West Hertfordshire Hospitals NHS
NHS Trust

Paper6207

Full Business Case

Approved by Chairman's Action as agreed by the WHHT Trust Board 11 January 2007

Full Business Case (FBC) for Investment to facilitate:

The development of the Elective Care Centre at St Albans City Hospital
The centralisation of Admissions at St Albans City Hospital
The centralisation of Orthopaedic Trauma at Watford General Hospital

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1. Executive Summary

Introduction

1.1. This Full Business Case (FBC) seeks approval to invest £1.1 million in order to establish an effective elective care centre at St Albans City Hospital (SACH). This investment is essential to the Trust's overall financial recovery programme, delivering savings and facilitating:

- the centralisation of day surgery at SACH;
- the centralisation of elective orthopaedic surgery at SACH;[1]
- the centralisation of orthopaedic trauma at Watford General Hospital (WGH)[2]; and
- the centralisation of admissions administration for West Hertfordshire Hospitals NHS Trust (WHHT) at SACH.

1.2. The scheme forms part of the wider service reconfiguration throughout West Hertfordshire, known as 'Delivering a healthy future in West Hertfordshire (DaHF)'. The remaining elements will be subject to a separate Business Case later in the year, pending the outcome of the current legal challenge. Overall the DaFH reconfiguration consists of three main elements:

- consolidation of emergency services, including A&E and Critical Care services at Watford General Hospital;
- segregation of planned surgical services from acute services by the establishment of an elective care centre at St Albans City Hospital; and
- creation of two vibrant non-acute hospital sites providing a range of outpatient, diagnostic, urgent care and intermediate care.

1.3. The service configuration concept described above are consistent with both the previously agreed Investing in Your Health (IiYH) strategy developed by the Bedfordshire and Hertfordshire Strategic Health Authority in 2003 and the current PCT led Acute Services Review. WHHT has expedited these aspects of IiYH in advance of the intended implementation timetable and therefore in advance of the new hospital, as a consequence of the severe financial pressures currently being faced.

1.4. The DaHF reconfiguration proposals included two sub options relating to the location of the elective care centre. In Option 1, elective care services are located at SACH as an interim solution in advance of the Independent Sector Treatment Centre (ISTC) opening at Hemel Hempstead General Hospital (HHGH) and in Option 2 these services are located at HHGH. The Trust carried out a comprehensive public consultation exercise regarding the two sub options and Option 1 was selected as the preferred option. The overriding reason for this selection being the significant additional cost and disruption required to expand and upgrade the theatre capacity at HHGH, whilst 5 well maintained theatres at SACH would have to be closed. This FBC addresses the implementation of this element of the DaHF proposals.

1.5. This scheme is justified as a stand-alone development independent of the decision to proceed with the remainder of 'DaHF' and the outcome of the legal challenge albeit not all transfers will take place until the outcome of the legal challenge is known. The scheme not only provides clinical benefits but also delivers a service model in line with government policy and delivers significant revenue savings to contribute towards the Trust achieving financial balance in the future. Implementation of these proposals does not prejudice any future decisions regarding the remaining DaHF proposals.

[1] Service transfers will not take place until the outcome of the legal challenge is known

[2] This will necessitate minor adaptations to ward accommodation at Watford General Hospital estimated to cost £20,000.

1.6. The implementation of this service configuration enables the Trust to realise significant improvements to the patient experience. These improvements include: more efficient day surgery processes and organisation; fewer operations will be cancelled as acute will not take precedence; and lastly, due to enhanced anaesthetic cover, it will be possible to manage an increased number of patients with a high anaesthetic risk.

1.7. The Trust has a statutory obligation to achieve financial balance, whilst providing a safe working environment for its staff, as well as providing safe environments for patients, visitors, contractors and other persons in, on and around our estate.

Performance Assumptions

1.8. The development of an elective centre at SACH and the centralisation of trauma at WGH will enable the Trust to deliver significant performance efficiencies in terms of lengths of stay and day case rates. In addition to this, the Trust is currently implementing a reduction in theatre sessional requirements, which will yield significant savings within the turnaround project.

1.9. A summary of the Trust's current performance for elective services compared to that achieved as a consequence of this Business Case is as follows:

Performance Indicator	Current Performance	Planned Performance
Average Length of Stay	3.96	3.84
Occupancy	72%	83%
Number of Elective beds (Orthopaedic)	90	85
Day Case Rate (all)	70%	75%
Number of Day Case Beds (all)	40	36

Table 1: Performance Comparison

1.10. Without the development of a dedicated planned care service the Trust would not be able to achieve the targeted performance.

Current Financial Position

1.11. TheTrust's month 8 Report highlighted a deficit at Month 8 of £13.6 million, broadly in line with the revised plan of £13.4 million. Savings amounting to £4.8 million had been achieved and removed from budgets and this is forecast to increase to £11 million by the end of March. Additional measures and initiatives totalling £16 million are identified during the remaining months of the year

1.12. A detailed year end forecasting process will take place during January however the Trust is likely to have a deficit of between £11.5 and £17 million at the end of the financial year based on different approaches to assessing the likely position. A number of factors are within the Trust control e.g. management of expenditure, other factors are subject to negotiation with funding partners hence the large range at this time. The Trust continues to formally report to the Strategic Health Authority (SHA) that it will meet the control total on the basis that it is possible to deliver this.

1.13. Table 2 shows a summary of performance against the original budgets including the income and expenditure position on both an annual basis and the year to the end of November 2006.

	Annual 2006/07			Year to 30/11/06		
	Plan £m	Forecast £m	Variance £m	Budget £m	Actual £m	Variance £m
Income	220.1			147.1	145.1	-2.0
Expenditure	-214.0			-149.5	-147.3	2.2
Depreciation	-9.8			-6.5	-6.2	0.3
Operating Deficit	-3.7			-8.9	-8.4	0.5
Public Dividend	-8.1			-5.4	-5.4	0.0
Interest Receivable	0.3			0.2	0.2	0.0
Deficit for the year	**-11.5**	**-11.5**	**0.0**	**-14.1**	**-13.6**	**0.5**
Deficit b/fwd from previous years	-37.3	-37.3	0.0			
Total deficit c/fwd	-48.8	-48.8	0.0			

Table 2: Summary Income and Expenditure Position – Annual and Year to Date

1.14. In its assessment of its year end financial position at Month 8, the Trust has a highlighted the risks in achieving the £11.5 million deficit described above and the measures needed to mitigate these risks. Some of the measures taken are inevitably non recurrent and will need to be replaced in 2007/8 by further recurrent measures. Other areas such as temporary staff reductions may be used on a recurrent basis as the Trust reviews how best to manage its staffing requirements flexibly. This position also reflects changes in assumptions since the agreement of the control total such as the reduction in MADEL funding, the impact of previously agreed service transfers and the part year effect of some measures.

Capital Costs

1.15. The capital costs for the preferred option have been identified as £999,040 at MIPS 455 price base including non recoverable VAT. The Executive Team at the SHA will need to approve the funding of the development at SOC stage but it is not anticipated that it will need to approve the Full Business Case, assuming the OBC/FBC are approved, as set out in the WHHT Standing Financial Instructions, by the Trust Board. Capital charges have been estimated on a capital investment of £1.10 million.

Revenue Impact of SACH Development

1.16. The table below shows the estimated additional costs and savings per annum as a consequence of the SACH Business Case. These are the minimum quantified savings at this point and the Trust will seek to drive further savings out as the implementation evolves. A benefits realisation plan will be developed over the next month, which will identify these savings in more detail.

	£
Capital Charges[3]	97,724
Increase in Clinical Staff Costs	297,172
Savings in Clinical Staff costs	(538,240)
A&C Savings	(168,400)
Non Pay cost increases	3,655
Non Pay savings	(20,557)
Total Revenue Savings	**(328,646)**

Table 3: Estimated cost and saving assumptions

1.17. Further detail in respect of these costs is included in Appendix 1.

1.18. It is expected that further significant savings will be made as a result of additional capital investment related to Delivering a Healthy Future. This will be subject to a separate business case later in the year.

Overall Affordability

1.19. This Business Case not only delivers service improvements but also delivers financial savings and will contribute to the Trust 's overall financial recovery programme.

1.20. Due to the current legal challenge, the implementation of the proposals will be in two parts:

- Includes the centralisation of admissions, centralisation of day surgery and the establishment of a surgical admissions lounge with a contribution of at least £70,000 per annum.
- Includes the segregation of Trauma and Orthopaedics, generating a further saving of £262,000 per annum. This will be implemented after the Legal Challenge issues have been resolved.

Impact on the Balance Sheet

1.21. The Trust has assumed that the funding for the capital development will be made available from Strategic Capital through Public Dividend Capital. Capital charges have been calculated on the basis that the expenditure is on SACH buildings. It is likely that the development will not increase the value of the site by the full cost and may lead to an extension of the current life of the buildings. This assessment is therefore prudent.

1.22. The Trust will make a small improvement in affordability as a result of these measures. However, by implementing these in advance of the main DAHF Business Case, the Trust will be able to ensure the main development is delivered with a minimal level of risk, thereby enabling it to realise the greater savings identified in DAHF more quickly. However, if the rest of DAFH does not proceed the investment is still justified.

[3] Capital charges have assumed all investment will add to value, this is reality is unlikely, the DA's view is that the impact on capital charges on buildings is negligible, any increased value is likely to be offset by an increased life.

1.23. This development anticipates the consolidation of most elective activity on to one site in West Hertfordshire. If the proposed development of an independent sector treatment centre (ISTC) Surgicentre is completed, then the Trust has invested a minimal amount of money to deliver a savings over a 2 to 4 year period. The investment can still be justified over this period of time with a payback period of 3 years if savings are adjusted for capital charges. However, if in the event the development of (ISTC) Surgicentre does not proceed for any reason at HHGH or is further delayed, then there are opportunities to invest further in to the SACH site ensuring a medium term future for it, subject to SHA and PCT approval public consultation, etc.

Consideration of backlog maintenance issues

1.24. The Trust is fully cogniscent of the backlog maintenance issues on the SACH site and is currently conducting a risk assessment in order to ascertain what if any of the back log maintenance issues need addressing as a consequence of this development. Should the risk assessment identify a need to upgrade the infrastructure in the immediate term, the Trust will resolve this by funding the necessary works as a priority from operational capital funding in 2007/8.

1.25. Should the Health economy's strategy change in relation to the location of the Surgicentre at any time making the use of SACH become a longer term option then a further risk assessment will be undertaken and any outstanding backlog issues would be revisited accordingly.

Timetable

1.26. Given the immense financial pressures the Trust is keen to implement all aspects of the DaFH proposals as soon as possible. However, a recent proposed legal challenge to the decision made by the Trust Board on the 16th November may delay the implementation of certain elements if a Judicial Review was progressed.

1.27. The Trust has sought legal advice regarding the impact of the possible Judicial Review on the various elements of this business case and is confident that as this business case, with the exception of Trauma and Orthopaedics, mostly relates to elective service transfers and internal departmental moves that the impact is likely to be negligible. This is still subject to any reasonable objection from the claimant that these proposals can proceed.

1.28. The element most affected would be the centralisation of Trauma services, as this relates to an emergency service being transferred from HHGH. However, as Trauma services are part of the wider orthopaedic service, it is not possible operationally to centralise elective orthopaedics in isolation.

1.29. Whilst the facilities will be prepared for the Trauma and Orthopaedic Services, the physical transfer will only take place after the conclusion of the legal challenge on the Trust Board Decision.

1.30. Therefore, the Trust is keen to pursue the unaffected proposals with immediate effect. This phased programme begins with the transfer of Day Surgery and the establishment of the Surgical Assessment Lounge (SAL) during May 2007, followed by the centralisation of admissions and the relocation of the Pre-operative Assessment service. Assuming the SHA approve the funding of the development on 29th January 2007, work will commence in February 2007.

1.31. The facilities created to achieve the above service transfers will also enable the centralisation of elective Orthopaedics as soon as the legal challenge is resolved.

1.32. The project will take a total of 5 months to complete, with significant milestones achieved during that period. The expected expenditure on the development is assumed to be as follows:

Month	Expenditure £'000
February 2007	240
March 2007	360
April 2007	319
May 2007	185

Table 4: Estimated profile of capital expenditure

Key Risks

1.33. The main risks to the successful delivery of the project are described in detail in section Risk Appraisal. The key risks identified in that section are as follows:

- Delay caused by a legal challenge resulting in a possible Judicial Review
- Lack of investment in backlog maintenance in SACH leading to closure of facilities
- Inability to achieve savings
- Failure to agree revised staffing level
- Reductions in referrals from Dacorum and parts of Watford and Three Rivers
- Delay in delivering SACH development leading to double running costs
- Lack of support from community and clinicians
- Increased cost of development due to unforeseen conditions
- Failure to achieve performance improvements

2. Introduction

Purpose of Document

2.1. This Full Business Case (FBC) seeks approval to invest an estimated £ 1 million in order to establish an effective elective care centre at St Albans City Hospital (SACH). This investment is essential to the Trust's overall financial recovery programme, delivering savings and facilitating:

- the centralisation of day surgery;
- the centralisation of elective orthopaedic surgery at SACH;[4]
- the centralisation of orthopaedic trauma at Watford General Hospital (WGH)[5]; and
- the centralisation of admissions for West Hertfordshire Hospitals NHS Trust (WHHT).

2.2. The scheme forms part of the wider service reconfiguration throughout West Hertfordshire, known as 'DaHF'. The remaining elements will be subject to a separate Business Case later in the year. Overall the reconfiguration consists of three main elements:

- consolidation of emergency services, including A&E and Critical Care services at Watford General Hospital;
- segregation of planned surgical services from acute services by the establishment of an elective care centre at St Albans City Hospital; and
- creation of two vibrant non-acute hospital sites providing a range of outpatient, diagnostic, urgent care and intermediate care.

2.3. This scheme can be justified as a stand-alone development and is independent of the decision to proceed with the remainder of 'DaHF', and the outcome of the legal challenge albeit not all transfers will take place until the outcome of the legal challenge is known.

2.4. The scheme not only provides clinical benefits but also delivers a service model in line with government policy and delivers significant revenue savings to contribute towards the Trust achieving financial balance in the future.

Background

2.5. The service configuration concepts described above are consistent with both the previously agreed Investing in Your Health (IiYH) strategy developed by the Bedfordshire and Hertfordshire Strategic Health Authority in 2003 and the current PCT led Acute Services Review which is due to go out to public consultation in March 2007. West Hertfordshire Hospitals NHS Trust (WHHT) has expedited these aspects of IiYH in advance of the intended implementation timetable and therefore in advance of the new hospital, as a consequence of the severe financial pressures currently being faced.

2.6. West Hertfordshire does not have a clear focal point of population and as a result no obvious location on which to centralise all health services. WHHT provides acute health services to the residents of Dacorum, Watford, Three Rivers, St Albans and approximately a third of the Hertsmere population, a total catchment population of around 463,500 resident in 88 electoral wards.

[4] Service transfers will not take place until the outcome of the legal challenge is known

[5] This will necessitate minor adaptations to ward accommodation at Watford General Hospital estimated to cost £20,000.

2.7. The West Hertfordshire Hospitals NHS Trust was formed in 2001 following the merger of two former Trusts. In common with many Trust mergers, the organisation has been slow in altering its culture to reflect the larger organisation, with many departments and specialities remaining loyal to the original Trusts or the hospital buildings.

2.8. Until the end of September 2006, the Trust provided services on four sites:

- Hemel Hempstead General Hospital (HHGH);
- Watford General Hospital ((WGH);
- St Albans City Hospital (SACH), and
- Mount Vernon Hospital (MVH).

2.9. Full district general hospital (DGH) services are provided at WGH, including centralised women's and paediatric services.

2.10. HHGH also offers DGH services with the exception of women's and paediatric services, both of which have been centralised at WGH over recent years due to difficulties in covering the services with appropriately trained staff. Each site currently offers a full A&E Department and critical care services.

2.11. The management of inpatient paediatric services was transferred to the Trust on 1st October 2006 from Hertfordshire Partnership NHS Trust (HPT).

2.12. The services provided at St Albans have changed considerably over the last few years. A wide range of outpatient and diagnostic services along with some elective short stay and day surgery and a minor injuries unit are provided on the site. Intermediate care beds operated by the PCT and some inpatient mental health facilities operated by Hertfordshire Partnership NHS Trust are also located on the site.

2.13. Until recently, the Trust operated a range of services at Mount Vernon including Burns and Plastics and Cancer services, however, over the last few years many of the services have transferred to other NHS organisations.

2.14. Cancer services were transferred to the management of East and North Hertfordshire NHS Trust in 2005 in advance of the proposed Hatfield hospital developments. As a consequence the Trust retained only the management of Burns and Plastic services. However, a number of clinical governance and safety issues this situation has not proved sustainable and therefore, following significant discussions the inpatient services and overall management of the service was transfer to the Royal Free NHS Trust from the 1st October. Arrangements are in place for the Trust to withdraw completely from the Mount Vernon site.

Trust Context

2.15. Almost without exception, the condition of all Trust buildings and the infrastructure that supports them is extremely poor, having suffered many years of little preventative maintenance and investment. All the sites have grown up over a period of years and have suffered from the impact of a number of ad-hoc developments. As a consequence clinical adjacencies are not fit for purpose resulting in significant inefficiencies and an extremely inferior environment for patients, staff and visitors. The internal layouts of all sites are not clear making way-finding difficult and confusing for patients.

2.16. The Trust has a history of significant financial deficit that at the end of 2005/06 had risen to £26.8 million. In addition the Trust has an accumulated deficit of £43m. This gap between income and expenditure existed before the Trust's inception in 2000. Although the Trust has reduced the recurrent deficit as described in paragraph 1.12, further measures are necessary to bring the Trust in to sustainable financial balance.

2.17. Financial stability is essential if the Trust is to retain the prospect of the new hospital as well as future financial stability.

2.18. The challenge for the Trust is to sustain and improve clinical quality and meet NHS performance standards whilst reducing costs.

2.19. In essence, the cost of providing the current range of clinical and support services across the Trust's sites is greater than the level of income it receives. This has led to a lack of investment in core services, buildings, site infrastructure and equipment. As a consequence, despite the best efforts of staff, this situation has resulted in a variable patient experience that is in danger of deteriorating further.

2.20. Over the past few years the Trust has met most operational performance targets. This has been a challenge and has been achieved in many areas by funding additional capacity or resources. The recent cost pressures in the Trust have made achievement of performance targets more challenging.

3. Strategic Context

National and Local Policy Imperatives

National Context

3.1. The NHS is constantly subject to significant change in the pursuit of better quality patient services that harness new clinical technologies and treatment regimes whilst delivering tight financial targets. The tension between service improvement and value for money has never been stronger particularly with the development of Payment by Results, provider plurality and a trend to shift care from acute hospitals to community providers and primary care.

3.2. Access targets remain central to service provision with, for example, no patient waiting more than 18 weeks from consultation with their GP until treatment by 2008. Targets related to service quality for example NSF targets and A&E performance continue to be relevant. These issues, along side the choice agenda, that allows patients to be extended a free choice of provider by 2008, makes the view of patients regarding the re-configuration of services vital if the future 'patronage' of the catchment population is to be counted on for the long term viability of the Trust.

3.3. Adequate critical mass of clinical services will become a more pertinent issue as sub-specialisation develops further, for example the Royal College of Surgeons have recently announced that effective general surgical service require a minimum catchment population of 300,000.

Local Health Economy Context

3.4. Until recently the local health economy comprised of four Primary Care Trusts (PCTs) albeit that operated as two strategic alliances. This structure was reorganised from the 1st October and as a consequence there are now two Primary Care Trusts one covering West Hertfordshire and the other covering East and North Hertfordshire. One executive team covering the two organisations manages the PCTs. The financial position of the local health economy has been fragile for many years with a planned deficit for the West Hertfordshire PCT 2006/7 of £17million.

3.5. In response to these pressures the NHS organisations in Hertfordshire and South Bedfordshire jointly agreed to undertake a review of services in June 2001. The objective of this review was 'to create a network of high quality and sustainable health services[6]'. This review, known as Investing in Your Health (IiYH), was subject to public consultation and in November 2003 the health economy agreed the final configuration of services as detailed below:

- two acute hospital sites for Hertfordshire;
- segregation of planned care from acute care site;
- the creation of community Diagnostic and Treatment Centres (cDTCs); and lastly
- the expansion of primary care services.

Trust Strategic Direction

3.6. Against the national strategic context the current financial position and action necessary to resolve this dominates the short-term strategic direction of the Trust, without financial stability the Trust's ability to meet its statutory obligations, in terms of the delivery of safe acute services and financial balance will be severely affected.

[6] Source :Investing in Your Health – A Consultation Paper – March 2003

3.7. The need to embed high quality financial management and operational control into the organisation is a high priority.

3.8. The Trust has explored a number of other strategies over the last twelve months to deliver financial stability. Individually these strategies have led to significant cost reductions being implemented, however by amalgamating these strategies into an overall package offers even greater service and financial benefits.

3.9. These strategies fall into three main categories:

- Improving operational efficiency (Turnaround Programme)
- Improving clinical effectiveness ('Best Practice, Best Value' Reviews)
- Streamlining services (DaHF)

3.10. The scale of the financial problem suggests that the Trust's workforce needs to be reduced by in excess of 500 posts. Whilst approximately 100 of these can be achieved by redesigning how clinical services are delivered, the remainder requires a significant reduction in service duplication and multi-site operation.

3.11. To this end the Trust has explored a number of options to reconfigure services as rapidly as possible in order to maximise the financial and service benefits. Whilst the reconfiguration proposals are in line with the principles set out in IiYH, and the PCT's Acute Services Review, DaHF seeks to achieve the reconfiguration broadly within the estate currently available, therefore, in advance of the new hospital been opened.

3.12. This FBC only address the case for establishing the elective care centre at SACH centralising orthopaedic trauma at WGH. The funding required to complete phase II of the service reconfiguration will be subject to a further Business Case to be submitted later this year.

Overview of Investing in Your Health

3.13. The Trust's strategic direction has been heavily influenced by the IiYH strategy since 2003 as it describes a future strategic model for primary, community and intermediate care services as well as hospital services. Clinicians and managers at WHHT fully endorse the service model proposed under IiYH, but acknowledge that significant service re-design will be necessary for the new models to be fully implemented across the health economy.

3.14. As a consequence of the IiYH formal consultation process a strategic outline case (SOC) was submitted to the Department of Health. The SOC proposed that acute hospital services should be centralised on one location for each locality with services located at Watford General Hospital site for West Hertfordshire and at a new location in Hatfield for East and North Hertfordshire. It was proposed that the Stevenage and Hemel Hempstead sites would both become planned care centres with the co-location of all low risk elective surgical services. These services were to be complemented by enhanced primary care services and a network of community diagnostic and treatment centres (cDTC). With the latter providing local outpatient and diagnostic services.

3.15. In response to capital affordability issues and other financial pressures, the new East of England Strategic Health Authority has announced a review of acute services across the East of England. This review has begun in Hertfordshire and the new PCT has been commissioned to carry out a technical affordability analysis of the IiYH strategy.

3.16. This review has challenged the planning assumptions of IiYH particularly regarding the capital cost of acute hospitals and the impact of changing patient flows and income. The PCT have already indicated they following assumptions in respect of reductions in acute care commissioning:

- Emergency admissions: 10% reduction
- Elective admissions: 5 % reduction
- Outpatient Attendances: 30% reduction

3.17. The Trust has been fully involved in the review and believes that the review is extremely unlikely to significantly alter the proposed configuration of hospital services in West Hertfordshire from that outlined in IiYH. The most major change is expected to be the location and extent of capital development for east and north Hertfordshire. This is likely to increase the size of the catchment population for WHHT.

3.18. The outcome of the review is expected in early 2007. This revised strategy will be subject to public consultation, which will take place from March 2007.

Independent Sector Treatment Centre

3.19. In response to the Government's drive to improve competition in the NHS and encourage plurality, the SHA and previous PCTs agreed to utilise the Government's Independent Sector Treatment Centre procurement initiative to deliver the planned surgical services at Hemel Hempstead and Stevenage. Transition relief is to be made available to the health economy, by the Department of Health, in order to enable a reform of services of this scale.

3.20. The health community, including both acute Trusts has been participating in the negotiation of the ISTCs over the last year. A preferred bidder, Clinicenta were selected in October 2005 and the ISTC, know locally as Surgicentres, were originally due to open in autumn 2007. However, both the financial close and therefore opening of the Surgicentres has been delayed. The timing and future of the Surgicentre is expected to be clarified in 2006/7

4. Objectives, Benefits and Constraints

Investment Objectives

4.1 The investment objectives for this project are described below in Table 5 below:

Investment Objective	Existing Arrangement	Problems associated with existing situation
1. To facilitate a reduction in the cost base of elective surgical services enabling the Trust to provide high quality services to its patients at tariff or below by 2008/9.	Elective services are currently duplicated across three sites. Staff, equipment and consumables are duplicated across the sites. Many staff have to travel between sites during the working day.	The current configuration of services generates many dis-economies of scale that increases costs and result in services costing more than the PBR tariff income generated.
2. To contribute to improved effectiveness of the elective surgical and trauma services in order to meet national performance and quality targets by 2008/9.	Services offer variable levels of quality across the Trust depending which site the service is provided from and the constraints of that site. Trauma patients are operated on in two sites.	Achieving clinical effectiveness and meeting performance targets has been a challenge for the Trust. This has often been achieved by increasing the resources available rather than by redesigning the services radically thereby increasing the financial burden on the Trust. Centralising Trauma services will enable the Trust to focus resources on trauma patients that will assist in reducing length of staff and improving patient outcome.
3. To improve efficiency and productivity of all clinical and non-clinical services to reduce unit cost to at or below tariff by 2008/9.	Capacity has not been effectively aligned with activity requirements due to the constraints around fixed and semi fixed costs and working practices as a consequence some services are fragmented across the Trust sites.	Facilities such as operating theatres are not routinely optimised to their fullest extent. This creates pressure on capacity elsewhere in the Trust and results in expensive resources being wasted. Leading to 'near' waiting list breaches and bed pressures compounding other operational problems in the Trust.
4. To reduce staff costs by facilitating significant service re-design by 2007/8.	Staff are spread across all site with variable levels of expertise, with vacancies routinely covered by temporary staff. The current duplication of services and the requirement to meet the European Working Time Directive requires additional staff across all sites.	Staff expertise is not maximised. Temporary staffing often carries a premium cost and can have a detrimental effect on permanent staff and their ability to deliver a high quality cost effective service. The creation of 'legal' rotas requires a significant number of additional staff and therefore, additional cost.

Table 5: Investment Objectives

Business Objectives

4.2 The overall objective of the Trust is to ensure the delivery of safe, high quality acute hospital services for the people of West Hertfordshire making best use of the resources available.

4.3 Against this objective the Trust is currently working in an environment where:

- In recent years it has fallen short of the performance standards required by the NHS despite having some very able staff. The Healthcare Commission's recently published *Annual Health Check*[7] found the Trust to be weak on both quality of service and on management of resources; one of only 24 Trusts to be found wanting on both counts. The Trust's lead commissioner, Watford and Three Rivers PCT was also assessed as weak. This performance accords with that of the previous star rating league tables, under which the Trust moved from zero star status in 2004 to one star in 2005;

- the current service configuration severely impedes the Trust's ability to deliver services within the PBR tariff income it receives, leading to an increasing deficit and therefore, makes it impossible for the Trust to meet its statutory responsibility to break even;

- the Trust's financial position has deteriorated significantly;

- the current configuration of services severely limits the opportunity to clinical teams to work effectively.

Scope of the Scheme

4.4 As stated previously this investment at SACH and WGH is a stand alone Business Case. A wider reconfiguration of services across West Hertfordshire could be developed following the implementation of these proposals. The subsequent stages will be subject to further Business Cases to be submitted in March 2007.

4.5 To this end the scope of this case is as described below:

- improved utilisation of the existing theatre suite at SACH;
- re-instatement of ward beds on Beckett ward at SACH to increase the inpatient capacity
- re-engineering the clinical models and patient pathways in order to improve utilisation potential;
- creation of a clinical procedure room to generate additional capacity within the theatres;
- improving the flow through of patients by the establishment of a surgical admissions lounge;
- alterations to the day unit in order to improve patient flow and maximise efficiency;
- ward reconfiguration at WGH to enable the centralisation of orthopaedic trauma;[8]
- Improved parking and patient drop off facilities at SACH in order to improve access and egress to the site.

[7] Annual Health Check, Healthcare Commission 2006

[8] This will necessitate minor adaptations to ward accommodation at Watford General Hospital estimated to cost £20,000.

4.6 The scheme will deliver the following changes to the SACH:

	Current Position	Future
Inpatient beds	28	40
Day Surgery Unit beds/ Trolleys	18	27
St Julians		Admissions Unit
Ophthalmology Procedure Room		1

Table 6: Summary of changes at SACH

Benefits

4.7 The main benefits of this Business Case are described below:

- elective surgical services will be more efficient as a consequence of theatre sessions and beds not being disrupted by emergency cases;
- patient care will be improved as services are collocated in one area enabling teams to maximise their expertise rather than dilute it as at present;
- day surgery performance will improve as the Trust focuses on increasing day case rate;
- due to enhanced anaesthetic cover at SACH, it will be possible to manage an increased number of high risk patients as day cases;
- revenue savings will be achieved as a consequence of centralising day surgery and orthopaedics; and
- the centralisation of orthopaedic trauma at WGH Centralised Trauma services will improve outcome and reduce revenue requirements.

Constraints

4.8 The main constraints around the project are:

- the pressure to deliver the service change very rapidly in order to deliver savings as soon as possible;
- the potential Judicial Review which may delay the overall implementation timetable;
- the likely development of the Surgicentre on the HHGH site within 2-4 years which severely restricts the level of investment possible to achieve the change;

Main Risks

4.9 The main risks to the successful delivery of the project are described in detail in Section 9 Risk Appraisal. The key risks identified in that section are as follows:

- Delay caused by potential Judicial Review
- Lack of investment in backlog maintenance in SACH leading to closure of facilities
- Inability to achieve savings
- Failure to agree revised staffing level
- Reductions in referrals from Dacorum and parts of Watford and Three Rivers
- Delay in delivering SACH development leading to double running costs
- Lack of support from community and clinicians
- Increased cost of development due to unforeseen conditions
- Failure to achieve performance improvements

5. Options Consideration

Introduction

5.1. Given the Trust's financial position the opportunity to expedite the clinical model described within IiYH was explored in order to ascertain whether the centralisation of acute service and the segregation of elective services could be achieved without the benefit of a new hospital at WGH. To this end, the feasibility of centralising emergency services at either Hemel or Watford was explored.

5.2. The outcome of this being that, whilst was feasible to centralise emergency services on either site, the cost of centralising at Hemel Hempstead is almost double the capital cost of the Watford option. This is due to the need to provide substantially more new accommodation at Hemel Hempstead than at Watford.

5.3. The HHGH option was retained until further discussion with the Overview and Scrutiny Committee (OSC) took place. The OSC felt the option should be discounted on the grounds of cost and non-compliance with IiYH. Once this had been established, focus of the other sub options became the configuration and location of elective surgery in advance of the ISTC being commissioned at Hemel Hempstead. Two clear options emerged.

Elective Surgery Options

5.4. **Option 1** - To establish SACH as the Trust's elective care centre, building on the existing elective surgical services on site. Under this option all non-complex day surgery will be undertaken at SACH along with a significant volume of other elective surgery including Orthopaedics, Ophthalmology and Breast Services.

5.5. This option predominately uses the existing theatre and bed accommodation and is predicated on improving efficiency and productivity of these resources. Therefore, the option can be achieved rapidly and at a relatively low cost. However, the option requires some staff to be moved twice, once to SACH and then finally to HHGH when the ISTC opens.

5.6. **Option 2** - Under this option the existing surgical block, Tudor Wing, at HHGH is adapted to create the elective surgical facility for the Trust. This option requires the installation of two additional theatres, refurbishment of the existing theatres and adaptation within the block to create day surgery unit. The case mix for this option would be the same as that for Option 1. Whilst this option means staff only move once, the cost and timescale are much longer than Option 1. The costs were estimated to be at least £2 million more than option 1.

5.7. Options 1 and 2 both seek centralise Orthopaedic Trauma at WGH.

5.8. Emergency services are located at WGH in both options subject to the separate Business Case as described previously.

5.9. Options 1 and 2 formed the basis of the Trust's 100-day public consultation exercise that began in July and concluded in October 2006. The outcome of the consultation was an independent report, which the WHHT Trust Board considered on the 16th November 2006. The outcome of this being that the Board formally approved Option 1 subject to obtaining the appropriate level of capital funding to support the alterations required.

6. Preferred Solution

Description of Preferred Option

6.1 The Trust's preferred option is to transfer the majority of elective short stay and day surgery services from Watford and Hemel Hempstead General Hospitals to the SACH site. Elective orthopaedic services form the majority of the case mix to be transferred.

6.2 The Trust's preferred option is to refurbish facilities at St Albans to accommodate the activity transfers within the current estate. Some refurbishment work will be required to Moynihan Block and to provide increased Day Surgery facilities. The only other option would be to develop facilities in new build accommodation. This was discounted due to:

- the requirement to deliver the services as soon as possible;
- the short term nature of the investment; and
- the additional costs associated with new build.

6.3 Trauma services will be centralised on the WGH site.

6.4 Facilities at SACH and WGH require minor adaptation in order to create sufficient capacity to accommodate the transferred activity as described below:

- creation of a clinical procedure room to generate additional capacity within the theatres;
- the establishment of a surgical admissions lounge on St Julian's ward;
- the establishment of the admission office on St Julian's ward;
- Alterations to the day unit in order to improve patient flow and maximise efficiency;
- modification of HDU at WGH to provide Fractured Neck of Femur Ward; and Increased parking and patient drop off facilities in order to improve access and egress to the site.

6.5 In addition the centralisation of the admissions function for the Trust will improve the overall co-ordination of waiting list and admission management.

7. Value For Money

Economic appraisal

7.1 A high level economic appraisal has been completed of the preferred option against the do nothing option. The GEM has not been used due to the relatively low level of capital investment and its impact on only a small part of the Trust's operations. However, standard discounted cash flow techniques have been used to confirm the value for money of the proposal.

7.2 Table 7 summarises the economic analysis of the two options using the following assumptions:

- Only the changes in costs have been used in calculating the Net Present Value of the options. Therefore additional costs, any savings and capital costs have been included.
- Similarly no opportunity costs have been assumed, as these will be the same in both options.
- The appraisal period is over 20 years. This is the expected remaining life of the assets where investment is proposed.
- Due to the relatively low level of investment there has been no risk adjustment. This is considered to be prudent given the timescales for delivering an FBC with fully worked up designs.

£	NPV [9]	EAC
Proposed option	(3,946,259)	(268,273)
Do nothing	1,275,001	86,677

Table 7– Economic Analysis of options over 20 year appraisal period.

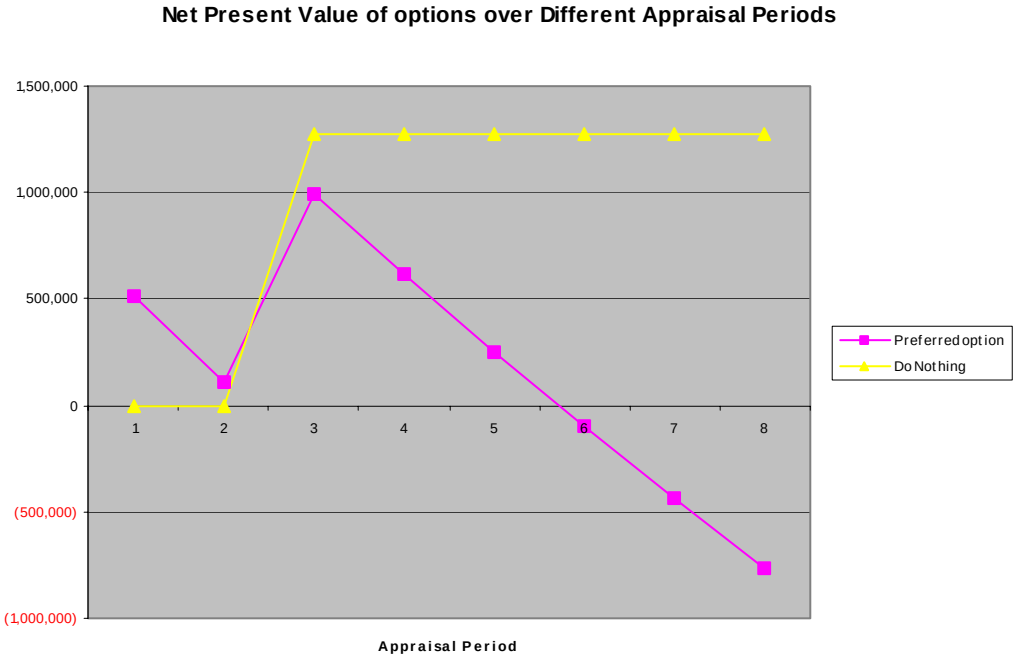
7.3 The proposed option is significantly economically advantageous as the investment has a payback of less than 3 years. If the appraisal were undertaken over 2 years the do nothing option would be marginally better as shown in Table 8.

£	NPV	EAC
Proposed option	110,151	56,023
Do nothing	0	0

Table 8 – Economic Analysis of options over 2 year appraisal period

The Graph below shoes the relative NPV/Cs in relation to the length of appraisal period. This reflects backlog maintenance investment of £1.3 million in year 3 for both options.

[9] A negative value indicated an overall financial benefit to the organisation



Graph 1: Relative NPV/Cs in relation to the length of appraisal period

7.4 Over the 20-year period the level of savings identified would have to reduce by £354,000 before the do nothing option was economically the better option.

7.5 The investment at SACH will have no impact on the remaining DaHF proposals or the new hospital development, the latter of which is expected to be funded through the PFI. There is therefore no risk that this development will affect the new hospital at Watford scheme. The risk of the Surgicentre scheme being implemented is considered as part of the 2-year appraisal sensitivity.

8. Affordability Analysis

8.1. The investment detailed in this Business Case will enable and facilitate the delivery of the DaHF project. A number of savings can only be realised on the delivery of the remainder of the DaHF project. The cost implications identified below only assume those, which are a direct consequence of this Business Case and are not reliant on other measures.

8.2. These are the minimum quantified savings at this point and the Trust will seek to drive further savings out as the implementation evolves. A benefits realisation plan will be developed over the next month that will identify these savings in more detail.

8.3. Changes in the Trust's cost base are as follows:

	£
Capital Charges	97,724
Increase in Clinical Staff Costs	297,172
Savings in Clinical Staff costs	(538,240)
A&C Savings	(168,400)
Non Pay cost increases	3,655
Non Pay savings	(20,557)
Total Revenue Savings	**(328,646)**

Table 9: Change to Trust Cost Base

8.4. Further detail behind these figures is included in Appendix 1.

8.5. There is a risk as a result of the legal challenge that the Trust will not be in a position to implement all the highlighted developments in this business case. The following table shows the potential savings potential at each stage of the implementation:

	Min £	Max £	
Centralised Admissions	70,676	158,140	Maximium assumes no added value re capex
CA plus Day Surgery	70,676	216,380	Maximium assumes no added value re capex and some reduction in beds due to increase in Day surgery
CA/Day Surgery plus T&O	328,646	918,560	Maximum assumes greater savings on junior on call rotas

Table 10 – Savings scenarios

8.6. It is expected that further significant savings will be made as a result of additional capital investment related to Delivering a Healthy Future. This will be subject to a separate business case later in the year.

8.7. The Trust has assumed that the funding for the capital development will be made available from Strategic Capital through Public Dividend Capital. Capital charges have been calculated on the basis that the expenditure is on SACH buildings will equal the additional value on those assets. It is likely that the development will not increase the value of the site by the full cost and may lead to an extension of the current life of the buildings. This assessment is therefore prudent.

8.8. The Trust will make a small improvement in affordability as a result of these measures. However, by implementing these in advance of the main DaHF Business Case the Trust will enable to ensure the main development is delivered with a minimal level of risk, thereby enabling it to realise the greater savings identified in DAHF more quickly. The implementation of this Business Case does not hinder future further savings

9. Risk Appraisal

Risk Appraisal

9.1 The identification and understanding of risks associated with the options is important early in the process to ensure these risks are managed and mitigated as far as possible. The Trust will be developing a detailed risk register and mitigation plan, which will be regularly reviewed and updated.

9.2 In summary the risks highlighted below need to be managed effectively. However the Trust does not consider any of these risks to pose a material threat to the successful implementation of the business case. The major risks to the Trust in respect of this project are the delays caused by any judicial review application and any unforeseen increases in capital cost, which may then require the Trust to seek approval of a revised capital sum from the SHA. Any delay in delivering the service changes will reduce, in the short term, the ability of the Trust to make significant financial savings. However the SACH development would still release net savings outside of the changes to day surgery and trauma and orthopaedics by the centralisation of admissions.

9.3 The table below highlights the key issues and risks for the Trust to manage in the development of the SACH scheme. It also defines a high level strategy for managing and mitigating these risks.

Description	Probability	Impact	Crystalisation	Mitigation Strategy
Delay caused by Judicial Review	High - An intent to proceed has been expressed	Medium – investment can still be made not all savings identified could be made until resolution	Delay beyond April 2007	Develop plan for implementation maximising savings at lowest risk
Inability to make identified savings	Low – Savings have been carefully worked through and are likely to be achieved	Low Dependent on the level shortfall of savings identified. Current assessment is relatively prudent. Different levels of implementation are considered in Section 8.5	Lack of signed off budgets/ workforce plans. (should be done by time of FBC)	Savings identified and agreed with all budget managers and clinicians Identify shortfalls in potential savings. Examine options for further reduction elsewhere
Lack of investment in backlog maintenance leads to closure of SACH facilities	Low – Although significant no greater than Watford	High – Potential significant loss of income or cost (up to £1.3 million)	Risk Assessments on the estate lead to a view that key departments may be closed	Review key risk areas and prioritise (on going management of capital programme) maximum exposure of £1.3 million against a historic operational capital allocation of circa £6 million. To be reviewed as a result of new capital

Description	Probability	Impact	Crystalisation	Mitigation Strategy
				regime
Failure to reach agreement on staffing issues.	Low – Should be agreed as part of the business case (Nurse staffing implications currently being agreed)	High – Failure to reach agreement may impact on cost and ability to deliver service model	Concerns raised by General Managers Lack of sign off	Development of contingencies to enable the development to proceed.
Reduction of referrals from Dacorum and Watford	Low – Outpatients still referred into Hemel Hempstead and Watford – therefore likely to keep surgical activity	High due to PbR. There is a possibility the Trust will get PbR activity from elsewhere	Elective surgery referral rate drops from Hemel and Watford residents. (Need to set up a system of not one already monitoring referrals from GPs)	Review referral patterns and overall referral rates. Examine opportunity for attracting referrals from elsewhere. Examine potential for further reductions in cost base – beds/ staffing etc. Review provision of outpatient clinics and services – accessibility maintaining same level of demand
Delay in delivery of SACH development – increases double running costs and potential loss of income.	Medium	Medium – Results in loss of savings – however major risk will be the reducing value for money of the investment resulting from delay	Failure to reach milestones	See Judicial Review comment
Lack of support from community and clinicians	Low – Managed through consultation process	High – difficulties in implementing change if not supported by clinicians.	Failure to agree timetables and job plans, theatre rotas	High profile clinical leadership to drive through and implement change
Increase in cost of development due to unforeseen conditions	Medium– Scheme now supported by detailed design, risk around condition when building starts	Medium	Surveys reveal requirement for extra work, or work itself reveals further work necessary	Risk Management Strategy to be developed looking for options to manage capital cost.
Failure to achieve performance improvements	High – dependent on other factors	High – Risk of bed blocking and reduction in capacity as a	Bed occupancy higher than 82%	Action plan to ensure performance improvements in place. Regular

Description	Probability	Impact	Crystalisation	Mitigation Strategy
	(intermediate care) outside of the Trust's complete control.	result. Alternatively requirement to open extra beds. Potential need for increased staffing to enable reductions in lengths of stay	Bed Blocking with lower activity	monitoring.

Table11: Key Risks and Mitigation

10. Project Management Arrangements

Programme Management Arrangements

10.1 The Trust has put robust project management arrangements in place to manage both this project and the wider service reconfiguration project. This approach reflects the principles of programme management and uses elements of PRINCE project management methodology.

10.2 The scheme is an integral element of the IiYH Programme, which comprises of portfolio of projects concerned with delivering strategic change in the Trust. The project is also an essential component of the Trust's financial turnaround programme, which consists of a range of projects to deliver financial recovery.

Project Reporting Structure

10.3 The DaHF Project Board reports to the Trust's IiYH programme board, a formal sub committee of the WHHT Board. This ensures a coordinated approach to strategic development within the Trust. The Project Team is accountable to the Project Board and each sub group is accountable to the Project Team for the implementation of their element of the Project.

Project Roles and Responsibilities

10.4 As stated above the project has been structured using the programme management principles and reflecting the PRINCE project management methodology. The Senior Responsible Owner (SRO) is Mr David Law, the Trust's Chief Executive. A Project Board has been established, the membership of which is detailed below:

- David Law - Chief Executive (Chair)
- Sarah Shaw - Director of Planning
- Graham Ramsay - Medical Director
- Ross Dunworth - Acting Director of Finance and Turnaround
- Simon Colbert - Director of Estates and Facilities
- Sarah Childerstone - Director of Human Resources
- Gary Etheridge - Chief Nurse, Director of Quality
- Nick Evans - Operations Director (Medicine and Clinical Support)
- Nick Chatten - Director of Business Development

10.5 The Associate Director of Communications (Sue Fay) will be in attendance in order to ensure key messages are briefed throughout the organisation and outside it. There is a communications plan that includes the Trust's approach to Public Consultation and Overview and Scrutiny, staff briefings, ministerial and MP briefings.

10.6 The Project Board is accountable for the overall success of the project and meet fortnightly to:

- Set clear direction for the project;
- Agree the terms of reference for the Project Team and workstreams;
- Review progress against project plan;
- Arbitrate between work streams where necessary;

- Oversee the communications and consultation processes, ensuring all stakeholders are fully appraised of action;
- Sanction plans and action;
- Appraise the board and SHA of progress on a monthly basis and ministers when necessary.
- Authorising commitment of project resources;
- Agreeing the Project Timetable

10.7 A Project Team has been established, chaired by the Director of Planning to oversee the overall delivery of the project to time and budget. This team meets fortnightly.

- Agreeing Business Case content and deliverables
- To set targets and agree a project control system to ensure delivery of the programme objectives
- Reviewing and approving the deliverables
- Reviewing and approving any changes to programme plans
- Providing advice and guidance on further work and content within each project stream which maybe required
- Reviewing and approving proposed action plans
- Signing off each completed phase
- Authorising the start of each stage of the Project
- Ensuring that all deliverables are complete and delivered
- Agreeing upon an Outline Business Case to be submitted to the Project Board
- To project manage and co-ordinate the different work streams that are required to produce an OBC in the required timescale
- To ensure effective decision-making that delivers and adequately resources the programme.

10.8 The Project Team is supported by:

- Clinical Re-design workstream, overseen by the Medical Director, with a key role for the Director of Service Redesign. Speciality based workstreams will be established as required, using the internal Hospital User groups that are already established for IiYH service planning; these will include representation from clinical teams

- Design Solutions and Infrastructure workstream, overseen by the Assistant Director of Planning with a key roles for the Director of Estates and Facilities

- Business Case Development workstream, overseen by the Director of Finance and Turnaround with key roles for the Directors of Operations; Director of Business Development and the Director of Planning

- Human Resources Group, overseen by the Director of Human Resources; with key roles for the Directors of Operations

- Communications, overseen by the Associate Director of Communications.

10.9 Detailed project plans are being developed that identify clear action plans for each group and dovetail overall to ensure a joined up approach. Each group will meet weekly to progress action. Each sub-group will co-opt other team members as required.

10.10 The Project Team consists of the following members:

- Sarah Shaw - Director of Planning
- Louise Gaffney - Assistant Director of Planning
- Phil Bargent - Acting Head of Capital Planning

- Melanie Cheshire - Health Service Planner IiYH
- Richard Simons - Head of Estates
- Tracey Moran - Deputy Director of Nursing
- Simon Green - Divisional Manager, Emergency & Acute Medicine
- Maxine McVey - Divisional Manager for Surgery
- Sally Tucker - Divisional Manager for Clinical Support
- Wendy Glendinning-Plews- Head of Facilities
- Richard Wilkes - HR Rep -Transformational Unit
- Dr Alfa Sa'du - Clinical Representative
- PCT Rep - PCT Representative

Timescale

10.12 Given the immense financial pressures the Trust is keen to implement all aspects of the DaFH proposals as soon as possible. However, a recent proposed legal challenge to the decision made by the Trust Board on the 16th November may delay the implementation of certain elements if a Judicial Review was progressed.

10.13 The Trust has sought legal advice regarding the impact of the possible Judicial Review on the various elements of this business case and is confident that as this business case mostly relates to elective service transfers and internal departmental moves that the impact is likely to be negligible. Subject to any reasonable objection from the claimant that these proposals can proceed.

10.14 The only element most affected would be the centralisation of Trauma services, as this relates to an emergency service being transferred from HHGH. However, as Trauma services are part of the wider orthopaedic service, it is not possible operationally, to centralise elective orthopaedics in isolation.

10.15 Therefore, the Trust is keen to pursue the unaffected proposals with immediate effect. This phased programme begins with the transfer of Day Surgery and the establishment of the Surgical Assessment Lounge (SAL) during May 2007, followed by the centralisation of admissions and the relocation of the Pre-operative Assessment service.

10.16 The facilities created to achieve the above service transfers will also enable the centralisation of elective Orthopaedics as soon as the legal challenge is resolved.

10.17 The project will take a total of 5 months to complete, with significant milestones achieved during that period.

Use of Special Advisors

10.18 In order to progress the overall 'DaHF' strategy the Trust has engaged a number of 'special advisors and consultants'. These have either been employed directly by the Trust or via Medicinq Osborne, the Trust's P21 advisor, the organisations consulted, their role is detailed below

Organisation/ Individual	Role
Tribal Secta	Activity and financial modeling
Medicinq Osborne	Procure 21
* Murphy Phillips	Architect
* DSSR	M&E Engineering
* Mott Macdonald	Traffic
* Arc Health	Health Planner
* Turner Townsend	Cost Consultants
* Paul Owen Associates	Structural Engineers
* Safetymark	Planning Supervisor
* Butler and Young	Building control
Ernst & Young	Business Case Support – commercial
Sedgwick Igoe	Business Case - financial
CLEAR Communications	Public Consultation Advice

Table 12: Trust Advisors

11 Conclusion & Recommendation

Conclusion

11.1 To conclude, this SOC details the Trust's intention to establish an elective care centre at SACH as an interim solution pending the decision regarding the Surgicentre. This includes the centralisation of trauma at WGH. The cost of achieving this is in the region of £1million and requires strategic capital funding to facilitate the change.

11.2 The Trust will deliver more clinically effective services and will benefit financially from this scheme as a result and as such this 'invest to save' scheme forms an essential facet of the Trust's overall financial recovery programme.

11.3 The reason for undertaking these changes is to enable the Trust to improve its financial position by releasing c. £300,000 per annum. Whilst the case can stand-alone the greater financial benefits will be occur once the final phase of the DaHF strategy is delivered. Phase 2 is the centralisation of acute service to WGH in advance of the PFI and will be subject to a separate Business Case later in the year.

11.4 Lastly, whilst this service reconfiguration will deliver savings for the Trust it also delivers benefits for patient care and will enable the Trust to make better use of its resources and facilities than is currently achievable.

11.5 The potential Judicial Review is likely to delay full implementation of the proposals however; it is possible to implement some elements so long as the adaptations to the facilities have taken place. These service changes will deliver financial savings and will promote changed clinical practice and improved productivity. Therefore, it remains vital that this work is carried out as soon possible.

12 Appendices

Appendix 1	Detailed Financial Workings
Appendix 2	Capital Cost Plan
Appendix 3	Detailed Drawings