Strategic Outline Case

Hemel Hempstead Interim Site Reconfiguration

WHHT Trust Board
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1. Executive Summary

Introduction

1.1. This Strategic Outline Case (SOC) seeks approval to invest approximately £4.1 million in order to reconfigure the Hemel Hempstead Hospital site. This investment is an essential part of the Trust's overall financial recovery programme, delivering savings and facilitating:

- the consolidation of the services remaining at the Hemel Hempstead site;
- the establishment of a cohesive 'front door' to continue the flow of patients through Hemel Hempstead to Watford or St Albans; and
- the potential for development of a Primary Care led Local General Hospital (LGH).

1.2. The scheme can be seen as phase 3 of the 'Delivering a Healthy Future in West Hertfordshire (DaHF)' programme. Overall the DaHF reconfiguration consisted 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 is 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 PCT led Acute Services Review. WHHT 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 faced at the time.

1.4. The implementation of this service configuration enables the Trust to realise significant improvements to the patient experience. These improvements include: more efficient outpatient processes and organisation; environmental improvements with re-design and relocation of outpatients, therapies and urgent care centre services.

1.5. 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. This scheme delivers a revenue savings contribution of £3.8m gross.

Performance Assumptions

1.6. Efficiency improvements will be achieved by the Trust delivering its services from a limited number of buildings, bringing co-locations of staff and patients in a more focussed environment. The efficient running of this element of WHHT services will be key to the success of the site rationalisation and new service model. It will be essential to have a successful 'shop window' to services provided by WHHT, so that patients and GPs in Dacorum continue to choose our services. Improvements to the environment, consolidation and delivering clinical adjacencies will improve the model of care for services at Hemel Hempstead and so improve performance through the acute site at Watford.

1.7. Without the reconfiguration of services between buildings at Hemel, the Trust's performance would suffer as it would be unlikely to achieve the targets required – both financial and operational.

Current Financial Position

1.8. The Trust's plan is to deliver a surplus in 2008/09 of £4.4m, which it is on track to achieve.

Capital Costs

1.9. The capital costs for the preferred option have been estimated to be in the region of £4,090,000 including non recoverable VAT at 15%. This cost estimates are high level but have been based upon industry norm rates on a cost per square meter basis. The Trust Board will need to approve the funding of the development at SOC stage, which will then move to an OBC/FBC.

1.10. It is anticipated that the works will be funded using Trust operational capital, which will require consideration by the Board to understand the prioritisation of schemes, proposed mitigation strategies and risks associated with not progressing certain schemes. This will be provided to the January Trust Board Meeting.

Revenue Impact of HHGH Reconfiguration

1.11. The table below shows the estimated additional savings per annum as a consequence of the HHGH Reconfiguration Business Case. These are the quantified savings and assumed revenue 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.

Summary	**2009/10, £k**	**2010/11, £k**
Savings on buildings	2,727	3,204
Urgent Care Centre (not yet agreed by PCT, basis of original profile of UCC rent)	650	650
Income from PCT, related to GP Led Health Centre / Intermediate Care Team Services	To be confirmed	To be confirmed
Intermediate Care (assumed recharge to PCT based on £350/m2)	191	191
Contingency Ward (part of £850k agreed by the PCT, £350/m2)	85	
Total	**3,653**	**4,046**

Table 1.1: Estimated savings per annum with reconfiguration.

1.12. Further detail in respect of the savings on buildings is included in Appendix 1.

Overall Affordability

1.13. This Business Case not only delivers financial savings and will significantly contribute to the Trust's overall financial recovery programme, but will deliver improvements in efficiencies in the operation of the site and an improved patient environment for their outpatient healthcare.

Capital Investment

1.14. The Trust has assumed that the funding for the capital development will be made through the Trust's own funds generated through depreciation.

1.15. The investment will enable the Trust to make significant savings enabling it to maintain a robust income and expenditure position.

1.16. Given the WHHT's current Health Care Commission rating of fair/fair, the Trust's approval limit for business cases for capital developments has increased to £8 million, and this scheme is within this delegated limit.

1.17. The long term future of the HHGH site is not yet clear as the PCT has not completed its business case for the Local General Hospital in Hemel Hempstead. The Hillfield Road site, or the site and part of the existing estate are only two of a number of options currently being considered by the

PCT. This position will become clearer over the coming months as the PCT carry out their site option appraisal exercises. Given this situation, these plans are cognisant of the need to balance an effective medium term reconfiguration of the site for the benefit of WHHT Trust, its patients and staff, and the needs of the PCT should they decide this site offers the best long term solution.

1.18. To this end, this reconfiguration plan is such that the designs could be adapted at a later stage, with the majority of investment likely to be relevant to a LGH configuration. The investment is stand alone from the LGH plans in some respects (although tests out the model of care) and is easily justified with the savings released from capital charges. If the proposed development of a LGH is achieved, then the Trust will have invested a minimal amount of money to deliver savings over a 5 year period.

Consideration of backlog maintenance issues

1.19. The Trust is fully cogniscant of the backlog maintenance issues on the HHGH site and vacating a number of buildings clearly assists the backlog position. In addition, the Estates department is currently conducting a risk assessment in order to ascertain what if any of the backlog maintenance issues need addressing as a consequence of the planned reconfiguration. Should the risk assessment identify a need to upgrade the infrastructure in the immediate term, this will be incorporated into the plans and prioritised within the Trust's operational capital.

Timetable

1.20. Given the contribution to the financial recovery plan, the Trust is keen to implement the reconfiguration plans with immediate effect. This phased programme begins with the vacation of the Day Hospital during February 2009, Windsor Wing during April 2009, Cheere House during May 2009 and Tudor Wing during June 2009.

1.21. The project will take seven months to complete, with significant milestones achieved during that period. The assumed commitment on the development is expected to be as follows:

Financial Year	Expenditure £'000
December - March 2009	£700
April – June 2009	£3400

Table 1.2: Estimated profile of capital commitment

Key Risks

1.22. The main risks to the successful delivery of the project will be fully documented with a risk appraisal, more detail is provided in Section 8. The key risks identified to date are listed below:

- inability to progress using the P21procurement route, which is already established;
- an over ambitious programme which cannot be delivered in the timescales set, which would have a detrimental impact on the level of savings achievable by the Trust in 2009/10;
- delays in establishing a robust guaranteed maximum price (GMP) and ensuring value for money within the timeframe;
- delays in decision making on funding priorities within the Trust;
- lack of funds available from capital programme;
- failure to agree design work with users (clinical and non clinical staff);
- alteration to plans of PCT for LGH, leading to a change in plans for the interim reconfiguration;
- delay in delivering decant arrangements leading to delay in savings timetable;
- impact of local community reaction to services physically moving from Hemel;
- increased cost of development due to unforeseen conditions; and
- failure to achieve expected rental from PCT.

2. Introduction

Purpose of Document

2.1. This Strategic Outline Case (SOC) seeks approval to invest an estimated £4.1 million in order to reconfigure services at Hemel Hempstead into a smaller footprint, including the provision of decant facilities at Watford and St Albans. This investment is essential to the Trust's overall financial recovery programme, delivering savings and facilitating:

- the consolidation of the services remaining at the Hemel Hempstead site;
- the establishment of a cohesive 'front door' to continue the flow of patients through Hemel Hempstead to Watford or St Albans; and
- the potential for development of a Primary Care led Local General Hospital (LGH).

2.2. The scheme can be seen as phase 3 of the 'Delivering a Healthy Future in West Hertfordshire (DaHF)' programme. Overall the DaHF reconfiguration consisted 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.

Background

2.3. 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 PCT led Acute Services Review, now Delivering a Quality Healthcare for Hertfordshire (DQHH). 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 that were being faced.

2.4. 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.

2.5. 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.

2.6. 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).

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

2.8. 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 offered a full A&E Department and critical care services until recently (1st November 2008), when A&E services at night were provided only at WGH.

2.9. An Urgent Care Centre has been established on site at Hemel Hempstead, run by a partnership between WHHT and a consortium of GPs running the Out of Hours services. This provides a 24 hour service on the Hemel site, from within the A&E department, using a combination of experienced trained nursing staff and GPs.

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

2.11. The services provided at St Albans have changed considerably over the last few years. This is now the location for the majority of elective care procedures for west Hertfordshire residents, depending on complexity of procedures. This is the result of the phase I implementation of the DaHF programme. There is also 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 and hydrotherapy services operated by the PCT and some inpatient mental health facilities operated by Hertfordshire Partnership NHS Foundation Trust are also located on the site. The latter are due to vacate the site by July 2009.

2.12. 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.

2.13. 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, due to 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 transferred to the Royal Free NHS Trust from the 1st October. The Trust now has only histopathology services running from the Mt Vernon site and is currently reviewing plans to withdraw completely.

Trust Context

2.14. Almost without exception, the condition of all Trust buildings and the infrastructure that supports them is extremely poor, having suffered many years of limited 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 poor environment for patients, staff and visitors. The internal layouts of all sites are not clear making way-finding difficult and confusing for patients.

2.15. Financial stability is essential if the Trust is to retain the prospect of the new hospital as well as future financial stability. The challenge for the Trust is to sustain and improve clinical quality and meet NHS performance standards whilst reducing costs.

2.16. 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 previously 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 has been in danger of deteriorating further.

2.17. This led to the implementation of the DaHF programme of work:

- Phase 1: to segregate planned surgical services from acute non-elective services through the establishment of an elective care centre at St Albans City Hospital;

- Phase 2: to consolidate emergency services, including A&E and Critical Care services at Watford, establishing an Acute Admissions Unit and reconfiguring specialist wards at Watford;
- Phase 3: to reconfigure services at Hemel Hempstead to create a vibrant non-acute hospital site providing a range of outpatient, diagnostic, urgent care and intermediate care services.

2.18. The implementation of phase 1 was the development of the elective care centre at St Albans City Hospital (SACH); this element of the programme was the subject of a Business Case approved by the East of England Strategic Health Authority (SHA) in January 2007 and implemented in September 2007.

2.19. The implementation of phase 2 is the consolidation of all acute services at the Watford General Hospital (WGH) site. This is an interim development that precedes the proposed new hospital redevelopment of the Watford General Hospital site by 2014/15. It allows for service models to be developed and established in advance of the new hospital. The Business Case for this phase was approved in August 2007; there has been significant reconfiguration of services and wards, and the new modular build Acute Admissions Unit (AAU) will open on the Watford site in March 2009. To this end, a significant migration of acute services to the Watford site from Hemel Hempstead will begin during February 2009.

2.20. This business case is concerned with the final phase of the reconfiguration, the interim configuration of services on the Hemel Hempstead Hospital site. This will provide an opportunity to pilot service models and co-locations in advance of the new local General Hospital (LGH), which is planned by the PCT to be established within the next 3-5 years. The interim reconfiguration will provide:

- Urgent Care Centre facilities;
- imaging and diagnostic services (MRI, CT scans, x-ray, blood tests etc);
- full range of outpatient services;
- endoscopy services;
- intermediate care and rehabilitation services;
- GP Led Health Access Centre (new service); and
- co-location of the Intermediate Care Team (new on site).

2.21. The reconfiguration of services at Hemel aims to optimise use of the site ensure that it is as operationally efficient as possible within constraints; that wherever possible improvements in the environment are made and that value for money is delivered.

2.22. Equally, there is a need to understand PCT space requirements and ensure joined up and co-located services for the local population.

2.23. Local out-patient and diagnostics services will remain at Hemel (including x-ray, CT & MRI scanner, elective endoscopy, pathology and mortuary services) and all requisite support services. In addition there is an Urgent Care Centre (UCC) and an intermediate care ward with associated team services. The PCT is also establishing a GP Led Health Access Centre (as part of the D'Arzi recommendations) on the site.

2.24. An interim scheme is needed on the Hemel site for approximately a 4-5 year period, as the PCT propose a new Local General Hospital to serve the local population. There is a separate consultation exercise underway to identify the site for this proposed development led by the PCT. This maybe the existing Hillfield Road site in either new build accommodation or part of the existing estate or could be another location in Hemel Hempstead.

2.25. Whilst awaiting the development of the LGH, the Trust is committed to the creation of a vibrant community hospital. This will be achieved by a phased vacation of estate and reconfiguration of services into fewer buildings. It is intended to vacate whole buildings and secure them. This offers the opportunity to:

- re-align clinical adjacencies within the site;

- make improvements to key areas of patient services, eg outpatients;

- improve the environment for the site which will be the ‘shop window’ for patients choosing to have their acute episode of care with WHHT;
- work with the PCT to align options for space requirements for the interim;
- reduce capital charges;
- make a significant contribution to the financial recovery plan; and
- align the reconfiguration with any potential land release, eg for the new PCT led Local General Hospital.

3. Strategic Context

National and Local Policy Imperatives

National Context

3.1. The NHS is 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 towards shifting 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 December 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, 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.

Local Health Economy Context

3.3. In October 2006, there was a reorganisation of the four Primary Care Trusts (PCTs) to two PCTs, one covering West Hertfordshire and the other covering East and North Hertfordshire. One executive team covering the two organisations manages the PCTs.

3.4. The financial position of the local health economy was fragile for many years however this position has improved significantly.

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[1]'. 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.

3.6. As part of the Delivering Quality Healthcare in Hertfordshire (DQHH), the PCT intends to develop a new Local General Hospital in Hemel Hempstead. Following the DQHH consultation, the Boards of both East & North Hertfordshire PCT and West Hertfordshire PCT confirmed the decision to develop two local general hospitals in Welwyn & Hatfield and Hemel Hempstead at a decision-making event on the 19th December 2007.

3.7. These will be campus style developments that will include the following (though not exhaustive) services.

- Therapy Services
- Mental Health Services
- Palliative Care
- Diagnostics
- Urgent Care
- Maternity Services

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

- Adult Outpatients
- Child Outpatients
- Social Services
- Local Authority Services
- Support Groups
- Intermediate Care Services
- Minor Surgery

3.8. As this will be a major capital development the PCT is required to undertake an in-depth option appraisal of potential sites to be assured that the site selected will provide the most suitable and sustainable location.

3.9. A short list of sites has been prepared by Lambert Smith Hampton, local chartered surveyors working on behalf of the PCT, in discussion with Dacorum Borough Council. These are sites in the locality and would enable the new hospital to be completed by 2012. Staff, local residents and stakeholders will get an opportunity to comment on the shortlist in the autumn 2009.

3.10. The current hospital site (Hillfield Road) will be compared to other potential local sites in Hemel Hempstead using a set of criteria that were agreed at a stakeholder event on 7th July 2008. The criteria includes issues such as accessibility, environmental impact, adjacency to other services and site suitability. A decision on the site of the PCT led new Local General Hospital will be taken early in the new year (January 2009), combining the site appraisal with the financial appraisal.

Trust Strategic Direction

3.11. The national strategic context, the financial position and actions underway to resolve this dominates the short-term strategic direction of the Trust, without financial stability the Trust's ability to meet its statutory obligations and, critically its ability to become a Foundation Trust will be severely affected.

3.12. The implementation of the DaHF programme of works, which is currently underway will be a major contributor to maximise service improvements and financial benefits. The interim reconfiguration of the Hemel Hempstead Hospital site is the final stage in that programme of delivery, which releases the capital charges on a significant number of buildings on the Hemel site and supports the investment in the remaining infrastructure and services for patients.

Future for Hemel Hempstead Site

3.13. The current assumption is that the Hemel hospital site will stay in possession of WHHT until the opening of the new PCT led LGH, the Trust will therefore reconfigure services to ensure provision of care to the local population within a revised footprint of the current site. This is a change to the position outlined in the original business case submission for DaHF in 2007, where the assumption was that the PCT were committed to taking on the site as soon as the acute services had transferred to Watford.

3.14. WHHT will aim to occupy an appropriate footprint on the Hemel site, with the remainder of the site vacated and secured.

3.15. As mentioned above, the PCT is considering a shortlist of 3 sites for a new build for the new local general hospital. The Hemel Hospital site is one of these options, and there does not appear to be an option of 'do minimum' for the planning of the LGH, ie a refurbishment of existing buildings on the Hemel site, although this could be option 2/2a (see below). The timescale for the new build is 3 – 5 years. WHHT are pressing ahead with interim service reconfiguration of the HHGH site immediately following the centralisation of acute services on the Watford site.

Transition to a Local General Hospital

3.16. It is assumed there will be a staged approach to the retrenchment of services at Hemel, firstly following the acute service move, then the second stage before the LGH is operational, although these two stages will merge into one, with the speed of implementation proposed. The services

listed below are those that are at Hemel by default and would not be considered appropriate for including in the new build LGH.

3.17. However, these are not necessarily services that would be moved elsewhere in the immediate reconfiguration that follows the acute service move. The list is shown broadly in order of likely magnitude of cost, together with potential relocation sites. It is likely that these would need to be funded from operational capital although some were anticipated as part of the DaHF business case.

Service	**Potential relocation**	**£m estimate**
Pathology laboratory	Campus/new hospital	-
Mortuary	Review options	-
Medical Records – including receipt & Delivery and Clinic preparation	Centralised store off site	£1.2m
IT File Server Room	St Albans City Hospital	£1 – 1.5m
Clinical engineering / medical electronics	Watford General Hospital	£0.8m
Nuclear medicine	St Albans City Hospital	£0.8m
IM&T support team	St Albans / Watford / off site	)
Business Development team	St Albans / Watford	) £0.3m
Any centralised admin support for WHHT	St Albans / Watford	)

Table 3.1: WHHT transition costs

3.18. The Trust will need to plan these moves into the strategic development of the capital programme and the clinical strategy for services until the opening of the new PCT led LGH.

Overview of Investing in Your Health

3.19. 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.

3.20. 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. This overall service model blueprint shaped the WHHT strategic direction ever since, albeit with two minor changes regarding elective care. One being the decision for WHHT to continue to deliver these services 'in-house' due to the affordability issues associated with the Surgicentre and secondly, a change of location from Hemel Hempstead to St Albans in order to utilise the St Albans City Hospital.

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

3.22. This review 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 indicated the following assumptions in respect of reductions in acute care commissioning:

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

3.23. The Trust was fully involved in the review. The most major change was the location and extent of capital development for east and north Hertfordshire. This has increased the size of the catchment population for WHHT.

3.24. The review endorsed the case for centralisation of acute services for residents of west Hertfordshire at Watford General Hospital.

4. Objectives, Benefits and Constraints

Investment Objectives

4.1 The primary investment objective for this project is to reduce the revenue implications of providing hospital services on the Hemel Hempstead site. With the relocation of acute services to WGH there will be a significant amount of 'vacant' space on the site, which provides opportunity for significant reconfiguration and a reduction in capital and utilities charges.

4.2 The reconfiguration of services into a smaller area of land will reduce revenue costs and provide the Trust with the opportunity for disposal of land.

4.3 The reconfiguration of the site will also deliver a new service model, which will improve the efficiency of the outpatient services.

4.4 Patients and staff will benefit from a more centrally focussed hospital site, with less fragmentation between buildings. Investment in the environment and producing clarity of purpose for the site will deliver benefits of staff recruitment and preferred provider status.

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

Investment Objective	Existing Arrangement	Problems associated with existing situation
Deliver significant infrastructure savings at HHGH	Currently Trust is occupying all buildings at HHGH.	WHHT has to continue paying for these buildings post March 09 when they are only half occupied unless this investment is made.
Maintain good clinical relationships	Existing relationships cannot be maintained post the transfer of acute services to Watford	Existing relationships cannot be maintained post the transfer of acute services to Watford
Maintain the "shop window" of WHHT at Hemel prior to the development of an LGH	Following acute services move, services will be fragmented and remain in poor environment	Service and staff fragmentation, patient perception of poor care, will affect WHHT status of provider of choice.
Maintain and deliver a solution which supports the future development of West Herts Hospitals and new hospital at Watford	Does not enable the Trust to deliver the sufficiently robust financial platform to support the development of the new hospital and become a Foundation Trust.	Does not enable the Trust to deliver the sufficiently robust financial platform to support the development of the new hospital and become a Foundation Trust.

Table 4.1: Investment Objectives

Business Objectives

4.6 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.

4.7 Against this objective the Trust will be working at Hemel in an environment where:

- the current service configuration severely impedes the Trust's ability to deliver additional savings, and invest in the 'front door' to the hospital;
- the Trust's financial recovery plan is dependent on realisation of these savings;
- the current configuration of services across buildings will severely limit the opportunity of clinical teams to work effectively.

Scope of the Scheme

4.8 As stated previously this investment at Hemel can be seen as phase 3 of Delivering a Healthy Future, although this could also be seen as a stand alone investment. It does require the migration of services to the Watford site to happen in order to be implemented, as delivered by the move of acute services to the Watford site. The Hemel scheme delivers a reconfiguration that will leave a safe operational site which will function until the development of the new Local General Hospital by the Primary Care Trust in the Hemel area.

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

- decant of admin services and pharmacy stores from Hemel to Watford;
- reconfiguration of services within the Hemel site to vacate and secure the following buildings:
  - Halsey House
  - Windsor Day Hospital
  - Windsor Wing
  - Cheere House
  - Tudor Wing
  - Medirest Portacabin
  - HR Portacabin
- improved utilisation of the remaining buildings at Hemel Hempstead;
- improvements to the patient outpatient environment;
- re-engineering of the clinical models and patient pathways for outpatient services to improve utilisation potential;
- re-engineering the clinical models and patient pathways in order to improve utilisation potential;
- improving the clinical adjacencies on site to create improved patient services and workforce efficiencies;
- creating space for the PCT to implement the new GP Led Health Access Centre, co-located with the Urgent Care Centre;
- creation of space for the PCT intermediate care team, in order to improve the throughflow of information the appropriate care of patients through their care pathway;
- creation of space for a rapid assessment unit adjacent to the UCC (business case yet to be agreed with the PCT but space allocation is approved) to avoid unnecessary inpatient admissions;
- creation of space for a day treatment service adjacent to the UCC and Rapid Assessment Unit to cater for services that can be given locally, and avoid admission or use of a clinical procedure room, eg blood transfusions, pleural tap etc;
- alterations to the urgent care centre to improve patient flow and maximise efficiency;
- creation of a revised permanent solution for Endoscopy to resolve the decontamination issues and avoid the use of Tudor Wing as a decant facility.

Benefits

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

- patient care will be improved as services are co-located in one area, enabling teams to maximise their expertise;
- less fragmentation of services between buildings;
- revenue savings will be achieved as a consequence of vacating buildings;
- new services will be provided on the Hemel site for the local community.

Constraints

4.11 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 availability of resource to deliver the project in a very tight timeframe, with the implementation of changes on the Watford site happening at the same time;
- the prioritisation of the capital programme to deliver the funding for the implementation of this project;
- the development of the Local General Hospital on the HHGH site as a refurbishment option within 3-5 years which may alter the current layouts and therefore delay the decant and vacation of other buildings;
- the requirement of the PCT to develop interim services at the HHGH site, e.g. UCC, intermediate Care and GP led health clinics; and
- uncertainty about the future location of the Local General Hospital.

Main Risks

4.12 The main risks identified to date are as follows:

- lack of investment in backlog maintenance in HHGH requiring additional funding as this project is implemented;
- inability to decant services to other sites;
- inability to deliver savings in the timescales proposed;
- to turnaround re-design with clinical and non clinical staff
- increased cost of development due to unforeseen conditions;
- longer than Delay in agreement from PCT on funding terms;
- timescales anticipated construction time;
- increased capital costs as a result of the Trust's requirement to deliver the changes quickly; and
- the need to comply to the latest building regulations which may require a high level of works to be carried out than originally envisaged impacting on both cost and time.

4.13 A more detailed risk appraisal is contained in Section 8.

5. Options Consideration

Introduction

5.1. With the implementation of DaHF phase 2 near to fruition, the reconfiguration of the Hemel Hempstead site should happen with immediate effect. The services at Hemel need to be able to operate efficiently as soon as possible to enable a smooth transition into an efficient community service which will encourage patients to choose WHHT as their preferred provider for their care.

5.2. The reconfiguration also delivers a significant level of revenue savings for the Trust (detailed in Section 7).

5.3. The overall aim is to maximise the value and speed of site savings from retrenchment consistent with service requirements.

5.4. The clinical service model uses the ambulatory care principles and has been drawn together with input from individual meetings with clinicians, managers, admin and those directly affected, and clinical service co-locations have been at the focus of the reconfiguration planning to match the essential co-locations and maintain clinical pathways.

5.5. The initial health planning and space utilisation input was provided by Spencer Harrison and Murphy Philipps Architects. The matrix of adjacencies which the reconfiguration would ideally achieve is set out in Appendix 1.

5.6. The PCT led services have also been afforded their clinical co-location requirements in the reconfiguration plans, yet there is a recognition that this comes at a cost, particularly where this has a knock on effect for space requirements of WHHT services on the site.

5.7. In summary the clinical model proposed consists of the following component parts:

5.7.1. A fully supported **out-patient** service, including fracture clinic and orthotics;

5.7.2. **Pathology** services (cold lab on site, hot lab at Watford with robust processes and operational policies that ensure timely effective services and results);

5.7.3. **Pharmacy services** that support the out patient and remaining in-patient services. To include a small dispensary. The main store is centralised at Watford as part of this investment;

5.7.4. An **Urgent Care Centre (UCC)** run by a partnership of Herts Urgent Care and WHHT. This will remain in its current location and be adjacent to the proposed new GP Led Health Access Centre and has one shared reception area from where the patients are directed to the most appropriate service;

5.7.5. A new **GP Led Health Access Centre** that sits adjacent to the UCC as above;

5.7.6. A new **rapid assessment unit (RAU)** for seeing patients (usually elderly) who have been seen by GPs and require a more detailed work-up. This is proposed as adjacent to the UCC and day treatment area;

5.7.7. **Day treatment unit/area** to undertake a whole range of day treatments, some currently performed in the Helen Donald unit (such as administration of Infliximab (biologix), transfusions, liver biopsies, bone marrow biopsies, glucose tolerance tests, lung biopsies, dressings etc.);

5.7.8. **Endoscopy suite** – this will be relocated within the site to address decontamination issues, meeting HTM 2030 guidelines;

5.7.9. **Imaging** – no change to existing services and adjacencies for MRI, CT scanner, x-ray rooms, fluoroscopy etc. Nuclear medicine also remains insitu;

5.7.10. **PCT led Intermediate care ward** (20 beds);

5.7.11. **Acute Rehabilitation Stroke ward** (12beds) ; and

5.7.12. **Contingency ward** (28 beds for up to 6 months following the acute service move).

5.8. A robust infrastructure also needs to be in place to support the clinical services and must be included in the reconfiguration. Some of these are not affected by the proposals for reconfiguration, but must be taken into account to ensure the working relationships are maintained or improved. These include:

- Communications: IT infrastructure; Telecoms; Switchboard/alarm system
- Catering facilities: Canteen/restaurant services (for patients and staff); Tea points for staff and departments
- Administration: Medical/health records; Information Management & Technology (IM&T); Offices (management, administrative, medics and nursing staff); Occupational health; infection control;
- Training: Education and Training facilities; Library;
- Estates: Workshop;
- Facilities management: Medirest (portering, cleaning, catering); Transport
- Supplies: Receipt and delivery; Stores; Surgical appliances
- Patient services: PALS; Patient affairs; Voluntary Services (Age concern, WRVS, League of Friends etc); Chaplaincy/Spiritual and Pastoral Care

5.9. The original options are shown below for information, with an associated option appraisal. In all options, the buildings to be vacated are listed below:

- Halsey House
- Windsor Day Hospital
- Windsor Wing
- Cheere House
- Tudor Wing
- Medi-rest portacabin
- HR Portacabin

5.10. The proposed layout of the Hemel Hospital site is detailed at the end of Section 6.

Hemel Hempstead Reconfiguration Options

Option 1 –"**The Ribbon"**

5.11. This option retains the series of buildings across the middle of the site, plus the Verulam Wing, although one half of the Verulam building is scarcely occupied. This option requires less investment, as the moves are minimised. This would mean the MRI and imaging services, including nuclear medicine stay in main block /Jubilee, and fracture clinic and the UCC remain insitu. Similarly there is no immediate need to move the IT fileservers (in QE block) which are a significant cost, both in time and money.

5.12. Movements are limited to those services that need to vacate Tudor Wing and Windsor Wing (the same for all options), plus respiratory care, cardiology, paediatric outpatients, womens services, patient affairs, facilities and various admin / office areas.

5.13. Although the option of vacating half of Verulam has been explored, this does not appear financially or practically viable, due to various plant issues (gas supply) and also the financial rules for saving capital charges. Therefore, this option has been costed with the potential to house the centralised medical records store in the Verulam Wing.

Pros	**Cons**
Causes least disruption to clinical services	Full potential of savings from release of buildings is not achieved (as per DQHH business case)
Will have least impact on clinical activity	Financial rules indicate it will be highly unlikely to release capital charges as a result of vacating half of verulam
Meets the service co-location requirements	Fabric of buildings is poor.
Offers an option to centralise WGH & HHGH medical records within the vacated half of verulam wing	Cost of moving plant and gas main supply negate the benefits of vacating half of verulam
There would be space to vacate the Maynard Road house occupied by ACS	Less flexibility for disposal of Hemel site
There may be opportunities for other health partners to occupy space in verulam and pay rent	
Consolidates high volume activity areas into the middle of the site, OPD / UCC	

Table 5.1 Analysis of Option 1

Option 2: "Verulam plus new extension"

5.14. This option moves as many services as possible into the Verulam Wing and vacates all other buildings on the site. There has been a significant shortfall in the space requirements identified in this option, even with an extension planned.

5.15. Movements of services in addition to those from Tudor wing and Windsor wing, would be: MRI and imaging (nuclear medicine likely to go to St Albans if moved); UCC; cardiology, Paediatric outpatients; women's services; fracture clinic and surgical appliances; dermatology; facilities, patient affairs and various admin and office space.

Pros	**Cons**
Full potential of savings from release of buildings to be made.	Will have significant impact on activity during works
Concentrates all services in one focal building.	Down time in relation to diagnostics will be high, or costs of decant and temporary facilities
Meets the service co-location requirements	Shortfall in space for some areas, still to be resolved
More flexible disposal arrangements for the rest of the Hemel site (potentially cash benefit)	Brings forward the investment required to relocate some non LGH services – ie IT File Server, clinical engineering, medical records
	There would not be space to vacate the Maynard Road house occupied by ACS
	Requires planning permission for extension
	Likely to increase the value of the building (subject to DV Valuations), therefore the capital charges will be higher
	Issue with making the business case stack up from value for money, given the life of the asset.

Table 5.2 Analysis of Option 2

5.16. The following assumptions are made with Option 2:

- There is an off-site capital solution for medical records, IT file servers, nuclear medicine, clinical engineering and some administration/support services.
- It is assumed that as there are WHHT services displaced to accommodate the PCT service clinical co-locations, cross charging would apply for the direct capital costs. That is, even if the PCT did not occupy the new extension that would be required, this would be at the PCT's cost, as WHHT are displaced.
- A mobile unit for MRI is assumed, which is shown on top of steel structure on top of the paediatric extension. The logistics of this are yet to be fully tested, although locating an MRI at the top Verulam entrance has been confirmed by suppliers and the estates department. This does not achieve clinical co-locations and may have an impact on workforce requirements

Option 2a: "Verulam plus Windsor Day Hospital"

5.17. This option is as described above, but instead of a totally new build extension, this makes use of the Windsor Day Hospital. This still requires all the off-site solutions and the same assumptions apply as noted above. Table 5.3 below shows only new or alterations to the pros and cons listed above in Table 5.2.

Pros	Cons
Less of an issue regarding planning permission	Likely to increase the value of the building (subject to DV Valuations), therefore the capital charges will be higher
Less capital charges, as less new building	Will have significant impact on activity during works
Less capital investment	Down time in relation to diagnostics will be high, or costs of decant and temporary facilities
	Shortfall in space for some areas, still to be resolved
	Brings forward the investment required to relocate some non LGH services – ie IT File Server, clinical engineering, medical records
	There would not be space to vacate the Maynard Road house occupied by ACS

Table 5.3 Analysis of Option 2a

Financial Appraisal

5.18. A summary of the capital costs and the likely revenue consequences is detailed below in Table 5.4. Given the short timescale of the investment, only Option 1 (or a variant, as described in Section 6) is a viable proposal. The additional savings in Option 2 and 2a do not cover the additional costs of the investment in sufficient time to make the investment worthwhile.

Option	Option 1	Option 2	Option 2a
Capital Cost (£'000)	7,709	18,620	16,665
Annual Savings, FYE (£'000)	3,205	3,999	3,980
Payback Period (in years)	2.41	4.65	4.18
Remaining Backlog maintenance (£'000)	2,600	2,000	2,250
Net Present Cost (£'000). Based on an appraisal period of 5 years	29,616	34,385	32,991

Table 5.4: Capital & Revenue Costs by Option

5.19. A sensitivity analysis has been run to ascertain the point at which any delay in delivery of the LGH makes the alternative options of 2 or 2a the preferred option. The appraisal period would need to be extended to 22 years before Option 2a would have a lower Net Present Cost than option 1.

Conclusion

5.20. Both of the variants for Option 2 require significant capital investment and have a long lead in to deliver the reconfiguration on the Hemel site, due to the amount of disruption and decanting required.

5.21. The Trust has therefore pursued variations of Option 1 to deliver a configuration based on the principles of:

- best clinical adjacencies;
- least disruption;
- least enabling works;
- speed of ability to implement;
- minimal capital investment; and
- maximum financial savings.

6. Preferred Solution

Description of Preferred Option

6.1 Further work on Option 1 to optimise the solution and minimise disruption to patients and clinical services has resulted in Option 1e,. This retains the principles of Option 1, albeit refined for a more effective configuration of services between the buildings and a more efficient implementation programme. This adheres to the principles outlined in Section 5 and has been refined to achieve the best clinical adjacencies, the least disruption, the least enabling works and the least capital costs within the constraints of the timetable whilst delivering revenue savings.

6.2 The revised capital costs and likely revenue consequences for Option 1e are shown in Table 6.1 below.

Option	**Option 1**	**Option 1e**
Capital Cost (£'000)	7,709	4,090
Annual Savings, FYE (£'000)	3,205	3,204
Payback Period (in years)	2.41	1.28
Remaining Backlog maintenance (£'000)	2,600	2,600
Net Present Cost (£'000). Based on an appraisal period of 5 years	29,616	26,228

Table 6.1: Analysis of Capital and Revue Costs for Options 1 and 1e

6.3 The required outline functional content by building is detailed in Appendix 2.

6.4 There are some key enablers which are outlined below. More detail is shown in Appendix 3 – which gives a breakdown of the movements of services by building.

- the endoscopy department will be re-located to Safari ward, which enables a quicker resolution for the required decontamination works and a single decant;
- pharmacy stores will use the AAU, enabling a quicker move of both supplies and therapies into the vacated space in Jubilee Wing. This will reduce the capital required and saves additional revenue consequences;
- the Contingency ward will be located in Churchill ward, in Verulam Wing, with no alteration. The Stroke ward will relocate to Simpson Ward;
- the PCT Intermediate Care ward will relocate from Lancaster ward to St Peter's Ward in Verulam Wing, with no alterations – subject to agreement of funds and timescales;
- outpatients will be relocated into the Cath Lab / CCU area (L2 Verulam Wing), and cardiology will co-locate with respiratory in the Chest Clinic (L3 Verulam Wing); modular facilities or the day hospital for decanting either outpatients or cardiology services will facilitate the earlier vacation of Tudor Wing; and
- Cheere House, education / training and library facilities will relocate to Verulam Wing (L1), depending on design solution for Endoscopy space, or may have to run with a split service until more space is available.

6.5 The vacation of the different buildings requires specific consideration of the relocation of services. This is detailed in the sections below:

Vacation of Windsor Day Hospital

6.6 This can be achieved with the relocation of consultant and admin offices, and the relocation of 5 patient clinics. Actions are underway to relocate the clinics with appropriate space. There is potential for this to be achieved by the **end of February 2009**.

Vacation of Windsor Wing

6.7 York and Stuart wards (Windsor Wing) will close when the acute services move across to Watford. The PCT intermediate care ward (Lancaster) will relocate to St Peters Ward (Level 3, Verulam Wing). It is assumed there will be little or no works required to transfer the ward. Discussions have taken place with the PCT to ascertain their requirements. A draft specification and 'Heads of Terms' are being drawn up.

6.8 Stroke services will relocate to Simpson ward and it is planned to run the contingency ward from Churchill Ward. The "contingency ward" is funded by the PCT for 6 months to manage the transition of services from Hemel to Watford and implementing the new model of care within the Acute Admissions Unit. Given the reduction in the number of beds for stroke services, this will still allow the area known as the Helen Donald Unit to offer space for blood transfusions and day treatment until the Jubilee Wing is ready to accommodate the service. There may be some minor works required to accommodate the stroke ward, and there may also be a delay in the vacation of one of the wards to accommodate the 'tail end' of patients following the move of the acute services. Therefore it is expected that a vacation of Windsor Wing will be achieved by **end of April 09.**

Vacation of Cheere House

6.9 It is proposed that this is achieved with the relocation of education and training meeting rooms into Safari Ward, alongside the proposed Endoscopy service. This is dependent on the outcome of the feasibility study, as design work is currently underway to assess the space available in Safari once Endoscopy has been accommodated. The contingency plan would be to have a split training and education service, on Safari (Verulam L1) and Hemel Birth Centre area, L3. There may be a need to have a limited service availability during Feb/March. If it were acceptable to have limited provision of education and training facilities over the period from February – April, then the vacation of Cheere House could be achieved by **end of March 09.**

Vacation of Tudor Wing

6.10 With an alterative location for the Endoscopy programme of works (Safari Ward, level 1 of Verulam Wing), the critical path now highlights the move of outpatients and also the move of therapies on the critical path. These are linked to the relocation of cardiology OPD and pharmacy stores respectively.

Pharmacy Store relocation to Watford

6.10.1 The pharmacy store releases space in Jubilee Wing, on two floors. The lower level is planned for conversion to the store for supplies as a receipt and delivery point. This needs to be fully tested as a solution, but offers access for delivers and re-routing around the remaining buildings. Level 2 of Tudor Wing offers the second part of the space required by therapies, as part of their relocation from Tudor Wing.

6.10.2 The original solution for pharmacy stores is to convert the old pharmacy building in Watford, once this is vacated in late February 09, with an already revised cost of £550k. The conversion works could start in mid March and vacation of the building at Hemel could be achieved by mid June 09, assuming a 12 week works programme. This means vacation for the part of therapies and supplies could be achieved by end of Aug/Sept 09.

6.10.3 However, the assumption in option 1e, is to use an alternative solution of AAU, "room 12.01" suite of rooms to facilitate the earlier vacation of Tudor Wing. These rooms would be available from February to start works for the conversion to a pharmacy store. There would only be minor works required in the AAU rooms to accommodate the pharmacy store, therefore this could potentially be completed within 4-6 weeks. There are issues with deliveries and access which would need to be resolved. This would an enable a timetable to vacate Tudor Wing **by June 09** into Jubilee Wing for therapies, speeding up the decant by approximately 3-4 months.

Outpatients

6.10.4 The works to the outpatient area cannot start until the vacation of the cath lab / critical care unit (CCU) as part of the relocation of acute services. The earliest the first part of the work could start is mid February 09. Cardiology services (L2) are proposed for relocation to L3, pending works in this area, then the final reconfiguration for the Outpatients area can be completed.

6.10.5 To speed this process up, option 1e assumes use of the day hospital and a modular facility to provide clinic space in the interim – either for the majority of outpatients or for the cardiology outpatient service. This will speed up the vacation of Tudor Wing and can be aligned with the other timetabling to minimise expenditure whilst maximising savings. As a minimum, the relocation of Cardiology outpatient to L3, alongside respiratory outpatient could be located in a modular facility immediately in March (or use the day hospital depending on cost/savings) as this will enable a quicker start to the works required in the CCU /Cath Lab areas.

Timetable

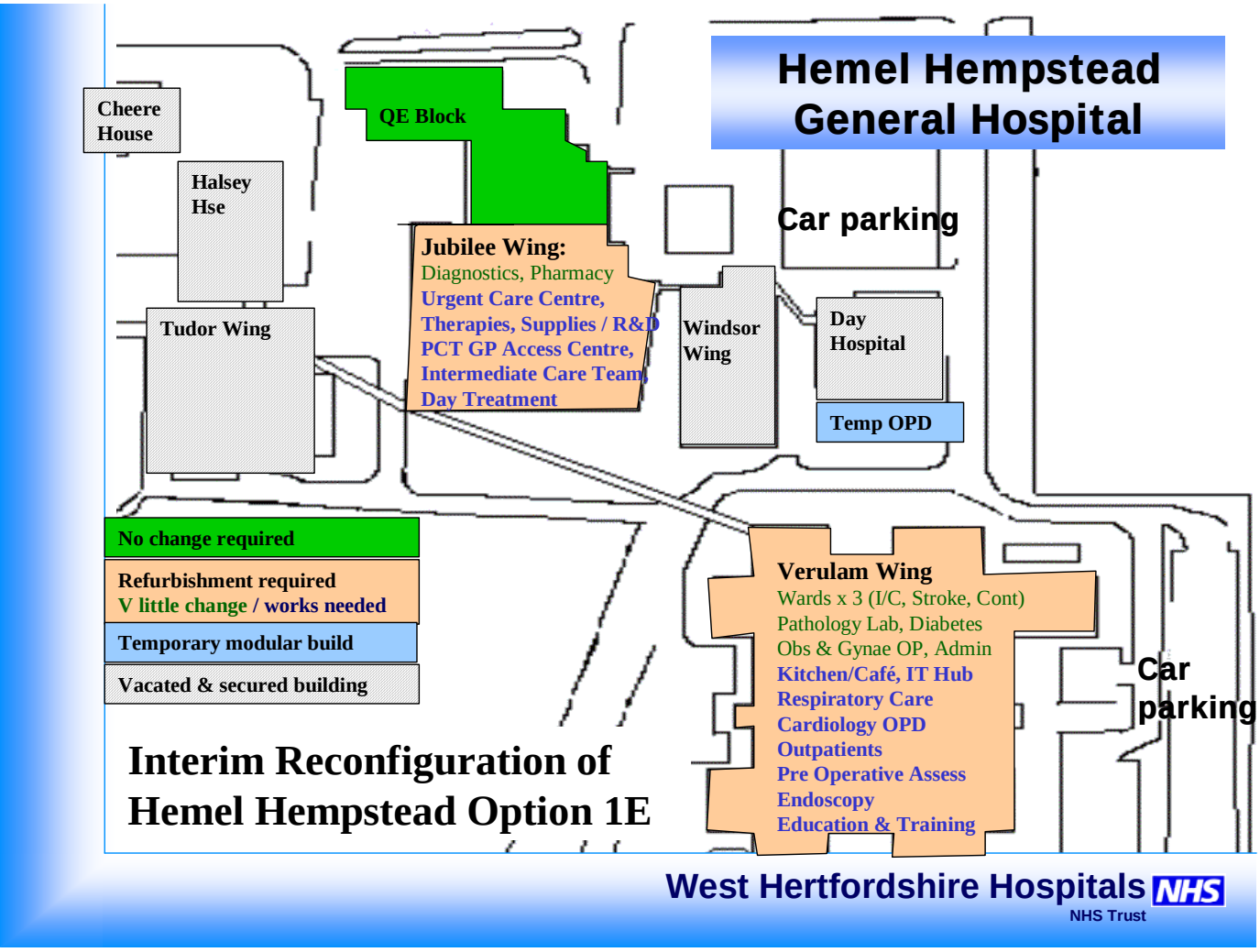
6.11 The indicative timeframe for vacation of the various buildings on site is as shown in Table 6.2 below. This is dependent on availability of funds; efficient turnaround of any redesign of areas (particularly sign off by users); dedicated resources for implementation; new decant facilities at Watford; and the implementation of the transition to the Watford site to the planned timescales.

Building	**Option 1e**
Halsey House	Vacated end of Dec 2008
Windsor Day Hospital	Vacated end of February 2009
Windsor Wing	Vacated end of April 2009
Cheere House	Vacated end of March 2009
Pharmacy Stores	Vacated end of March 2009
HR Portacabin	Vacated end of June 2009
Medirest Portacabin	Vacated end of June 2009
Tudor Wing	Vacated end of June 2009

Table 6.2: Proposed timetable for vacation of buildings

6.12 The revised layout for the Hemel Hempstead site is shown in Figure 6.1 overleaf. This shows the implementation of the reconfiguration plans outlined in Option 1e above.

Figure 6.1 Proposed Interim Reconfiguration of Hemel, Option 1e



7. Affordability

Economic appraisal

7.1 The preferred option scheme offers a significant return in revenue savings for a relatively minor capital investment, in anticipation of further reorganisation of services in 3-5 years time with the PCT led development of the Local General Hospital.

7.2 Table 7.1 summarises the savings available by vacating buildings:

Summary Costs / Savings Option 1e	**Capital cost £'000**	**Savings 09/10[2] £'000**	**Savings 10/11 FYE £'000**
Halsey House	50	164	164
Cheere House	250	172	172
Windsor Day Hospital	35	133	133
Windsor Wing	72	756	815
HR Portacabin	9	0	0
Medirest Portacabin	31	16	20
Jubilee Wing	486	0	0
Enabling in Verulam	362	0	0
Tudor Wing	2426	1,458	1846
General on site	369	0	0
Verulam		29	54
Total potential Revenue Saving (not including additional income from the PCT)	**4,090**	**2,727**	**£3,205**

Table 7.1: Potential savings by building

7.3 It should be noted that as a result of the investment being funded by the Trust depreciation, any additional capital charges would be absorbed within the Trust depreciation provision. However, it is unlikely that the value of the assets will be enhanced by the level of investment, potentially resulting in a saving on depreciation.

7.4 The savings in the DaHF business case were predicated on the transfer of the Hemel Hempstead site to the PCT. The target is shown in Table 7.2 below:

	£m
Capital Charge Savings	3.8
Utilities	1.4
FM Savings	1.0
Rates	0.5
Consultant Outreach costs	-2.1
Total Hemel Savings	**4.5**

Table 7.2: Original DaHF Savings Plan

7.5 As a result of the change in the position of the PCT, WHHT now needs to maximise the savings from this interim site configuration to try and achieve the target set out in the recovery plan.

7.6 The revised and current position is that the Trust will, in the medium term, retain the ownership of the Hemel site. Therefore the current position on the Hemel savings is set out in Table 7.3.

[2] This takes no account of any changes in capital charges as a result of the proposed investment

Summary	2009/10, £k	2010/11, £k
Savings on buildings	2,727	3,205
Urgent Care Centre (not yet agreed by PCT, basis of original profile of UCC rent)	650	650
Income from PCT, related to GP Led Health Centre / Intermediate Care Team Services	To be confirmed	To be confirmed
Intermediate Care (assumed recharge to PCT based on £350/m2)	191	191
Contingency Ward (part of £850k agreed by the PCT, £350/m2)	85	
Total	**3,653**	**4,046**

Table 7.3: Hemel Savings Plan

7.7 The Trust will also be in negotiation with the PCT to agree the most appropriate route to fund the changes required to their developments and changes on site and to secure the appropriate rental charges.

7.8 Given the WHHT's current Health Care Commission rating of fair/fair, the Trust's approval limit for business cases for capital developments has increased to £8 million, and this scheme is within this delegated limit.

8. Risk Appraisal

Risk Appraisal

8.1 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.

8.2 The risk regime developed for use with major capital schemes, first used in DaHF, will be applied to this scheme. The risks and issues will be recorded and managed through use of the Trust's DATIX system and with the Trust risk leads.

8.3 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.

8.4 The table below highlights the key issues and risks to date for the Trust to manage in the delivery of the HHGH scheme (Table 8.1). It also defines a high level strategy for managing and mitigating these risks.

Description	**Probability**	**Impact**	**Crystalisation**	**Mitigation Strategy**
Inability to make identified savings	Low – Savings have been carefully worked through and are likely to be achieved	High – depending on the level of shortfall	Programme of works indicates longer timescale; more detail work on budgets	Monitoring programme of works; early review of budgets.
Longer than anticipated construction time	Medium – detail construction programme yet to be finalised	Medium – may delay decants and vacation of buildings	Programme of works indicates longer timescale	Early engagement of the P21 partners, Medicinq Osborne. Review of the programme of works; review potential solutions in specific areas as they arise.
Timetable is delayed with failure to agree an initial Guaranteed Maximum Price assuming procurement route is P21	Medium – time available for negotiation of GMP is limited due to speed of required implemented	High – WHHT would have to accept higher cost or delay in timescales in order to progress negotiation of GMP	Sub contract packages are higher than expected.	Set a target cost and ensure there are review points to analyse sub contract packages against this.
Lack of design sign off within timetable from clinical and non clinical staff	Medium – Managed through immediate direct contact	High – difficulties in implementing change if not supported by clinicians.	Failure to agree sign off on design templates	High profile clinical leadership to drive and implement change. Appropriate project management arrangements. Subject to procurement route, relationship with Medicinq Osborne

Description	Probability	Impact	Crystalisation	Mitigation Strategy
				has delivered expedited results
Increase in cost of development due to unforeseen conditions	Medium– Scheme now supported by initial design, risk around condition when building starts	High	Initiation of works reveal requirement for extra work	Develop good communication channel between contractors and Estates Department to alert project team asap. Early assessment of estates risks already underway.

Table 8.1: Key Risks and Mitigation Strategy

9. Project Management Arrangements

Programme Management Arrangements

9.1 The Trust has put robust project management arrangements in place to manage this project. This approach reflects the principles of programme management and uses elements of the PRINCE 2 project management methodology.

9.2 The scheme is the third phase of the DaHF programme of works, which comprises of portfolio of projects concerned with delivering strategic change in the Trust.

Project Reporting Structure

9.3 The DaHF Project Board reports to the Trust's new hospital Programme Board, a formal sub committee of the WHHT Board. This ensures a coordinated approach to strategic development within the Trust. The Hemel Hempstead Reconfiguration Project Team is accountable to the Programme Board and each sub group is accountable to the Project Team for the implementation of their element of the project.

Project Roles and Responsibilities

9.4 As stated above the project has been structured using the programme management principles and reflecting the PRINCE 2 project management methodology. The Senior Responsible Owner (SRO) is Jan Filochowski, Chief Executive. The Programme Board is already established, the membership of which is detailed below:

- Jan Filochowski - Chief Executive (Chair)
- Sarah Wiles - Director of Strategic Planning
- Graham Ramsay - Medical Director
- Margaret Ashworth - Director of Finance
- Stephen Lloyd - Director of Estates & Facilities
- Sarah Childerstone - Director of Human Resources
- Gary Etheridge - Chief Nurse, Director of Quality
- Russell Harrison - Director of Operations
- Nick Evans - Director for Partnerships
- Mahdi Hassan - Non Executive Director
- Robin Douglas - Non Executive Director

In Attendance

- Louise Gaffney - Deputy Director of Planning

9.5 The Project Board is accountable for the overall success of the project and meets 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;
- sanction plans and action;
- authorise commitment of project resources; and
- agree the project timetable

9.6 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 weekly to:

- agree business case content and deliverables;
- set targets and agree a project control system to ensure delivery of the programme objectives;
- review and approve the deliverables;
- review and approve any changes to programme plans;
- provide advice and guidance on further work and content within each project stream which maybe required;
- review and approving proposed action plans;
- sign off each completed phase;
- authorise the start of each stage of the project;
- ensure that all deliverables are complete and delivered;
- project manage and co-ordinate the different work streams that are required to produce business cases in the required timescale;
- Ensure effective communication and involvement of the divisions and teams they are representing; and
- ensure effective decision-making that delivers and adequately resources the programme.

9.7 The Project Team is supported by:

- Operational Group
- Human Resources
- Communications

9.8 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.

9.9 The Project Team consists of the following members:

• Sarah Wiles	-	Director of Strategic Planning
• Louise Gaffney	-	Deputy Director of Planning
• Rob Emmins		Hemel Reconfiguration Project Manager
• Brian Hargreaves	-	Design Team Manager Estates
• Simon Green	-	Div Mngr, Emergency & Acute Medicine
• Ruth Connolly	-	UCC / RAU / Elderly Care Services
• Fiona Mitchell	-	Modern Matron (Medicine)– in lieu of new appointment to manage transition at HH
• Kate Jones	-	Women and Childrens Services
• Elaine Donald	-	Outpatient Services & Clinical Support
• Paul Mosley	-	Acting Director of Facilities and Estates
• Jacky Jones	-	Operational Reconfiguration Manager, HH
• Richard Ingram/K Axtell	-	Estate Hemel Site Lead
• Dr Ian Barrison	-	Clinical Champion
• Katrina Hall	-	Therapies representative
• Graham Wright	-	IT Programme Manager
• S McGowan/M Skilton	-	IT Project Managers
• Jo Brown	-	Head of Technical Services
• Bill Wilson	-	Capital Planning Projects Manager
• To be appointed	-	Capital Accountant
• To be confirmed	-	PCT representative

Timescale

9.10 Given the need to realise savings as soon as possible, and the imminent decant of services across to the Watford / St Albans sites as part of DaHF phase I and II, the Trust is keen to implement this proposal immediately.

9.11 This phased programme begins with the transfer of administrative / management services to the Watford site and the centralisation of the pharmacy store at Watford. This part of the programme should be implemented immediately in order to facilitate the decanting and reconfiguration within the site at Hemel.

9.12 The project will take a total of 7 months to complete, with significant milestones or tollgates achieved during that period.

Use of External Advisors

9.13 In line with 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
Medicinq Osborne	Procure 21
Murphy Phillipps	Architect
	M&E Engineering
	Traffic
	Health Planner
Turner Townsend	Cost Consultants
	Structural Engineers
	Planning Supervisor
Sedgwick Igoe	Business Case - financial

Table 9.1: Trust Advisors

10 Conclusion & Recommendation

Conclusion

11.1 To conclude, this SOC details the Trust's intention to reconfigure Hemel Hempstead as an interim solution, which will be in place until the opening of the PCT led Local General Hospital. The interim configuration includes the creation of space for various PCT requirements.

11.2 This service reconfiguration delivers benefits for patient care and will enable the Trust to make better use of its resources and facilities than would be achieved if no reconfiguration were to take place, in addition to delivering savings for the Trust.

11.3 The Trust will deliver more operationally effective services and will benefit financially from this scheme as a result. This scheme forms an essential facet of the Trust's overall financial recovery programme.

11.4 The reason for undertaking these changes is to enable the Trust to improve its financial position by releasing c. £3.7m in 2009/10 and subsequently £4.1m per annum. The cost of achieving this is in the region of £4.1million, subject to confirmation of the detailed capital costs (which will be developed further at Outline Business Case Stage).

11.5 As a result of the change in position by the PCT with regards to the ownership of the Hemel site, the Trust needs to reconfigure immediately to achieve the savings plan originally submitted in DaHF.

11 Appendices

Appendix 1 - Matrix of Clinical Adjacencies

Appendix 2 - Outline Functional Content

Appendix 3 - Components and Timetabling to Vacate Buildings

Appendix 4 - Phasing of Financial Savings by building