Bristol Health Services Plan

REPORT TO SHA
20 OCTOBER 2005

CONTENTS

SECTION	TITLE	PAGE
	EXECUTIVE SUMMARY	2
1	INTRODUCTION	8
2	MODEL OF CARE	10
3	PLANNING ASSUMPTIONS	11
4	WORKFORCE	12
5	CAPITAL PROGRAMME	14
6	AFFORDABILITY ASSESSMENT	20
7	FLEXIBILITY & CONTINGENCIES	24
8.	TRAVEL & ACCESS	29
9.	WORK IN PROGRESS	34
APPENDICES		
Appendix 1	Model of Care – Full Report	
Appendix 2	Workforce	
Appendix 3	Schedule of all Capital Schemes	
Appendix 4	Phasing of Capital Schemes	
Appendix 5	Community Schemes – Mitigation of Risk	
Appendix 6	Glossary	

EXECUTIVE SUMMARY

1. Introduction

This report provides a framework for the development of major capital investment of almost £690m in North Somerset, South Gloucestershire and Bristol via a series of capital schemes. This framework will provide a context for the submission and approval of Business Cases for these schemes – the business case process is the next main stage for further development of the BHSP.

The additional work requested by the SHA has been completed with the exception of the Phase 2 Report on Travel and Access which will be completed by 19 November 05.

2. Objectives of the BHSP Programme

The main objectives of this programme of development are:

- **To provide better care closer to home**: A far greater proportion of services will be provided in or close to people's homes.
- **Improved productivity and significant health gain derived from a more systematic and vertically integrated local care system** that will enable patients to access primary and specialist care in an efficient and streamlined way.
- To enable a more **systematic provision of secondary and tertiary hospital** services.
- **Flexibility to allow contestability** for services with the Independent sector
- **Improved NHS Estate** with buildings that contribute to the BNSSG Estate and provide high quality environments for staff and patients.

2.1. Care Closer to Home

The BHSP schemes will provide a significant change in focus from acute to home and community settings. This change in activity signifies a major change in direction for Bristol, North Somerset and South Gloucestershire Health Services.

2.2 Improved Productivity through more Systematic working and Vertical Integration

The Bristol Health Service Plan developments deliver a significant productivity gain. This productivity gain is due to a far more systematic provision of local health services between Primary and Secondary Care characterised by:

- Integration of local services around patient populations with teams providing both hospital and community services;
- Harmonisation of approach with joint protocols and procedures agreed across Primary and Secondary Care
- "No-wait" services with ease of access to specialist opinions and diagnostics
- Joined up programmes of care for long-term conditions including the application of case management across local services

2.3 Systematic provision of secondary and tertiary hospital services.

The new developments enable a concentration of A&E and acute assessment services within Bristol into 2 main receiving centres at Southmead and the BRI. These will complement services at Weston. This strategy allows the provision of an acute core that can respond flexibly to changes in demand and work as a single acute/emergency system. This integrated core will be characterised by a range of single processes including:

- Networked receiving arrangements for emergency patients to allow ambulance service in line with capacity at the acute sites
- Routing of GP referrals for a bed, based upon capacity and specialist treatment
- Single clinical teams e.g. for cardiology to allow for "round-the-clock" interventional/emergency rotas;
- Networking of imaging and telemedicine to enable decision-making at distance;
- Joint adoption of modern technological solutions

2.4 Flexibility to Allow Contestability

The BHSP strategy is to ensure that elective and diagnostic work in the new acute sector that could go to the Independent sector (defined in this report as "contestable" work) is housed, where appropriate, in existing refurbished or retained estate to make it easier to respond to increases or decreases in Independent sector provision.

The main elements of BHSP strategy are:

- Use of the Avon Orthopaedic Centre for NBT's contestable work with the ability to downsize this provision as required;
- Identifying the South Bristol development as one of the sites for Independent sector diagnosis and treatment services
- Providing flexibility on the UBHT site to enable downsizing as required
- Identifying flexibility and contingencies in the remaining community schemes in the event of transfer of work to the Independent sector

These initiatives open up the opportunity for transfer of activity to the Independent sector. Our affordability assessment has assumed that up to £20m of contestable elective activity will transfer to the Independent sector.

3. The NHS Estate

The new configuration provides a flexible estate with a core of new/good condition estate but in the short-term with some existing estate retained on both Bristol main acute sites without compromising their major capital investments. This will allow for development/decant potential to help minimise the difficulty of future development and will also provide a buffer if growth exceeds predicted levels or if the level of improved performance under achieves against targets. Key principles are:

- Use existing "good quality" accommodation at Southmead where this does not compromise the redevelopment of the site for the New Hospital
- Investment in the Bristol Royal Infirmary (BRI) site via a phased programme to replace existing poor facilities and, in the event of a reduced demand for services, to further concentrate UBHT services on the main BRI site
- Maximising the use of Weston General Hospital for North Somerset residents – this has the effect of reducing the need for about 60 beds between the 2 two Bristol Acute Trusts
- Closing the outdated and unsuitable facilities at Bristol General Hospital through the development of the new South Bristol Community Hospital

4. Planning Assumptions

The BHSP has been reviewed to take account of the:

- A Growth in Trust income from increased BNSSG activity not exceeding 1.5% per annum
- Risks and opportunities of *Patient Choice* to move or change the current flows of patients
- Projected impact of the use of the Independent sector – now £20m for BNSSG
- Efficiency gains as a result of the new investment in services and improved performance:
- Maximising and making appropriate use of available facilities that are in good condition (i.e. Weston General Hospital)
- Ensuring that projected patient activity is not duplicated between hospital and community services and that, wherever possible, each scheme contains flexibility to mitigate any risks relating to affordability or capacity
- All developments for services likely to be in direct competition with the Independent sector should not be part of any PFI

5. Capital Investments - Sensitivity and Risk

Based on latest estimates of cost given by Trusts/PCTs these schemes total £687m:

	Acute Trusts £m (inc Frenchay & Southmead Community Hospitals)					PCT BHSP Schemes £m	Grand Total £m	Percentage
	NBT Main scheme	NBT Other Scheme	UBHT	Weston	Total Acute			
PFI	320.0	0.0	66.0	0.0	386.0	0.0	386.0	56%
LIFT	0.0	0.0	0.0	0.0	£0.0	50.3	50.3	7%
Other	100.0	27.6	107.3	0.0	234.9	15.4	250.3	36%
Total	420.0	27.6	173.3	0.0	620.9	65.7	686.6	100%
Percentage of Total	61%	4%	25%	0%	90%	10%	100%	

Included in the £687m total is a centrally funded contribution (Heart Czar allocation) of £45m being almost 70% of the total cost of the UBHT/NBT Cardiac Developments including the new Regional Cardiac Centre at the BRI. If these schemes do not proceed:

- the £45m would be "lost" to the local health community
- it would not be possible to meet the Government cardiac targets

The £687m excludes the 2 Community Developments that are currently the subject of formal Public Engagement and Consultation:

- Kingswood & District (South Gloucestershire PCT)
- North Somerset (North Somerset PCT)

Both schemes will be taken forward after completion of public engagement and consultation and then considered within the overall affordability envelope

To handle the need for flexibility across the life of the programme it is recognised that the phasing of the schemes is essential to manage service priorities, reflect market changes and to ensure continue to be within the overall affordability envelope. This reflects the Health Community's recognition that they are working in a dynamic environment within the changing NHS landscape.

6. Flexibility and Contingencies

Given the changing NHS landscape and resultant uncertain impact on demand for services it is essential that the BHSP programme contain robust contingency and flexibility measures. These are detailed in the report but in summary:

- In the event of the need for expansion all sites including the 3 acute sites contain room for expansion

- In the event of there needing to be a contraction in services:

UBHT	Services could be transferred from the periphery of the UBHT campus site to create a larger core hospital on the main BRI site
NBT	Existing “good condition” buildings being retained (about 160 beds plus the Avon Orthopaedic Centre at Southmead) would be taken out of commission
Weston	Selected wards could be closed and also the opportunity taken to reduce the total number of beds and increase bed space by converting the existing 6-bedded rooms for 4-patient use
Community	The schemes contain flexibility to downsize secondary care activity without adversely affecting the viability of the individual scheme.

In addition, the phasing of the whole programme enables key enabling schemes to proceed from 2006 but still allows a final review to take place in 2007 when there will be the opportunity for final review before “financial close” of schemes amounting to about £523m (76%) of the total BHSP capital programme.

7. Affordability within BHSP

The capital developments are considered affordable under the following main assumptions:

- PCT annual average income growth of 1.5%
- Independent sector provision of up to £20m of contestable elective work.
- PFI used as the main procurement route for the major capital schemes in the Acute Trusts and LIFT for the Community schemes
- Use of “good quality” retained estate where possible
- Maximising use of beds at Weston Hospital when they become available as a result of increased productivity and loss of referrals from outside the area

8. Model of Care

The model of care, which has been developed, is considered to be robust and consistent with the Government policy articulated in *Commissioning a Patient Led NHS.* It is the cornerstone for taking the BHSP forward. The model of care will require ongoing development and, very important, engagement with the BHSP clinical community.

9. Workforce

There will need to be substantial changes to the workforce to deliver the BHSP including increased flexibility of working between organisations and the development of case management throughout the health system. These changes have been considered as part of the ongoing workforce review and linked to the BHSP Model of Care.

10. Travel and Access

The Joint Strategic Planning and Transportation Unit (JSPTU)has been commissioned to assess the travel and access implications of BHSP and has completed Phase 1 of its work and has concluded that the BHSP has the potential to reduce journey lengths to health care facilities significantly for the population, as well as various patient groups, staff and visitors.

Phase 2 of its work is to map the projected flows of each patient type, staff and visitors in 2012 following BHSP implementation. This will then be used to compare access to health care with the current provision. This work will be completed by 19 November 2005. The outcome will also enable provision of the travel and access data required for business planning purposes for individual schemes as required by the SHA.

SECTION ONE: INTRODUCTION

1.1 Background

On 14 March 2005 the Joint Decision Making Committee met and made a number of key decisions. These were reported to the Avon, Gloucestershire and Wiltshire Strategic Health Authority (SHA) meeting on 23 March 05.

The SHA noted the report of the Joint Decision Making Committee and, in doing so, required additional work to be completed before it considered the separate Outline Business Cases (OBCs) or Full Business Cases (FBCs) for each of the capital schemes that comprise BHSP.

The additional work requested by the SHA is summarised below:

1.1.1 Completed and reported to the SHA meeting 7 July 05

- Reviewing and strengthening the BHSP Programme Structure
- Social Services Impact Assessment of the impact of health plans on the demands for or shape of social services provision.
- Details of the business case process which all schemes are submitted to individually

Work is ongoing to take forward the results of the Social Services Impact Assessment and now all 3 Social Service Departments, including North Somerset, are involved in the Project Board, which oversees this work.

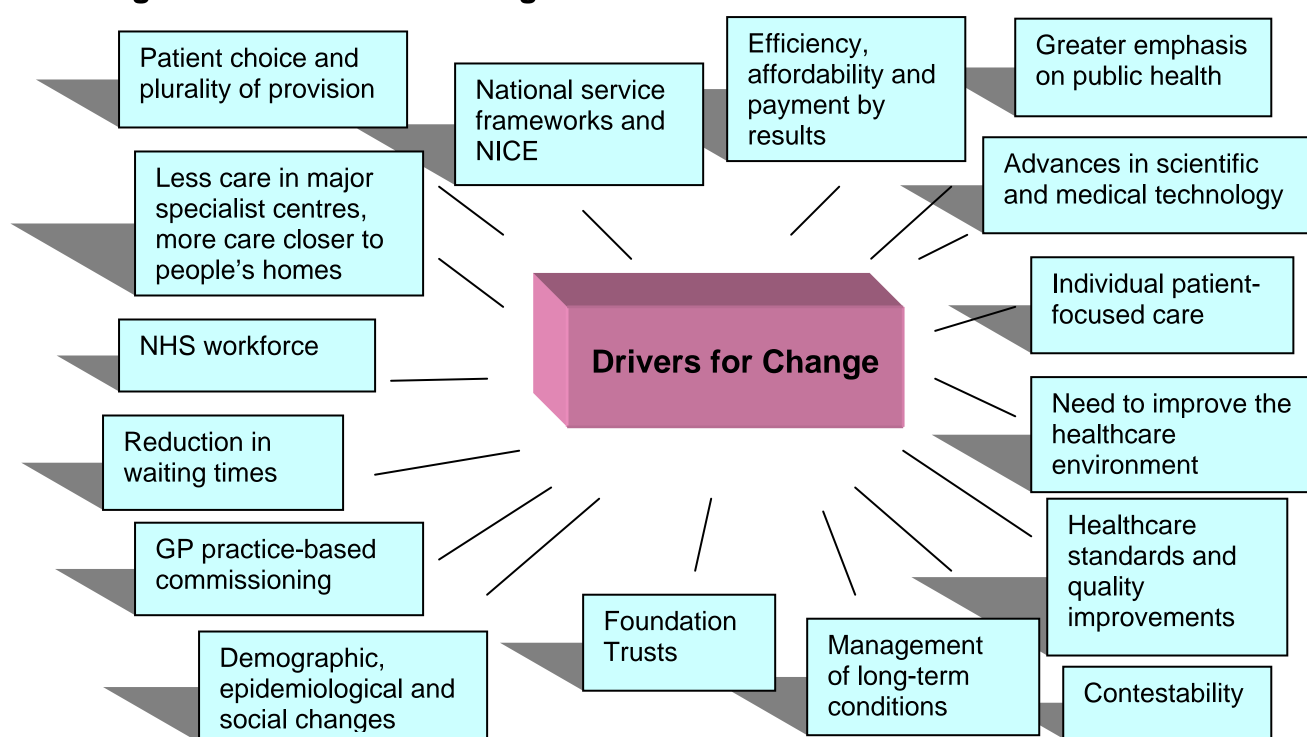
1.1.2 Work to be reported on 20 October 2005

- Model of Care
- Planning assumptions
- Workforce assumptions
- proposed phasing of the capital developments.
- Affordability Assessment
- flexibility and contingencies built into the plan.
- How the travel and access implications of each project will be fully assessed in the Outline Business Cases.

1.2 Context of report

The NHS is constantly changing and figure 1 highlights the *Drivers for Change* all of which will impact substantially on the BHSP but most of which are either new or at the early stages of introduction or development. One recent example is the increased use of the Independent sector. The value of this for Bristol, North Somerset and South Gloucestershire (BNSSG) has significantly increased to £20m.This now provides the opportunity to transfer a significantly higher volume of its elective work than previously thought and the potential impact of this transfer of work has been taken into account:

Figure 1: Drivers for change



This report takes account of the above as far as it is possible to do so given the continuing introduction of new policies and changes in the NHS both locally and nationally.

SECTION TWO: MODEL OF CARE

Underpinning the BHSP is a model of care that sets out the basis and rationale for these changes. The model has been developed by the BHSP Clinical Redesign Group and this summary describes its key elements. The full Model of Care is contained in **Appendix 1**.

The overall objectives of the model of care are to:

- provide care **closer to the patient's home**
- provide effective local health services by **harmonising primary care, social care and local hospital services**
- develop **specialist services and networks for a wider group**
- provide a **vibrant learning and education culture**
- improve the **efficiency, productivity and value for money** of services
- enable local services to **respond to national initiatives** such as *Creating a Patient-led NHS*, plurality of provision and contestability
- provide a model of care that is **robust and able to both withstand and inform organisational change.**

The model of care covers the following areas of healthcare: public health, acute, emergency and specialist services, community-based services, primary care and self-care.

The model of care is considered to be robust and consistent with the Government policy articulated in *Commissioning a Patient Led NHS.* It is the cornerstone for taking the BHSP forward but, as detailed in **Appendix 1** the model of care will require ongoing development and, very important, engagement with the BHSP clinical community.

SECTION THREE: PLANNING ASSUMPTIONS

3.1 Introduction

As detailed in the Model of Care the BHSP consists of a series of integrated developments in tertiary, secondary, intermediate, community, primary and self-care. Through the redesign of many current services, the BHSP will deliver patient-focused services that will:

- improve clinical outcomes
- enhance the patient experience
- increase the efficiency of services.

The services will be locally accessible, integrated, modern and sustainable. They will be developed and supported by all partners within the local health community, including independent providers, and they will take into account the potential of these independent providers. Central to these developments is the need to provide and deliver additional choice for patients, as well as modern and flexible healthcare that can adapt to changing needs.

The BHSP will ensure a strategic shift towards primary and community services. This shift will enable substantial numbers of people to be treated in local primary care and community settings, rather than in the major hospitals.

3.2 Planning Assumptions

The PCTs have reviewed their planning assumptions, which are summarised below:

- A growth in Trust income from increased BNSSG activity not exceeding 1.5% per annum between 2008/9 and 2013/14;
- Elective activity valued at up to £20m per annum would transfer to the Independent sector.
- The 3 Acute Trusts to meet productivity performance (including length of stay, bed occupancy rates, percentage of day cases) to match the current performance of their top performing "peer group" hospitals elsewhere in the NHS.
- PFI to be used as the main procurement route for the major capital schemes in the Acute Trusts and LIFT for the Community schemes
- Retain use of "good quality" retained estate where possible
- Maximising use of existing assets
- Need to use 60 "surplus" beds at Weston Hospital when they become available as a result of increased productivity and loss of referrals from

outside the area. These will be used for some of the North Somerset emergency cases that are currently admitted to Bristol Hospitals.

The above assumptions have been used to review and size capital developments and to formulate risk mitigation measures and identify contingencies where relevant.

SECTION FOUR: WORKFORCE

4.1 Introduction

There will need to be substantial changes to the workforce to deliver the BHSP including increased flexibility of working between organisations and the development of case management throughout the health system. These changes have been considered as part of a workforce analysis and linked to the BHSP Model of Care.

The BHSP Workforce review is the first attempt by NHS organisations across Bristol, North Somerset and South Gloucestershire (BNSSG) to take a whole system-wide, holistic and analytical approach to the workforce implications arising out of the Bristol Health Services Plan and other major developments. It relates directly to staff currently employed by the 3 acute Trusts and 4 PCTs across BNSSG and makes reference to changes in other parts of the healthcare sector – including the GP/primary care workforce, mental health, ambulance services – and other related sectors such as social care.

The review is addressing out the workforce implications arising out of the emerging national policy framework and associated local service changes in acute/emergency services, community-based services and primary care over the next 10 years.

Much progress has already been made by local NHS organisations to develop and implement a range of significant workforce initiatives – including new pay arrangements and role redesign. There is strong commitment within the organisations to continue this work.

Appendix 2 contains a summary of the progress made to date.

4.2 Conclusions

The following are the key conclusions:

- Despite the significant challenges that lie ahead, local PCTs and NHS Trusts are confident in their ability to manage the workforce changes required to successfully deliver the Bristol Health Services Plan and other major developments in the area. This will require a clear and holistic approach to workforce strategy, workforce planning and change management.

- The total net effect on staff numbers as a result of BHSP implementation is as yet unknown. Activity growth, changes in the model of care and demand for healthcare, balanced with acute services rationalisation and ongoing financial recovery and management will be key factors that will affect overall staffing numbers in order to support future service provision

- The benefits of a strong and collaborative approach to system-wide workforce issues are obvious. Through closer collaboration – whilst recognising the need to compete in a demanding labour market – local healthcare employers are able to review and monitor national policy changes, ensure a smooth transition to new organisational forms and functions, share best practice, resolve problems and contribute to the overall image of the BNSSG healthcare sector as an employment area of choice.

- A comprehensive workforce strategy for BHSP implementation is the next stage of work for the Workforce project group.

SECTION FIVE: CAPITAL PROGRAMME

5.1 Introduction

Since the progress report to the SHA in July 2005, further work has been completed to ensure that the BHSP capital programme meets the core requirement necessary to implement the BHSP Model of Care and yet does not contain potential surplus investment.

5.2 Acute Schemes

The work has included a detailed assessment of:

- The acute bed requirement
- Key principles, which determine scheme size at the sites that comprise the largest part of the BHSP capital programme namely:
  - the NBT/SG New Acute/Emergency Hospital
  - the investment in the main UBHT site.
- The balance between "new build" and retention of existing buildings of acceptable condition at Southmead
- The amount of "new build" at the BRI and retention of existing space of acceptable condition in UBHT
- The impact of cross boundary flows on beds and the capital schemes at the BRI following the closure of Frenchay Acute Hospital
- The impact of the Independent sector at all acute hospitals
- The impact of additional productivity resulting from planned investment in acute services e.g. reduced length of stay and increased number of day case treatment and investigation
- The impact of the use of 60 existing beds at Weston General Hospital, which will become available on a phased basis between 2008-2012. It is intended these be used for North Somerset emergency cases which are currently admitted to Bristol hospitals

5.3 Community Schemes

There are eight community schemes that comprise the significant BHSP investment in local services.

The capacity of the schemes has been reviewed to ensure that there is no duplication with the acute services in any of the patient groups including:

- Non-elective inpatients
- Elective inpatients
- Day cases
- Outpatients
- Accident & Emergency attendances
- Minor Injuries & Illness

The sizing of the community developments has taken account of this capacity requirement.

The functional content of each scheme including number and type of inpatient beds will be developed prior to the OBC process. and refined through to the Full Business Case (FBC) stage

- The new secondary care capacity in the community developments is a key driver to enable:
- Closure of Bristol General Hospital (mainly via South Bristol Community Hospital)
- Acute capacity to be released in North Bristol NHS Trust (NBT)
- Release of outpatient and A&E space at the BRI
- Help enable the acute hospitals to concentrate on their "new" specialist/emergency role (as per the BHSP Model of Care)
- Successful implementation of demand management measures to enable:
    - more accessible care by local provision
    - care and treatment to be provided more appropriately with less reliance on hospital provision

Each of the community schemes have been reviewed and adjusted to take account of the above. In addition, a sensitivity analysis has been completed to highlight the effect of the provision of services by the Independent sector.

5.4 BHSP Capital Programme

The overall BSHP capital programme has been evaluated to take account of the acute inpatient bed requirement and changes made as a result of the reviews described in Section Three: Planning Assumptions.

The resultant list of all major capital schemes relating to BHSP is contained in **Appendix 3.** This contains details of schemes including:

- Land purchase if necessary
- Current estimated total capital cost
- Projected start/end date for construction (excludes commissioning period)

Based on latest estimates of cost given by Trusts/PCTs, these schemes total £687m and are summarised as follows:

	Acute Trusts £m (inc Frenchay & Southmead Community Hospitals)					PCT BHSP Schemes £m	Grand Total £m	Percentage
	NBT Main scheme	NBT Other Scheme	UBHT	Weston	Total Acute			
PFI	320.0	0.0	66.0	0.0	386.0	0.0	386.0	56%
LIFT	0.0	0.0	0.0	0.0	£0.0	50.3	50.3	7%
Other	100.0	27.6	107.3	0.0	234.9	15.4	250.3	36%
Total	420.0	27.6	173.3	0.0	620.9	65.7	686.6	100%
Percentage of Total	61%	4%	25%	0%	90%	10%	100%	

This does not include:

- Longer term development including at BRI and at Southmead

- Schemes subject to Public Engagement and Consultation:
  - Kingswood & District
  - North Somerset Community developments

The Kingswood and North Somerset developments will be taken forward after completion of public engagement and consultation and then considered within the overall affordability envelope

Included in the £687m total is a centrally funded contribution (Heart Czar allocation) of £45m being almost 70% of the total cost of the UBHT/NBT Cardiac Developments including the new Regional Cardiac Centre at the BRI. If these schemes do not proceed:

- The £45m would be “lost” to the local health community
- It would not be possible to meet the Government cardiac targets

There are five other community schemes, which are not directly BHSP-related schemes, but are related in terms of overall affordability to the PCTs. They are not included in the £687m and they total £18.2m capital costs:

- Shirehampton Health Clinic
- Fishponds Health Clinic
- Hampton House Refurbishment
- Whitchurch Health Centre

Amelia Nutt Clinic, Withywood

5.5 Affordability

The ongoing revenue costs of all the schemes summarised above and listed in **Appendix 3** have been taken into account by all Trusts and PCTs in submitting their financial forecasts for the Affordability Assessment. These financial forecasts, for affordability purposes, also include the investments being made in Mental Health and NPfIT (National Programme for Information Technology).

5.6 BHSP Programme – Scheme Linkages and Phasing

Central to the BHSP is a wide range of transfer of services both from:

- The acute hospitals to community-based locations
- Between NBT and UBHT in order to concentrate key specialist services on one site e.g. ENT, Paediatrics, Breast Surgery etc.

Efficient phasing and grouping of schemes is necessary to :

- Minimise new build
- Facilitate decanting arrangements
- Ensure that the necessary community developments are completed before services are transferred from the acute hospitals:

Appendix 4 contains a Phased schedule of all schemes, with estimated construction periods and their linkages. The schedule also contains key questions to be addressed in the forthcoming business planning process (OBCs and FBCs).

The schedule highlights some schemes, which need to be completed before others can proceed:

Schemes which need to be completed	**In order for the following to occur**
Completion of South Bristol Community Hospital (this is the main scheme re transfer of services which enables closure of BGH)	Closure of Bristol General Hospital (BGH)
1. Woodlands Paediatric transfer from Southmeads to Bristol Royal Hospital for Children (BRCH) 2. Children's ENT centralisation 3. Community Developments: • Central & East Community Health Care Centre • Yate Community Health Care Centre • Thornbury Community Hospital 4. Pathology Centralisation	Completion before or by early stage of Southmead New Hospital

Schemes which need to be completed	**In order for the following to occur**
1. Specialist Paediatrics centralisation **2.** Additional capacity at BRI to accommodate extra cross-boundary flows when Frenchay emergency services transfer to the new acute hospital at Southmead **3.** All community schemes including Southmead Community Hospital and Kingswood (but excluding Frenchay Community Hospital & N Somerset)	Completion before opening of Southmead New Hospital
Completion of NB/South Gloucestershire new hospital at Southmead	Frenchay Community Hospital & Southmead Community Hospital
Completion of: 1. Regional Cardio-Thoracic Centre 2. Conversion of Levels 8 & 9((part of existing Pathology Unit at BRI) or the PFI new build	Re-provision of Old Building, BRI
• Specialist Paediatrics centralisation • Children's ENT centralisation • Transfer of Woodlands to BRHC	Completion of Centralisation of Children's Inpatient Services

5.6.1 Key milestone reviews

Some key "enable" schemes are programmed to start from 2006 but the majority of the value of the capital programme is not due to start construction in or after 2008. Excluding Kingswood & District and North Somerset Community schemes being subject to Public Engagement and Consultation the schemes not due to start until 2008 or afterwards are:

- NB/S Glos new hospital at Southmead
- Thornbury Community Hospital
- BRI Redevelopment including re-provision of BRI "Old Building"
- Specialist Paediatrics – centralisation

These schemes total about £523m being 76% of the total capital programme. This provides an opportunity in early 2007, and before the "financial close" of individual projects, to check that the capital programme continues to be robust relating to:

- Service priorities
- Market changes
- Overall affordability

5.7 Conclusion

The capital programme has been reviewed, as has the use of each major acute site. Details of the outcomes of this review have been described in this section together

with details (**Appendix 3)** of each of the schemes, the linkages and inter-relationship between schemes and the phasing (**Appendix 4**) that is required to:

- Minimise new build
- Facilitate decanting arrangements
- Ensure that the necessary community developments are completed before services are transferred from the acute hospitals
- Ensure that the BHSP "vision" as detailed in the Model of Care can be achieved
- Provide a "break-point" in 2007 to take stock across BHSP of the overall affordability of programme before £523m of schemes are contractually committed

The proposed configuration provides a flexible estate with a core of new/good condition estate but in the short-term with some old estate at the fringes of both main acute sites. This will allow for development/decant potential to help minimise the difficulty of future development and will also provide a buffer if growth exceeds predicted levels or if the level of improved performance under-achieves against targets.

SECTION SIX: AFFORDABILITY ASSESSMENT

6.1 Introduction

6.1.1 This section summarises the main conclusions of the work to assess the affordability of proceeding with the Bristol Health Services Plan. Of particular significance are the following two major schemes:

- NBT reconfiguration and community service developments;
- UBHT redevelopment of the City Centre Campus and closure of Bristol General Hospital (BGH).

6.1.2 Outline Business Cases (OBCs) for these schemes are not due for completion until winter 2005/ spring 2006.Therefore, assessment has been based at the level of planning currently achieved which recognises that the planning is a rolling process and at this point the majority of schemes are not yet at OBC stage. The next phasing of business planning of all schemes will have to ensure they deliver within the affordability framework.

6.1.3 The expectation is that the next spending review will bring NHS "real" growth back into line with GDP and other areas of public spending. The assumption is that BNSSG as a whole will receive NHS average "real" terms growth of 2% although individual PCTs may attract higher or lower levels of funding. No attempt has been made to differentiate between the allocation growth rates for individual BNSSG PCTs as this will depend on the impact of implementing PbR, distances from target in three years' time, and the speed of any necessary 'equalisation'.

6.1.4 The BHSP Programme Board considered the full Affordability Assessment. The BHSP Steering Group considered a summary of the Affordability Assessment following further work commissioned by the BHSP Programme Board.

6.2 Assessment Conclusions

6.2.1 Following consideration of the Affordability Assessment in September, the Programme Board initiated further work based on more challenging assumptions. These included:

- A growth in Trust income from increased BNSSG activity not exceeding 1.5% per annum between 2008/9 and 20013/14;
- An expectation that elective activity valued at up to £20m per annum would transfer to the Independent sector.

6.2.2 The key conclusions of the Affordability Assessment took into account these revised assumptions, and are outlined below:

BNSSG PCTs

6.2.3 On the basis of the assumptions in the assessment, the BNSSG PCTs plans are affordable. There are however risks, the four most significant being as follows:

- The PCTs plans are based on the assumption that growth in patient activity with the acute hospitals will be less than has been the case over the past 8 years and will be contained using ‘demand management schemes’ which create less expensive alternative services outside hospitals. The net saving from demand management schemes could be significantly less than anticipated: activity may not reduce as much as expected and/or the cost of alternatives may be greater than assumed. These assumptions need to be reviewed.

  This is by far the biggest risk.

- PCTs may be faced with additional commitments not yet identified.

- Some of the community hospital/primary care centre developments have still not been fully costed. Currently it has been assumed that they will be viable.

- Two PCTs have to eliminate an underlying financial deficit during the LDP period. North Somerset PCT expect to do this by earmarking cash growth, which is 11.6% in 2007/8 compared with a national average of 9.4%. Bristol South and West are working to identify the level of savings required.

UBHT

6.2.4 UBHT are currently reassessing their capital plans and finalising their bed requirements. On the basis of the assumptions in the assessment, and the capital investment of about £173m, they are likely to be affordable, but will, of course, require full appraisal.

6.2.5 The main risk relates to the assumptions about activity levels but by preparing an OBC with flexibility to adjust the capital stock based on a range of assumptions this risk could be minimised.

NBT

6.2.6 NBT’s plans are well advanced and the Trust provided a detailed assessment of their financial implications, including a sensitivity analysis with a range of scenarios. On the basis of the assumptions in the assessment they are affordable. However, there are very significant risks are addressed. The main risks were identified as follows:

- The very challenging savings requirement of £13.5m which is likely to mean the Trust must become one of the 15% most efficient acute trusts in the country. These savings come on top of their recovery plan, which is currently being implemented, and

at a time when there are uncertainties about the impact of PbR, particularly the approach to setting tariffs, e.g. will tariff reductions remove the potential for marginal savings on activity growth?

- The unreliability of activity projections, at a time when there is a strong national and local commitment to using the Independent sector and investing in primary and community care at the expense of the acute sector.
- The management of a capital scheme costing £420m will in itself be a major risk, even allowing for the substantial experience of the Trust's executive team.

6.3 BHSP Programme Board and Steering Group Conclusions

6.3.1 Details of risk mitigation and contingencies were provided to the Programme Board by NBT and UBHT including the project management support for the NBT PFI. The schemes of these 2 Trusts are estimated to cost £621m, which represents the major share (90%) of the total capital programme. It is particularly important therefore that the risk mitigation measures and contingency plans for these 2 Trusts are robust.

6.3.2 Following careful consideration of the Affordability Assessment the BHSP Programme Board concluded that the BHSP as a whole was affordable. However, they acknowledge that there were obvious risks, which must be mitigated before the finalisation of business cases, and contingencies would need to be put in place. The Programme Board agreed it was as great or particularly important to ensure plans were sufficiently flexible to respond to changes to the health sector environment.

6.3.3 The Programme Board also agreed that there were greater financial and other risks in "doing nothing" and that this therefore was not an option.

6.3.4 The BHSP Steering Group accepted these conclusions, and in particular agreed that:

(a) A savings requirement of £13.5m for NBT by 2013/4 was not unreasonable.

(b) In their business case NBT should set out the reasons why it was not appropriate to phase their £420m scheme.

(c) An assumption by Trusts of a 1.5% pa growth in income from activity increases was appropriate for planning purposes.

(d) An assumption by Trusts of a transfer to the Independent sector of activity valued at £20m in BNSSG was appropriate. This transfer is after the 1.5% pa activity increase referred to at (c) above.

(e) Business cases should be prepared taking account of the potential use of vacant beds at Weston Area Healthcare Trust.

(f) Further work should take place to establish whether changes could be made to the planned development of community facilities in order to reduce costs or financial risks, prior to submission of business cases.

(g) PCTs overall plans are affordable on the basis of growth of 1.5% per annum in acute activity. This is less than historic growth and will need to be delivered through demand management schemes.

(h) PCTs should review their plans to create flexibility, so that unforeseen commitments and pressures could be accommodated

6.3.5 Finally, the BHSP Programme Board and Steering Group noted that the Affordability Assessment was not a substitute for properly scrutinised Outline Business Cases (OBCs).

SECTION SEVEN: FLEXIBILITY & CONTINGENCIES

7.1 Introduction

The NHS is constantly changing and Section One: **Introduction** of this report highlights the *Drivers for Change* all of which will impact substantially on the BHSP but most of which are either new or at the early stages of introduction or development. One recent example is the increased use of the Independent sector. The value of this for Bristol, North Somerset and South Gloucestershire (BNSSG) has significantly increased to £20m.This now provides the opportunity to transfer a significantly higher volume of its elective work than previously thought and the potential impact of this transfer of work has been taken allowed for in the BHSP contingency plans.

The need for flexibility and contingencies across the BHSP programme is therefore extremely important to deal with the changing NHS landscape and any substantial impact on overall affordability. This section addresses this in the following ways:

7.1.1 BHSP Capital Schemes

Section Five: Capital Programme details the review of all BHSP schemes which will minimise new build, allow for development/decant potential to help minimise the difficulty of future development and will also provide a buffer if growth exceeds predicted levels or if the level of improved performance under-achieves against projected targets. It also identifies a "break point" in 2007 to allow a final check to be made for about 76% of the value of the total programme for continuing robustness relating to:

- Service priorities
- Market changes
- Overall affordability

7.1.2 Hospital Sites

The three Acute Trusts have reviewed their hospital sites to ensure there is sufficient flexibility and contingency planning in the event of 2 scenarios:

a) Future expansion
b) Need for contraction

The following is the outcome of this review:

	Scenario 1: Need for future expansion	**Scenario 2: Need for future contraction**
North Bristol NHS Trust	Selection of the Southmead site for the	The new PFI at Southmead (800 beds)

	Scenario 1: Need for future expansion	Scenario 2: Need for future contraction
	new Hospital provides the opportunity for a very significant expansion of the new hospital should this be required in the long term	assumes retention of some existing "good condition" buildings (about 160 beds). This provides scope for "downsizing" across the site by the existing 130 beds should this be required. "Contestable" services (routine elective cases – inpatient and day cases) will be sited in existing "good condition" buildings in the Avon Orthopaedic Centre at Southmead Should this elective work transfer to IS then this accommodation can be used to further downsize the PFI scheme at Southmead.
UBHT	The site development control plan highlights substantial opportunity for further expansion of the BRI should this be required	Services could be transferred from the periphery of the UBHT campus site to create a larger core hospital on the main BRI site
Weston General Hospital	The existing hospital site has substantial scope for expansion of the existing hospital should this be required	Selected wards could be closed and the opportunity to increase bed space by using the 6 -bedded rooms for 4 -patient use

7.1.3 Impact on acute beds

The impact of choice across all areas of the service including primary care will mean some changes to traditional patient flows. The quality, accessibility or availability of service providers may mean increased use of alternative providers outside of the NHS sector within BNSSG. In addition, the advent of new and alternative providers into the network within BNSSG will change the provision of the traditional NHS sector.

This will impact on the size of any facilities to be planned. The traditional NHS provider will only maintain this work if they match the Independent sector quality of

service and environment. Capital investment in any of the areas will need to be subject to testing under the future Foundation Trust regime.

The PCTs have therefore laid down alternative scenarios (see Section Three: **Planning Assumptions)** , which the Acute Trusts have used to revise their capital schemes. These take account of:

- The agreed use of up to 60 beds at Weston General Hospital for a proportion of emergency patients from North Somerset who currently go to either UBHT or NBT – this has enabled a downsizing of beds at UBHT and NBT.

- The transfer of an element of cross boundary flow emergency patients who are likely to go to UBHT when Frenchay Hospital closes (about 65 beds before efficiency adjustments) – this has enabled a downsizing of beds in the North Bristol/South Gloucestershire PFI new hospital but an increase in UBHT bed provision.

- Revised productivity performance (including use of acute beds, percentage of day cases) to match the current performance of the appropriate top performing "peer group" hospitals elsewhere in the NHS. The planned investment in new facilities at the BRI and in the new Southmead Hospital are key enablers to this improved performance.

7.1.4 Community Schemes - Contingency Planning Future Proofing And Resilience

7.1.4.1 Introduction

The community schemes in the Bristol Health Services Plan (BHSP) include:

- Thornbury Community Hospital
- Yate Community Health Care Centre
- Southmead Community Hospital
- Frenchay Community Hospital
- Kingswood and District Community Health Care Centre
- Central and East Bristol Community Health Care Centre
- South Bristol Community Hospital
- Clevedon Community Hospital

These schemes have been worked up to varying degrees of detail. South Bristol has an approved Outline Business Case (OBC) with Central and East Bristol, and Yate being considered for OBC approval from November. Frenchay and Southmead Community Hospitals have been subject to detailed planning ready for the outline business case for North Bristol and South Gloucestershire in spring 2006. An OBC for Thornbury Community Hospital Development is planned alongside the BN/SG OBC in spring 2006. OBCs on the remaining schemes are expected following

public engagement on North Somerset's 'Shaping our Future' and South Gloucestershire's 'Future Health Services for Kingswood & District'.

The schemes provide a mix of minor injuries and illness units or services, out-patients (provided by a range of specialist practitioners), diagnostics, and accommodation for community teams and in some cases accommodation for GP practices, day and minor surgery and intermediate care beds.

Each scheme responds to its own particular population needs and synergies with local facilities and hospitals. However, they have all been designed to provide an interlocking set of services which will provide more care closer to home, ensure more effective linkage with primary care services and allow the acute hospitals to focus on their new specialist role. The schemes support the delivery of the "*Ten High Impact Changes*" and fits within the framework of "*Commissioning a Patient Led NHS*".

South Bristol has an approved OBC with outline planning permission and is directly linked to the IS procurement for both diagnostics and elective for AGW. The business case includes a detailed assessment of the future proofing and resilience of the scheme including an assessment of the financial risks and the range of methods that have been identified for managing these.

The following describes the ability of the remaining schemes to respond to a variety of future risks.

7.1.4.2 Risks and contingencies

The main risk facing community schemes is that the fixed costs of new or refurbished buildings will not be covered by the assumed activity and income. The activity could change because of patient or referral choice, changes in commissioners' intentions or increased plurality of providers. Income could change not only due to variation in activity but also to the structure of tariffs (especially the possibility of tariffs for community services being reduced) or the transfer of revenue streams to Independent sector providers in other locations. Costs could increase due to either unexpected inflation or different treatment of public private partnerships.

The advantage of community schemes is their flexibility for a range of uses and providers. As a local facility, they can be adapted to the preferences of local populations, referrers and commissioners to provide a wide range of health and social care services. They can provide sessionally, in part or as a whole facilities for a wide range of independent and NHS providers. As comparatively small schemes, they can be sized, increased in efficiency and adapted comparatively easily.

There will be a need to ensure that the redesign of services underpinning the model of care is maintained.

All the future schemes of the BHSP depend on a high level of activity being transferred to community settings. Redesigned services are already showing the

demand for facilities, which are not yet available in the community. So these schemes are responding to actual need as well as projected need resulting from the re-design of the whole health system envisaged in BHSP.

Appendix 5 details the contingencies to meet the risks that have been identified for the community schemes:

- Financial:
    - Reduction in tariff
    - Variation in activity
    - Changes in revenue costs
    - Transfer of revenue streams to Independent sector
    - Inflation on rental of buildings
    - Transfer of facilities to balance sheet
    - Changes in funding GP services
    - Changes in capital borrowing regime under Prudential Borrowing Code
- Non-Financial:
    - Change in Commissioner intentions
    - Increased plurality of providers
    - Delays in major schemes
    - Double counting in activity in “neighbouring” community schemes

7.1.4.3 Conclusion

Appendix 5 shows how the community schemes will meet the potential risks they face. Most schemes are comparatively small and of a design that can be adapted to changing conditions. They are an essential part of the jigsaw that allows a significant number of people to be treated closer to home, linked with their primary care services and ensuring that hospitals can concentrate on the specialist work which they will be designed for. It is considered that an appropriate conservative approach has been taken to assessing the transfer of work to the community. The main risk may be that facilities will need to be expanded as the community based approach, technology and introduction of a wider range of local commissioners and providers develops.

SECTION EIGHT: TRAVEL & ACCESS

8.1 Introduction

The Joint Strategic Planning and Transportation Unit (JSPTU) has been commissioned to assess the travel and access implications of BHSP.

The work is in 2 stages:

Part 1: Overview of travel and access to current hospital provision especially for areas of high deprivation, existing public transport provision and potential impact of BHSP new provision

Part 2: Detailed analysis of the new BHSP provision highlighting "for what proportion of the public will the BHSP for travel time and distance:

- **improve travel & access**
- **be travel & access-neutral**
- **worsen travel & access to health services"**

To show the impacts on "blue-light' and non-emergency patient / visitor / staff travel

The Phase 2 work has been designed to enable continual analysis on an ongoing basis, this includes an in-depth, drill-down examination for individual schemes as well as taking a high level strategic view of transport networks in order to develop these further with the public transport and community transport sector as well as Local Authorities.

This section summarises the results of Part 1. Part 2 of the study will to be completed by 19 November 2005.

8.2 Summary of Phase One Conclusions from The Joint Strategic Planning and Transportation Unit (JSPTU)

8.2.1 The Plan has the potential to reduce journey lengths to hospitals significantly:

- 4% more people will be within 30 minutes' journey of healthcare treatment[1], and
- work so far has suggested average reductions in journey time of between 4% and 7% for different groups of patients totalled across the whole BHSP area.

[1] defined as providing a range of outpatient facilities

- It is also thought that mechanisms within the Health Service for directing people toward their nearest relevant health care facility could double these figures.

Table 1: Comparison of Journey Times for the Whole Population $ to BHSP Health Facilities Before, and After, Implementation of the Plan

	Percentage of households living within 15 minutes		Percentage of households living within 30 minutes	
	At present	After BHSP implementation	At present	After BHSP implementation
Bus & Rail - am peak period [i]	25%	28%	68%	72%
Bus & Rail - middle of the day [ii]	21%	24%	64%	68%
Bus & Rail - late evening [iii]	22%	22%	60%	63%
By car	78%	81%	99%	99%
By bicycle +	53%	57%	75%	79%
On foot +	12%	12%	31%	36%

[i] 0700 - 0900 [ii] 1200 - 1300 [iii] 2100 - 2200
+ Walking and cycling are significant modes of transport for staff, although infirmity makes it difficult for many patients to use these modes
$ Figures relate to the whole population of former Avon i.e. Bath & NE Somerset, Bristol, North Somerset and South Gloucestershire

8.2.2 The percentages of households living within 15 and 30 minutes travel time of a health facility are shown in Table 1 above. 15 minutes is the limit of most people's willingness to walk, while 30 minutes is the upper limit of people's willingness to cycle, and also represents about the average bus journey, including walking time[2].

8.2.3 In aggregate, the proportions living within 15 or 30 minutes of a health facility generally increase by 3 or 4 percentage points. No increase is shown in the number of people within 15 minutes on foot, partly because a large number of people in Bedminster etc live close to Bristol General Hospital, which is due to

[2] 2001 Census, Journeys to Work: - Walk 78% less than 2km = 15mins, Cycle 73% less than 5km = 35 minutes, bus 90% less than 23km

close. (Though Bristol General focuses on rehabilitation and care of the elderly and hence does not provide a full range of treatment).

8.2.4 Likewise there is no increase in the number of people within 15 minutes by bus in the late evening. Some of the new BHSP sites have poor bus services at this time. The analysis also shows no increase in the number of people within 30 minutes by car; this is because, in off-peak periods, the majority of the area can be reached by car in 30 minutes.

8.2.5 People living in the 10 designated Neighbourhood Renewal Areas in Bristol, which have all fallen into the lowest 5% of Output Areas in England on Multiple Deprivation scores, will obtain significant benefits from the Plan. In these areas:

- the Plan will increase the proportion of non-car owners who are within 30 minutes of a hospital by 31% on foot, 23% by bus in peak periods, and 24% by bus at other times.
- before the implementation of BHSP, 4 of the Neighbourhood Renewal Areas are within 15 minutes walk of a hospital; with the BHSP, this doubles to 8.

Another area in the lowest 5% on Multiple Deprivation scores is in Weston-super-Mare South ward, but this is unlikely to be significantly affected by the BHSP proposals. There are no other areas in the lowest 5% on Multiple Deprivation in the BHSP area.

8.3 Recommendations

An extensive package of public transport improvements has been agreed by the organisations developing Hengrove Park, of which the new South Bristol Community Hospital is one. This includes extensions to 5 existing bus routes and a new showcase route connecting Hengrove with the city centre. The South Bristol Community Hospital project already has a travel and access sub- group with local people, council transport and private operators co-opted.

There is:

- Possible scope for further improvement to secure better access from the east of Wells Road, Knowle although more analysis and mapping work is required to confirm this

While the site of the new Central and East Bristol Healthcare Centre already has generally good car and bus access, there is a need to

- improve evening bus services to the site, and

- improve bus services from the far east of its catchment area.

Southmead has generally good access by the non-car modes, and has much potential for future improvement in access by these. However, expansion of Southmead hospital will bring with it the need for

- improvements to evening bus services to serve the hospital
- a new bus service to link Southmead and the homes of Frenchay staff transferring to Southmead
- a (possibly dedicated) night bus to link Southmead staff and their home locations

8.4 Phase Two

The second stage of analysis will provide:

- Detailed analysis of the new BHSP provision highlighting "for what proportion of the public will the BHSP for travel time and distance:
  - **improve travel & access**
  - **be travel & access-neutral**
  - **worsen travel & access to health services"**

  - To show the impacts on "blue-light' and non-emergency patient / visitor / staff travel

The detailed analysis of the new BHSP provision, as described above, will be completed by 19 November 2005.

SECTION NINE: WORK IN PROGRESS

Specific ongoing work pan-BHSP is summarised below:

- Individual organisations will continue the business planning process to progress to the OBC and then FBC stages.

- Following completion by 19th November 2005 of Phase 2 of the Travel and Access assessment it is intended that further work will continue as an ongoing process including "drilling-down" in the data provided by the Joint Strategic Planning and Transportation Unit (JSPTU) to address specific areas raised in the Travel and Access Assessment and to decide what further work is required.

- The next phase of tasks on Workforce will include: -

    - Identifying ways in which the revised model of care can be best delivered in the context of '*Creating a Patient-Led NHS'*
    - Identifying the full implications of the BHSP affordability assessment
    - Developing a more sophisticated system of integrated service/workforce planning in the context of rapid service and organisational change
    - Developing a system-wide 'management of change' protocol and process
    - Developing a health community-wide workforce strategy
    - Identifying and funding senior level project management input for this work stream.

- The Model of Care will be further refined

- A clinical engagement strategy and process will be developed and implemented by the Clinical Redesign Group

- Following the Joint Decision Committee meeting on 14 March 2005 good progress has already been made in developing plans to centralise and rationalise specialist services (breast services, adult ear, nose and throat (ENT) and children's inpatient services). Additional work is now required to identify the long term location and co-location of other acute, specialist and – in the case of the two major Bristol hospitals - tertiary services, at each relevant acute hospital centre. This will take account of the new BHSP Model of Care.