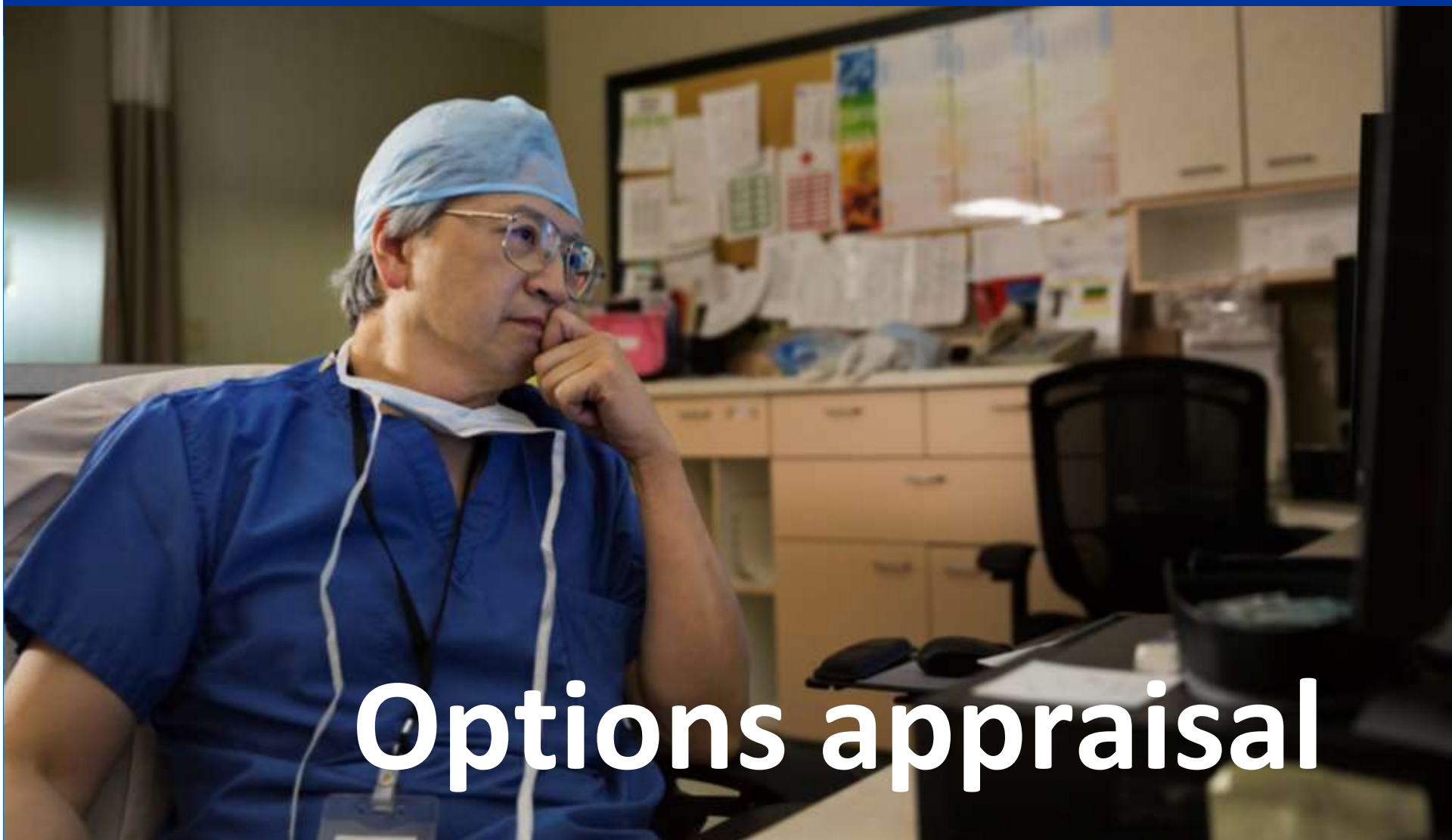

Options appraisal

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Options appraisal approach

- we will assess a longlist of options against pass/fail **evaluation criteria** to identify a **shortlist for detailed appraisal** by a panel
- senior leaders and clinicians will draw on information, expert analysis and evidence to carry out the longlist to shortlist process
- a panel comprised of; public/patient representatives; clinicians and managers; local authority partners; Healthwatch; and the voluntary sector will undertake a **qualitative** benefits appraisal of the shortlist
- the outcomes of this will be combined with a **quantitative** economic appraisal to determine a **preferred way forward** for Boards to sign off.

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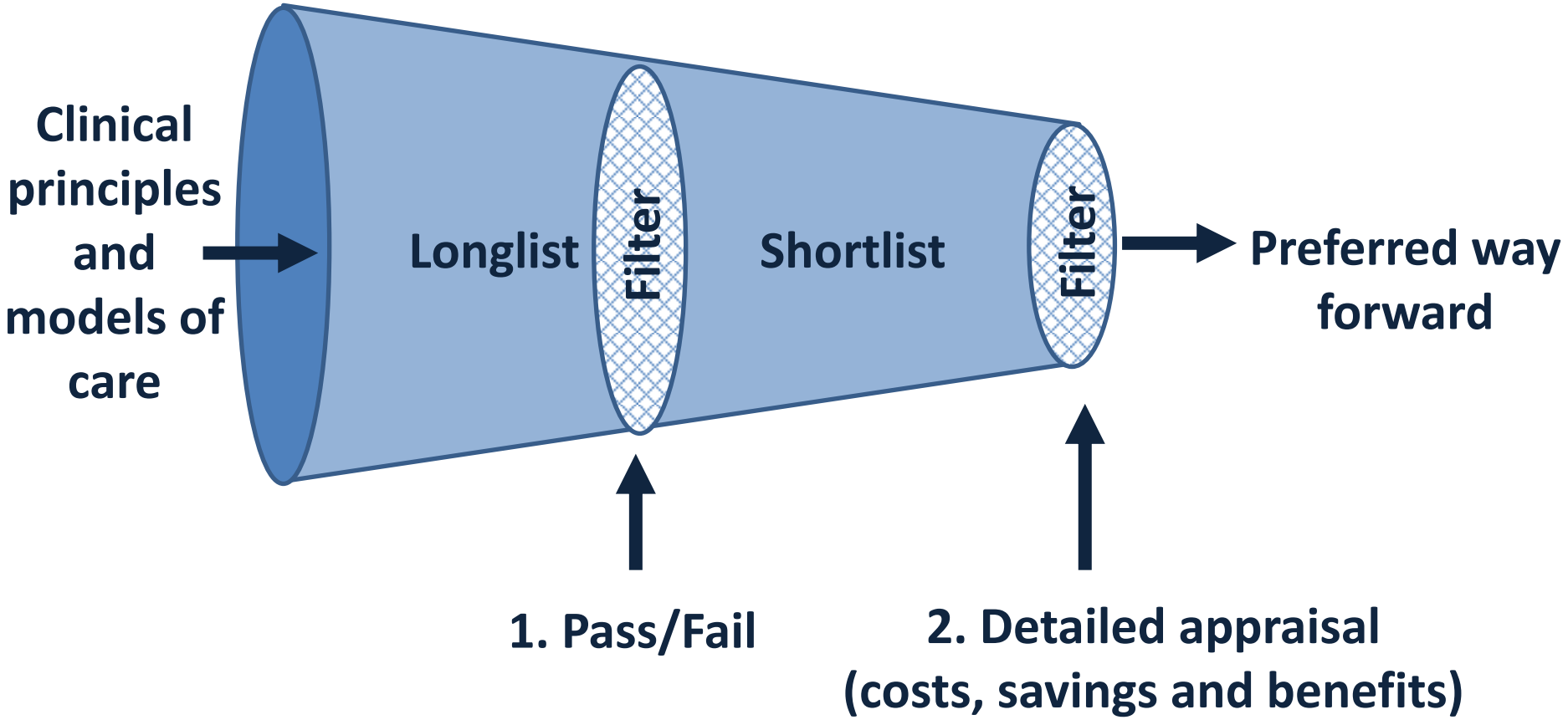
Options appraisal process



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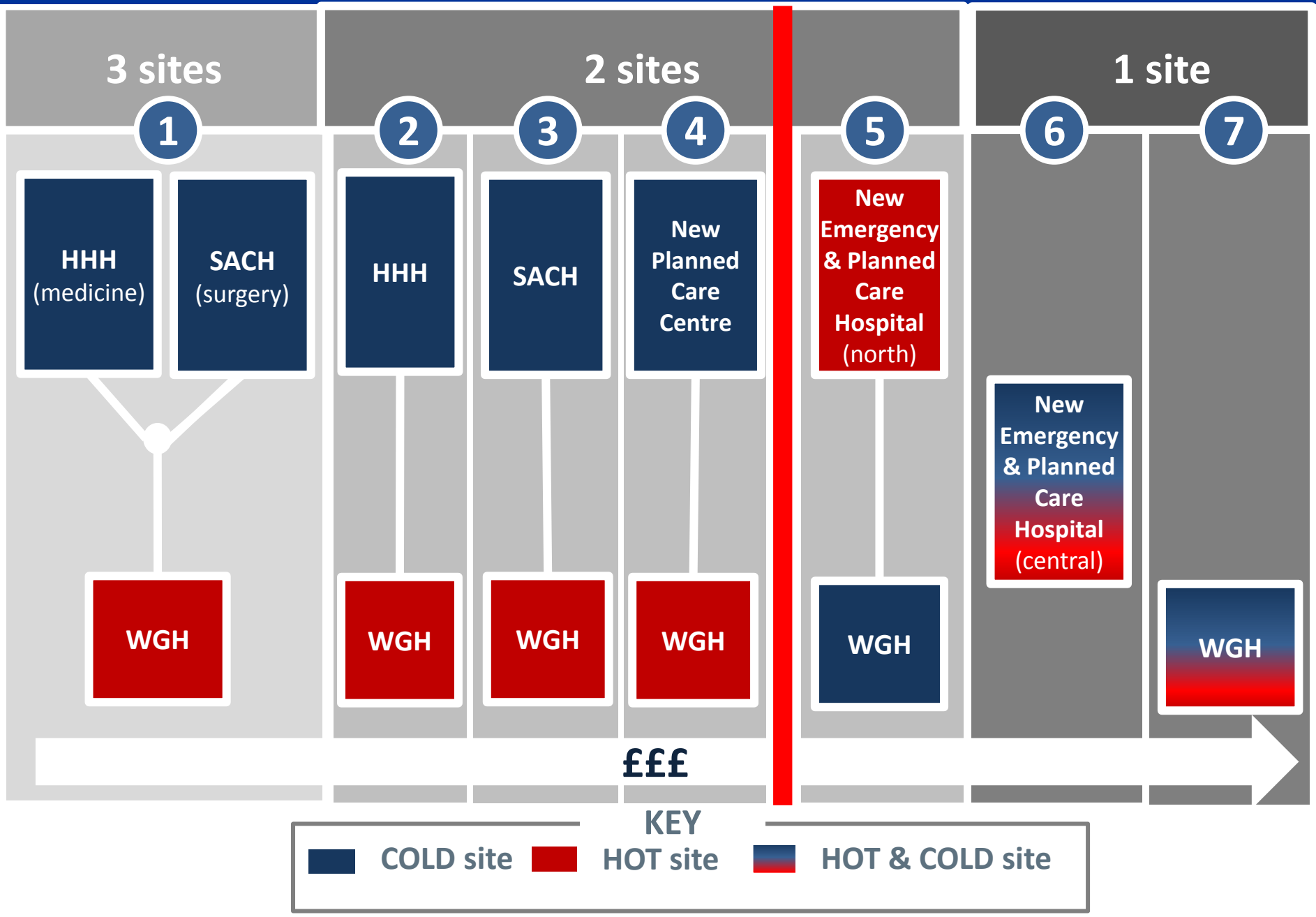
Affordability is the defining criterion for the short list

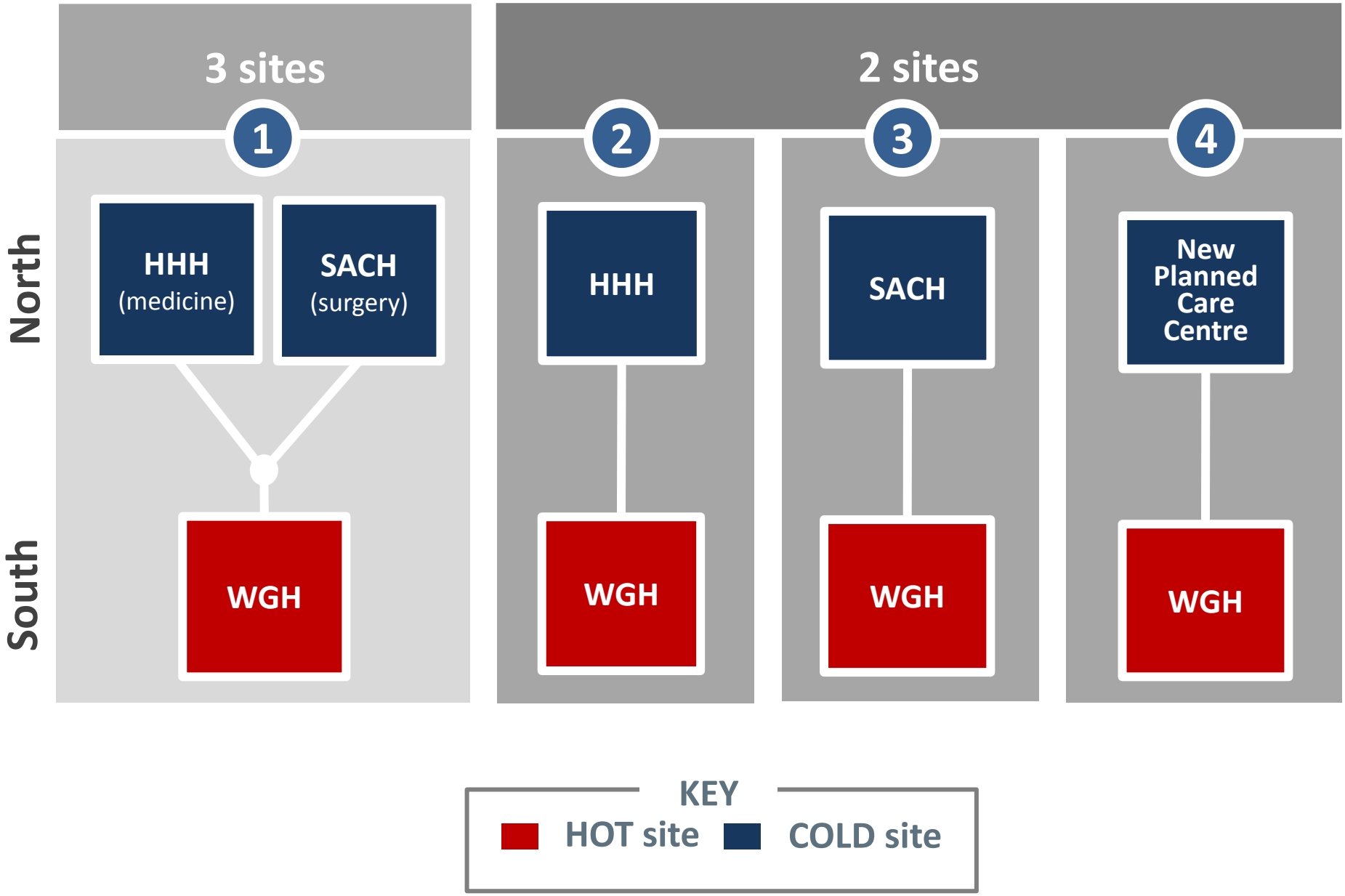
The **same evaluation criteria** as before will be used but with a **new pass/fail threshold**

Criteria	Pass/fail threshold
Affordability	The option must not seek capital investment greater than Trust's annual turnover
Quality	The option must not reduce patient safety from current levels
Patient experience	The option must support an improvement in patient experience from current levels
Access	Services must be located to serve the Herts Valleys population
Deliverability	The site locations must have sufficient space to accommodate the requirements of the preferred model of care for the relevant site configuration option
Value for money	The option must not worsen Trust's financial position in the long term
Strategic alignment	The option must deliver the agreed acute transformation investment objectives and provide flexibility for the future

Options beyond the red line will FAIL the affordability test



There will be four categories of options, plus a ‘do minimum’



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Focus for options evaluation

For emergency and specialised care ('HOT' services):

- The investment to be used to improve facilities at WGH

For planned care ('COLD' services):

- The location/s where services are provided **AND** amount of investment possible
- The location/s may include SACH **AND/OR** HHH **OR** a brand new planned care centre at a new location

Given the pass/fail affordability criterion difficult decisions are required about how to get maximum benefit within the affordability threshold.

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Conclusion

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Next steps and timescale

- our refreshed proposal needs to be submitted during **summer 2019**
- we need to **conclude the options appraisal work before March 21** to fit in with the local elections ('purdah' begins in March and lasts until early May)

February	March	April	May	June
• **stakeholder panel to confirm short list** • **engagement** with public to discuss shortlist • **options appraisal** with stakeholder panel to appraise the shortlist		• extended analysis on **preferred way forward** • **documentation** of proposal		• **update public** on the preferred way forward • **approve** proposal • **submit** proposal to **regulators**

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Key messages

- we **urgently need to improve** our hospital estate
- we have **regulator support for an affordable** proposal
- we need to **work at pace**
- the financial **constraints are real** but we still have a **fantastic opportunity** to **transform** services and address **urgent estate issues**
- agreeing the preferred way forward will involve **compromise** – but we must **unite** behind it so we are at the **'top of the list'**
- your support and the support of our politicians will **strengthen our case**
- we are **closer than we have been for years** to securing funding.

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Thank you &
Questions

questions that aren't asked tonight can be sent to:-

enquiries.hvccg@nhs.net

Transforming hospital estates and services
Questions and answers from 29 January public meeting

INTRODUCTION

The following questions and answers give an overview of information provided by representatives from West Herts Hospitals NHS Trust and NHS Herts Valleys Clinical Commissioning Group at a public meeting on 29 January 2019. They are provided for information purposes rather than an official record of the meeting.

These questions and answers are best reviewed alongside the slide presentation. Both the presentation and the question and answer sheet explain the process and situation at the time of the meetings. This is a 'live' process and so some of this information will be superseded as things evolve.

Dacorum

Q: What happens if we have no agreed plan by June?

A: We are working towards submitting a plan to our regulators in time for this to be considered as part of the Comprehensive Spending Review. It is our understanding that this opportunity comes up every five years. So realistically if we miss this opportunity there is no other immediately available route for obtaining capital we need to develop our hospitals.

St Albans

Q: What engagement are you planning over the next few months and are there going to be real opportunities for the public to get involved?

A: We will be going through an appraisal process to go from a long to a shortlist. A panel of experts from different organisations and seven patient representatives will carry out this task over two sessions in February and March. On 7 March there will be another public engagement event to look at the options and the appraisal work that has been carried out so far. This will allow the public to provide feedback which will be consolidated in the final option appraisal that will happen in mid-March. At the same time we will also meet with other key stakeholders as part of our engagement.

Watford

Q: £350m is lower than we expected would be available to spend on developing hospitals. What is a realistic plan for spending £350m including planned care? How do you refurbish Watford General and also ensure planned care is up to standard? And how can it not worsen the position of the Trust financially?

A: Realistically, for £350m we cannot do everything to bring our facilities up to 21st century standards and ensure a 60 year lifespan for our hospital buildings. However, roughly, we have

looked at options for planned care that cost between £40-50m across Hemel Hempstead and St Albans or up to £180-190m for a single planned care centre. There is a huge amount of detail to work through to in order to prioritise investment in services and buildings. How much we change needs to be decided. There are some buildings at Watford General Hospital which are challenging but we need to spread the investment across the site. Moreover, we need to account for IT and optimism bias* which are both accounted for in the NHS rule book for investment. Regarding implications for the Trust's financial position, we need to pay a dividend of roughly 3.5% on the investment, which comes to £18m per year, or rather 5% of the trust's turnover. Currently, 4% of the Trust's turnover has been saved each year over the last three to four years. With the investment we expect this to increase so covering the 5% is manageable.

** this means the need to make adjustments to projected costs, benefits and duration based on data from past projects or similar projects elsewhere to account for any optimism in project estimates.*

Dacorum

Q: We need to see all documentation relating to your discussions with the regulators and know what the figures really are. An MP has asked for this and has not yet received a response. If there are 'knockout blows' to building a new hospital on a new site you will only gain public acceptance and trust through full documentation being available.

A: We are in the process of responding to the information request by the MP. However we cannot vouch for what information NHSE and NHSI will make available. We have asked them for a letter that states our budget.

St Albans

Q: We are sceptical about the hospital plan, given it has been in progress for a long time, and also because the Trust has been selling the land. It would better to pursue development on flatter site, using money from existing sites to build the new hospital. Could that not be a solution?

A: An external company has done all the relevant measurements and analysis of site values and has concluded that Hemel Hempstead's site is worth around £15m, St Albans around £15-19m and Watford up to £20-25m. These figures are fairly insignificant considering the level of investment needed to build a new hospital, including purchasing land.

Three Rivers

Q: What would the new Watford General Hospital look like? What buildings would be 'knocked down'?

A: It is not possible to say at this stage as we are working through the options with our clinicians. We want to maximise value of the investment therefore we will aim to have the maximum amount of new build possible. There are specific departments/parts of the hospital which will definitely need

refurbishing e.g. maternity. The new multi storey car park, which opens next year, will free up space for new buildings so we can build new without needing to knock down buildings first.

St Albans

Q: There are some concerns around money not being enough and no clear indications on how the money will be raised. What would happen if there is not a united response to the plan we may use? Also there are concerns around privatisations.

A: £350m is not enough for everything but it is a real opportunity to drastically improve our services. The NHS sometimes subcontracts work to private providers but we try to work within the NHS as much as we can. Private care can have a role to play in service redesign and private providers can sometimes provide the most cost-effective care. It is our job to ensure we deliver the best possible care so there are many things at play. It is not to be forgotten that NHS care is free at point of access even if it is provided by private companies.

Watford

Q: We have wealthy villages, clubs and companies in Hertfordshire, why don't we fundraise?

A: West Hertfordshire Hospitals Trust has a charity and it will support redevelopment where possible.

St Albans

Q: I am worried people are over-optimistic about fundraising.

A: Indeed. Fundraising could help to build specific parts of the hospital or buy specific equipment but previous evidence shows that it is extremely unlikely for us to be able to raise very significant amounts of money.

Q: There are some concerns around money not being enough and no clear indications on how the money will be raised. What would happen if there is not a united response to the plan we may use? Also there are concerns around privatisations.

A: £350m is not enough for everything but it is a real opportunity to drastically improve our services. The NHS sometimes subcontracts work to private providers but we try to work within the NHS as much as we can. Private care can have a role to play in service redesign and private providers can sometimes provide the most cost-effective care. It is our job to ensure we deliver the best possible care so there are many things at play. It is not to be forgotten that NHS care is free at point of access even if it is provided by private companies.

Q: How are residents being represented on the stakeholder panel?

A: There are seven members of the public (2 from Watford & Three Rivers, 2 from St Albans, 2 from Dacorum and 1 from Hertsmere) who will be on these panels. We put out a general invite for people to submit expressions of interest and people were selected on the basis of their interest and involvement.

Three Rivers

Q: Our hospitals are horrible and inaccessible. How are you going to fix that?

A: We will do our best to use the money wisely. As well as making improvements to our buildings, we want to change the way we provide services. We are trying to separate 'hot' (emergency) and 'cold' (planned) care so that the need to prioritise care for emergency patients coming in to hospital does not result in us having to cancel elective procedures. Also, it would not be feasible to have three A&E as it is already difficult to staff one. Ambulance staff who transport emergency patients are very well trained and can get to Watford extremely quickly from anywhere in our catchment area.

Watford

Q: Will the CCG merge with others and how would that affect decision making?

A: There is an STP (sustainability and transformation partnership) for Hertfordshire and West Essex and this is the body that will oversee our capital bid. Although the three CCGs with the STP area are working increasingly more closely, each will continue to make decisions for their own area.

Dacorum

Q: How can we not put towns against each other in this process?

A: We do not want to put anybody against each other. We are engaging all relevant stakeholders to prevent that from happening. Everyone is being informed and the shortlist will be reached through fixed criteria.

Watford

Q: How will you move 40% of outpatient care into the community?

A: Our aim is to shift care that does not require hospital attention into the community. We are at the beginning of that journey but on track to reach that target by 2024 as outlined in our *Your Care Your Future* plans. We have already launched new community-based services in a number of clinical areas and will be rolling out more services this year. GPs now offer extended hours and an increased range of clinics are run from GP surgeries.

Dacorum

Q: Given that we expect population numbers to rise in the future, surely this generate more income for the Trust. The current turnover is £350m which is the limit given for the Trust to access finance for developing hospitals but what if in five years the Trust's turnover has increased significantly?

A: Demographic growth is factored into any analysis. Our current expenditure is £370m and our profit is around £320m so the £350m is about between those two. Our cost calculations for developing new facilities are based on today's prices but they will inflate every year around 3.5% so if even if our turnover (and therefore the amount of finance we are able to access) was to increase our building costs would also increase.. The CCG does a capacity plan to ensure we commission for the adequate amount of people but we need to focus on here and now and the plan for the next five years. The NHS is not only about hospitals, it is also about primary care, self-management, prevention and new work streams to manage transformation. This will also need to be supported by IT which the Health Secretary is pushing for.

Q: What about the phasing of capital?

A: We were given the impression that we would be able to borrow some money now and then bid for some more later, but unfortunately that is no longer the case and our limit is £350m. However the refurbishment and building will need to be phased. There is however enough space at Watford General Hospital to maximise new build.

Watford

Q: How long will the redesign take?

A: We will need to involve all relevant stakeholders in this. However, we would probably see the first building around 2022-2023 and very optimistically be finished by 2025.