West Hertfordshire Teaching Hospitals NHS Trust

Agenda Item: ***x***

Summary and Conclusions: Preferred Options – Emergency and Specialist Care and Planned Care

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Background

1. This paper summarises the outputs of the work undertaken to arrive at 'preferred options' for the Emergency Care site and the Planned Care sites and to make recommendations on that basis. This is the culmination of extensive work undertaken by the programme team and a range of specialist and professional advisors during 2020 and 2021.

2. The paper also highlights the key steps in the Business Case process and the purpose of each step in that process. Next steps are also identified.

Business Case Process and Purpose

3. The Business Case process, as set out in the 'Green Book' (*Central Government Guidance on Appraisal and Evaluation*) and 'The Business Case Guidance for Projects' published by Her Majesty's Treasury (HMT) identifies three key approval and assurance stages:

   - ***The Strategic Outline Case***: this sets out the key strategic drivers behind a proposed investment to inform the high-level **scope** of that investment. An appraisal process is undertaken that identifies a long list of potential solutions, from which a shortlist is selected for more detailed appraisal to support identification of a preferred way forward. The SOC provides a high-level assessment of costs, risks and benefits of the preferred way forward for further refinement and development in the Outline Business Case.

   - ***The Outline Business Case***: this sets out a more detailed appraisal of shortlisted options based on a further assessment and confirmation of the strategic drivers and identifies any key changes from the SOC. The OBC then uses the more detailed economic appraisal to select a preferred option, which balances cost, benefits and risk, whether the investment is affordable (in capital and revenue terms) and how the trust will **plan** and manage its activities to ensure deliverability of the preferred option. This is the stage the trust is currently at in the development of these investment proposals.

   - ***The Full Business Case***: this is the final point of approval. It sets out the process the trust has been through to select a partner to implement the preferred option and a detailed description of the preferred solution which will actually be **delivered**. It sets out how the associated costs, risks and benefits will be managed. Value for money and affordability of this preferred solution will also need to be demonstrated

The ‘Five-Case Model’

4. Each of these stages and the resultant documentation divides the Business Case into five separate but interdependent chapters:

    - *The Strategic Case* – sets out **why** an investment is being proposed and **what** are the potential options to deliver that investment. This is established at SOC stage, reviewed and refined in the OBC, but is less dominant in the FBC (as the Strategic Case has been accepted by then).

    - *The Economic Case* – sets out **which** options are the most economically advantageous and which should be selected as the preferred option after a thorough analysis of costs, benefits and risks. This case is important at OBC stage and selects a preferred option for further development to complete the remainder of the OBC. At FBC stage, the economic case identifies the most economically advantageous solution for the preferred option following a procurement exercise to identify a partner to implement the option (in this case a building contractor).

    - *The Commercial Case* – sets out the likely method to select a partner with **whom** to implement the preferred option, within the public procurement rules and the scope and likely cost of the preferred option. It is not really a factor at the SOC stage, but is important at OBC stage. In the current context the commercial case will be significantly informed by the national New Hospital Programme commercial strategy which is currently being developed. At FBC stage, the Economic and Commercial Cases work in tandem to identify the cost for undertaking the implementation of the preferred option, following a procurement exercise, and the value for money of this solution following a competitive process or rigorous benchmarking. At FBC stage, the Commercial Case will also identify the contractual arrangements to be put in place between the trust and contractor and how this affects cost, time and risk.

    - *The Financial Case* – examines **how much** the preferred option will cost in capital and revenue terms (whilst allowing for risk and uncertainty) and the impact that the identified benefits will bring to the overall affordability of the preferred option. At OBC stage the financial case also examines key points of sensitivity which demonstrate how much key factors would have to vary before the identified option ceases to be preferred and the likelihood of these variances is assessed. This effectively tests the robustness of the preferred option identified. At FBC stage the finance case demonstrate in detail the affordability of the solution to implement the preferred option which has been identified with the contractor and the impact of the contractual arrangements.

    - *The Management Case* – sets out **who** will implement the solution (from the contracting authority and the contractor) and who is responsible for delivering benefits and managing risks. It also sets out **when** key actions are expected to be delivered (for example, start on site, completion and when benefits are to be realised) and **how** this will be done and monitored – through programme management, governance and assurance structures in line with good and best practice. At SOC stage this sets the overall framework. At OBC stage it includes a more detailed assessment of how the procurement process will be managed and plans for risk and benefits management based on the preferred option.

      At FBC this is much more detailed setting out the key interfaces between the trust and the contractor, how these will be managed and much more detailed assessment of how costs, risks and benefits will be managed to deliver the required outcomes based on the preferred solution.

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The Strategic Case

5. A draft of the Strategic Case (not be confused with the Strategic **Outline** Case) has been developed, setting out the key national, regional and policy drivers which underpin the scope of the scheme and the resultant analysis. The draft will be further refined and finalised over the coming months for final approval within the completed OBC.

6. The trust has been through an extensive exercise, with key partners from Herts Valleys CCG to determine the likely demand and capacity that is expected to be generated due to:

   - Changes in the number and age profile of the population served (demographics, based on statistics from the Office of National Statistics).

   - Changes in local factors affecting the likely demand for services (non-demographics based on historical trends).

   - National targets and expected standards: such as waiting times in emergency departments, access to diagnostic facilities (and particularly to increase the provision of x-ray/imaging facilities and endoscopy facilities) and numbers of ensuite inpatient rooms.

   - Separation (as much as possible) of emergency and planned care facilities, which is in line with the trust's Clinical Strategy and the NHS Long Term Plan.

   - Occupancy of inpatient beds: the trust's current occupancy regularly exceeds 90% for emergency (non-elective) beds (which are the majority of the trust's beds). Based on good practice benchmarks (from NHS England & Improvement) and in line with discussions with the NHP, the trust has increased the number of beds from those in the SOC in order to reduce occupancy to 85% for emergency beds and to maintain occupancy of elective beds at around 92%. There is good evidence to suggest that planning for 85% occupancy in emergency beds aids patient flow and improves the patient experience because it reduces the instances of moving patients due to peaks in demand and / or not having sufficient numbers of 'appropriate' beds (bearing in mind the need to allocate beds according to gender, clinical need and infection status).

   - Utilisation of facilities: the trust has also examined how efficiently facilities such as outpatient rooms, diagnostic facilities (e.g. x-ray and endoscopy) and treatment facilities (such as cardiac catheterisation lab and operating theatres) are used: by bringing such facilities into closer groupings (rather than distributed across a site or sites) and improving delivery models they can be used more efficiently and effectively.

   - Out of Hospital Care: how more care can be provided appropriately in the community or at home, supported by digital technology (such as the Virtual Hospital).

   - The case also considers the impact that the trust's digital strategy (aligned with national policy) will have in supporting and underpinning all the above.

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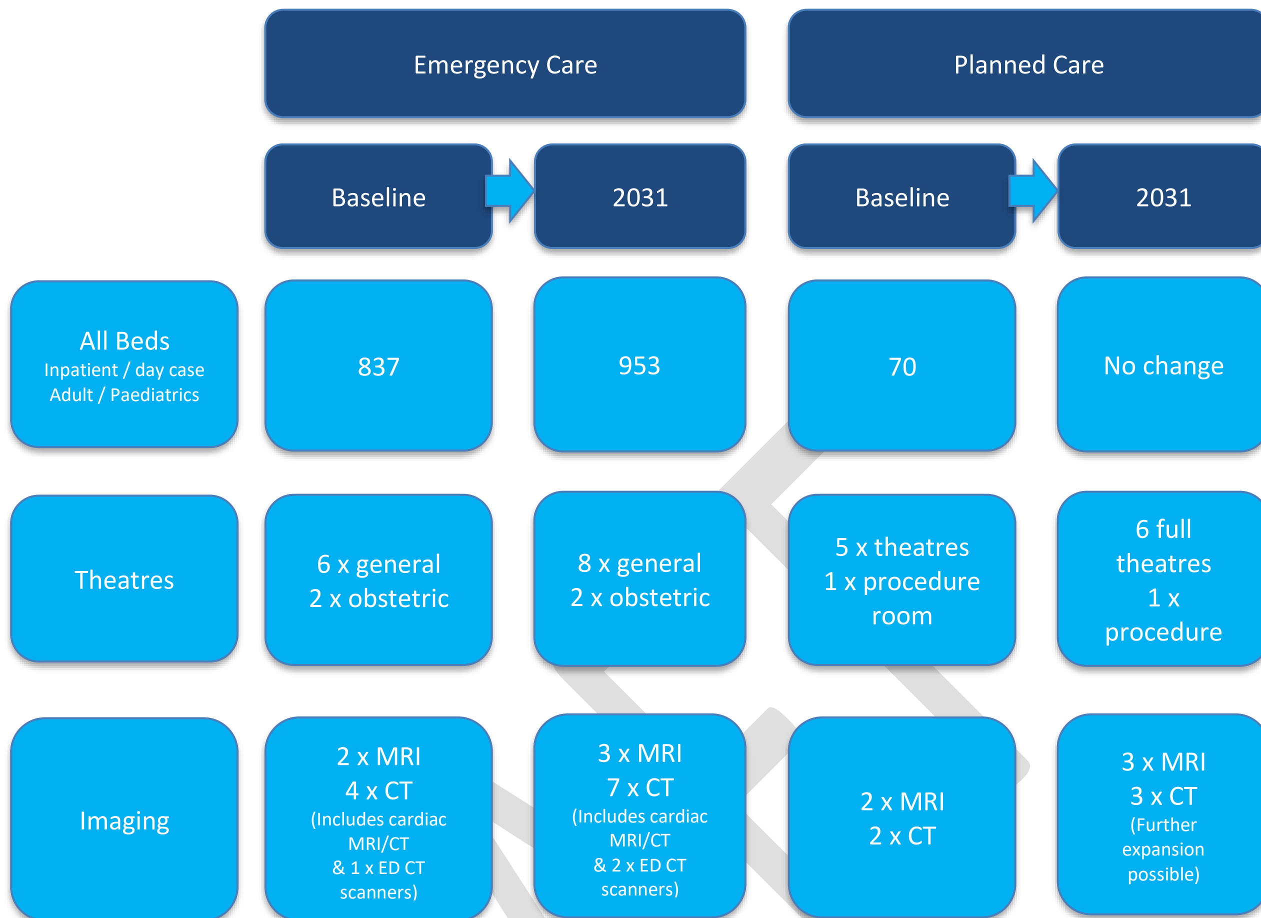
7. In summary and taking all these factors together the following capacity is planned:



8. The Strategic Case also sets out the case for change based on these demand and capacity projections and the state of the current estate – in terms of configuration but also in terms of condition. The trust's estate is in dire need of major investment to improve the fabric of our buildings, to improve the surrounding infrastructure, to move towards net zero carbon and to improve the levels on technology support across the trust to support patient care.The shortlisted options in the Strategic and Economic Cases identify the continuum of options from 'Business as Usual' (maintaining the estate as it is now but adding some additional capacity as investment allows), through 'Do Minimum' (the absolute minimum required to meet capacity requirements and the challenges of failing infrastructure) with some investment in digital infrastructure (driven mainly by the suitability of the estate to accept these technologies) and onto more extensive refurbishments (to meet expected standards, especially for the size and number of single, ensuite inpatient rooms).

9. The strategic case also summarises the engagement, involvement, and communication that the trust has undertaken with patients, staff, local people, the CCG, other health partners and other public bodies in developing the clinical strategy and model of care and how this is translated into the options which have been described.

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Economic Case

10. The Board is presented with a final draft of the Economic Case. This has been prepared using inputs from the architect-led design team for capital costs, the estates workstream for capital risks, the finance & activity workstream for revenue costs, risks and benefits, the digital workstream for the costs and benefits associated with that (over and above the recently implemented Electronic Patient Record) and the clinical workstream for the clinical design input into the shape, scope and efficiency of each option.

11. The final output of the economic case is (as shown in table 50 of the economic case):

	Planned Care	Emergency Care	Combined preferred option
NPSV (£m)	87	1,468	1,555
BCR	2.25	4.19	3.93

12. This indicates that the overall redevelopment achieves a benefit to cost ratio (BCR) close to 4. Although not a hard and fast rule, this is the preferred value as it is close to the assessed BCR for the NHS on a day-to-day basis.

13. The Net Present Social Value (NPSV) is defined in the HMT Green Book as being: *"..the present value of a stream of future cost and benefits to UK society (that are already in real prices) that have been discounted over the life of a proposal by the social time preference rate*". This means that £1 in the current year is worth marginally less in the next year and HMT set the value by which this decreases (the 'discount rate'). This effectively says that £1 today is worth £0.985 next year and less the year after and so on.

14. The purpose of this exercise is to enable the costs and benefits to be calculated over the expected life of the investment. In the case of a major new build, this would be expected to be 60 years from the building coming into use (although in practice the building may last much longer).

15. The Net Present Social Value for the recommended preferred options is also the highest.

16. It should be noted that the BCR and NPSV for SACH Option 2 (not Option 3) are the highest when this site is considered in isolation. However, when the interdependencies between the SACH and HHH sites (particularly for delivery of the expanded endoscopy service) are considered, **the recommended preferred option for planned care is Option 3 on both sites.**

17. **The recommended preferred option for the emergency care site is Option 6.**

18. These options remain preferred under a prudent range of sensitivity analyses to demonstrate what would need to change to alter the ranking of options.

19. Relatively small changes in key input assumptions would be required to change to make Option 5 the preferred option at the Emergency Care site (as cost and benefits are close in value terms to option 6). However, there would need to be a significant shift in costs for Option 6 (57%) for Option 4 to become preferred (or a 28% reduction in benefits). Effectively there is a clear differential between the economic benefits of Options 5 and 6 vs Options 3 and 4, with a relatively small differential benefit between Option 5 and 6.

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20. The sensitivity analyses for the planned care sites also illustrate that there would need to be significant increases in costs or reduction in benefits for the preferred options to switch to ‘do minimum’ at each site.

21. The analysis is shown in tables 53-55 of the economic case.

Financial Case

22. The Financial Case draws on the same source of inputs as the Economic Case.

23. In summary, the implementation of the preferred options across Emergency and Specialist care and Planned Care shows a positive contribution to the trust’s financial position over the planning period when compared to the ‘Business as Usual’ position (please see table 63 in the financial case):

		BAU scenario	Preferred Option
Estates and capital	Capital expenditure	Avg. c.£32m p.a.	£1,268m
	Land sale receipts	-	£15m
	Estimated year of completion	n/a – ongoing annual maintenance	WGH: 30/31 HHH: 26/27 SACH: 26/27
Finance	36/37 Trust income	663.2	665.5
	36/37 Trust expenditure	(666.2)	(653.8)
	- Of which depreciation	(17.5)	(44.6)
	- Of which PDC charge	(17.3)	(38.2)
	- Of which cash releasing benefits	-	61.2
	36/37 net surplus / (deficit)	(3.0)	11.7

24. However, this also assumes that a significant level of cash (and non-cash) releasing benefits can be realised over this period. This will require strong organisational focus in delivering cost improvement programmes and significant service transformation (in and out of hospital) over the period. The trust’s track record suggests this is possible but this will need to be clearly evidenced within the OBC submission and approval process.

25. One of the areas for refinement will be a view on the ‘impairments’ of new buildings when completed. These are a non-cash transaction for the trust but the impact (write-offs of part of the capital cost when they are valued upon completion) will need to be covered at system or national level post completion of the build (this is normal). The current, conservative and prudent assumption in the financial case is that 20% of the value will be written off at the point the buildings are opened. This assumption is currently under review and may be revised prior to finalisation of the OBC, with the potential to improve the overall affordability of the investment.

Conclusion

26. Taken as a piece:

- The Strategic Case has set out the key requirements in terms of capacity, demand and performance which has informed the scope of each option considered.

- The Economic Case has taken the costs, risks and benefits of each option and used these as inputs to the CIA model. The outputs of this analysis point firmly towards the preferred options being Option 6 for Emergency and Specialist Care and Option 3 on both Planned Care sites.

- The Financial Case identifies that the implementation of the preferred option provides a net surplus position for the trust by 2036/2037 following completion of the redevelopment when compared to business as usual.

27. Further work will also be required to support other chapters of the OBC (Commercial and Management Cases) which are not presented currently. The Commercial Case will be dependent upon the outputs of the New Hospital Programme's Commercial Strategy. The Management Case will be predicated directly upon the RIBA Stage 2 designs for the preferred options. Please see appendix 1 for an explanation of the RIBA stages of work).

Next Steps

28. The next steps are:

- To resolve to take forward the preferred options for further development to inform the final version of the Outline Business Case (towards the end of this calendar year, subject to confirmation by the New Hospital Programme).

- To undertake further discussion with Integrated Care System and HWE CCG and NHS England colleagues on the assumptions made relating to demand, capacity and financial projections when taken in the ICS context as a precursor to securing formal support for the OBC.

Recommendation

29. The Board is asked to approve the outcomes of the strategic, economic and financial cases to select preferred options.

- **Option 6 at WGH for Emergency and Specialist Care site (100% new build clinical facilities, with some existing estate retained for non-clinical and support accommodation).**

- **Option 3 at HHH – Planned Care (medical)**

- **Option 3 at SACH – Planned Care (surgical).**

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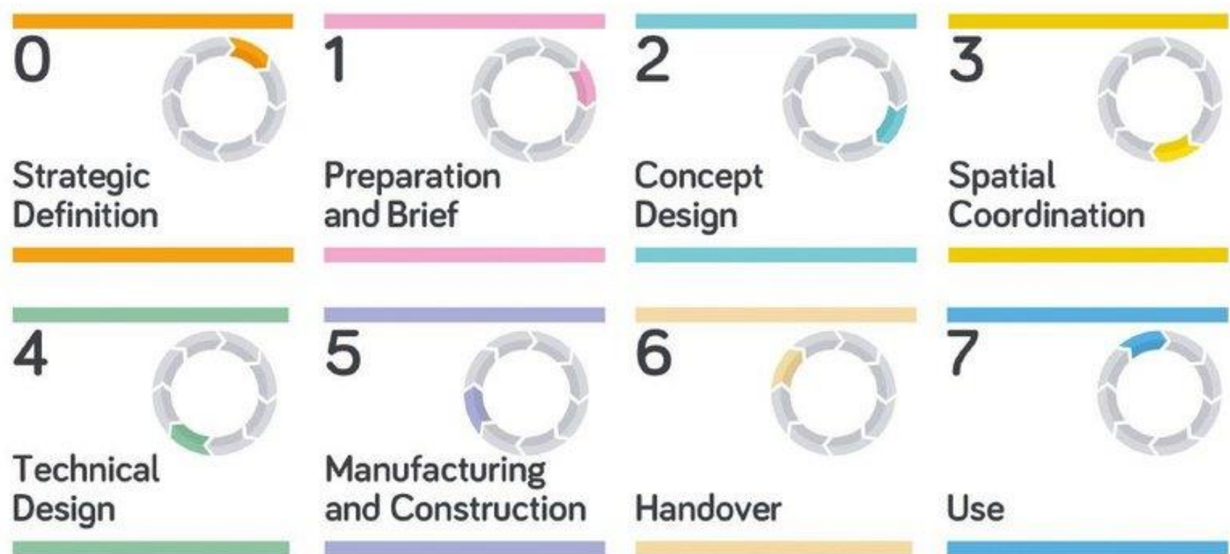
Appendix 1

RIBA Plan of Work ('Stages')



Stages 0 and part of Stage 1 are prepared for the SOC
Stages 1 and 2 are completed for the OBC
Stages 3 and 4 are completed for the FBC
Stage 5 is completed during construction
Stage 6 as handover is being effected
Stage 7 during use to identify lessons learnt

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