Special Adults Wellbeing and Health Overview and Scrutiny Committee

7 September 2018

Update – Shotley Bridge Hospital Project

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Purpose of the Report

1. The purpose of this briefing note is to offer a further update in relation to the CCG's work concerning Shotley Bridge Hospital. This briefing note will outline:

    - The background to the project
    - The Functional case for change
    - The Strategic case for change
    - The Economic Case
    - The Financial Case
    - The Clinical case for change
    - Stakeholder briefing sessions (2017)
    - Progress made since last briefing (6th March 2018)
    - Issues to be resolved/possible outcomes
    - Decision making in healthcare – notes/guidance
    - Next steps and timescales

Background

2. Shotley Bridge Community Hospital (SBCH) is a NHS Property Services (NHSPS) freehold site comprising a medium sized hospital building circa 10,500 m2 gross internal area (GIA), which formed part of a larger hospital site, the majority of which has been demolished.
3. The buildings on the site consist of a six storey tower with basement containing wards, offices and various day services including a day theatre, outpatient's areas and various one and two storey extensions to the tower buildings containing ancillary services, outpatients, a restaurant and offices.
4. The main tower was constructed in 1969 with a two storey tower and basement with corridor link in circa 1950. A rear extension was added in circa 1990 with further extensions in 2001.
5. The associated building infrastructure services to the older blocks have not been replaced since their original installation and as such have exceeded the expected operational lifespan, leading to a number of operational risks.

6. North Durham CCG have been working alongside NHS Property Services to look at the area, the existing services being provided out of Shotley Bridge Hospital site and what future service delivery options may look like.

7. To support what will ultimately be an outline business case; discussions have taken place with our stakeholders from an early stage to look at options and possibilities for how future services may be delivered. North Durham CCG will continue talking with stakeholders to encourage openness and transparency.

The Functional Case for Change

8. Shotley Bridge Hospital's functionality and condition is not fit for the future. It no longer provides a clinically appropriate environment to meet the health needs of local patients. The configuration of the building limits what services can be delivered and does not support the delivery of proposed new models of care as outlined in the CCG's Commissioning Plan.

9. A 6 Facet Survey was carried out in 2009 and updated in 2015 which highlighted circa £2m (excluding VAT) of backlog maintenance being required over the next 5 years.

10. The operational costs to run Shotley Bridge are circa £1.8m per annum (exc. VAT).

The Strategic Case for Change

11. The NHS nationally and locally in North Durham, Durham Dales Easington and Sedgefield (DDES) and Darlington requires real planning to meet the needs of a population in which most of the disease is attributed to chronic diseases. We need to look carefully at how this can be delivered if the NHS is to be sustainable for the next generation.

12. The driver for change is the current state of the building. By reviewing the actual health needs in the area now (and looking at future need) gives us an opportunity to align our strategy to provide more care closer to home.

13. The ageing population in West Derwentside and surrounding areas, as well as an increased prevalence of chronic illnesses requires a move away from hospital care. To truly improve the health of the population, a move towards self-care and enabling the patient is needed. This requires more consistent provision of primary care, care that is well coordinated, planned and integrated but most of all, care that is delivered as close to a patient's home as possible.

14. Our aim is to improve the quality of community services by focusing on the frail elderly population and to ensure that we provide a modern, supportive environment for delivering high quality and integrated care in line with national objectives that we are expected to meet as an organisation.

The Economic Case for Change

15. As a CCG we pay void costs on any vacant clinical or non-clinical space. Over the years, it has been well documented that the cost of empty public space to taxpayers is millions and millions of pounds. This includes all public estate, not just health estate. There is a national drive for rationalisation of the estate, as well as release of poor or inadequate estate that is no longer fit for modern day healthcare. There is also some national interest in public sector organisations working more closely together when delivering their services through the 'One Public Estate' vision.

16. It is critical that any decisions we make as an organisation about future provision in the area not only meet the national and regional direction of travel in terms of estate costs, but that these also satisfy likely future clinical need. This future need may only be predicted based on the information we have available to us now. This includes information we have about current local service, future changes that are likely to impact the development, our own strategies such as Estates and our Teams Around Patients work and also information relating to our providers and how able they are going to be, to deliver services from a new development in future.

17. Aside from these challenges we need to ensure that we do not leave the CCG (and so ultimately the taxpayer) with avoidable estates costs in future through lack of use.

Financial Case for Change

18. Regional Estates strategies suggest that the eradication of backlog maintenance is a priority, as is the release of older buildings that are no longer fit for purpose. Such estate is expensive and unsustainable for the local health economy. Shotley Bridge hospital falls into this category.

19. CCGs are expecting a 20%-25% reduction in their Running Cost Allowance (RCA) in the next year or so. Premises costs including void costs are funded from the CCG RCA, it is essential where possible that any savings that can be made are made through an improved use of estate.

20. This will ultimately allow more money to be made available to improve health services for our population.

Clinical Case for Change

21. This is a functional case for change however; at the same time it is sensible to review clinical activity in the area while aligning this to what we are likely to need in the future. In doing this we also need to consider national and regional changes in delivery of care to patients.

22. The GP Five Year Forward view sets out a number of priority areas to develop primary care services. These are mainly to bring them closer to a patient's own

home using new models of delivery and bringing multiple specialties together. Nationally, it is a priority to develop community services that can be flexible in delivering care to meet individual patient needs.

23. GP services are developing rapidly, as are relationships between health and social care. It is a priority going forward that health and social care services work closer together than ever before in delivering appropriate care. This means sharing resources and facilities where it is appropriate to do so. Our work on Teams Around Patients is evidence of this shift in care delivery.

24. This project is an opportunity to look at what we are doing now, look at national guidance/expectations and see how we may be able to improve the experiences of our patients by keeping them closer to home and in appropriate accommodation for their needs.

Current and Planned Arrangements

Stakeholder briefing sessions (2017)

25. A series of workshops took place with representatives from different organisations and these workshops were broken down into three key groups.

26. *Workshop No. 1* - Its purpose was to brief the North Durham CCG Executive of the approach being taken to prepare the Outline Business Case (OBC) for the re-provision of services out of SBCH, and to specifically discuss the strategic case and its requirements.

27. *Workshop No. 2* - The purpose was to review the OBC methodology, review the status of Shotley Bridge Community Hospital including the services being delivered and current levels of utilisation. Review strategic drivers including local and national policies, discuss the future service needs of Shotley Bridge/West Derwentside and agree on a high level vision – strategic case, review the options to deliver the vision.

28. *Workshop No. 3* - The purpose was to facilitate a similar discussion to Workshop No.2 but with a wider audience including the local MP Laura Pidcock, council members, members of the 'Friends of Shotley Bridge Community Hospital', representatives from the NHS providers who deliver services from SBCH and key officers from Durham County Council, Karbon Homes and North Durham CCG.

Steering Group Establishment

29. A steering group was established in November 2017 which meets monthly. The purpose of the Shotley Bridge Steering Group is to:

- Consider information and data relevant to the need for healthcare provision in Derwentside.
- Consider options for the future Shotley Bridge Hospital estate.

- Act as the overall control group and receive and consider reports on detailed proposals.
- Steer implementation of the final model once agreed.

Project Group Establishment

30. A project group was also established in November 2017 to develop a functional case for change and clinical options for future service delivery. This group will also support the development of an Outline Business Case and may evolve into overseeing the activities that support the implementation of service changes.

Progress made to date

31. We have briefed elected members regularly on all of the work undertaken and how the work had enabled more accurate activity data in relation to the services currently running out of the hospital. This has since been shared with an independent healthcare planner.

32. We said at the last report that options may include the transfer of stand-alone clinics to other sites (clinics that don't require additional facilities such as diagnostics) or indeed clinics which have low levels of activity.

33. The Healthcare planner has set out the space requirements for a new build based on current activity with a 10% allowance for population growth. The figure also assumes a 75% occupancy rate across clinics which we are advised is high. Throughout the process potential solutions have emerged which also consider use of existing space where there may be equipment that is currently underutilised. For example we know that we have space at Stanley Primary Care Centre and we know that we also have unused audiology suites, as well as radiology equipment there.

34. A summary at Appendix A outlines the options that have been derived from this work. We have further work to do with our colleagues at NHS property Services around the costings but hope to conclude this by autumn and work through some affordability modelling. These options assume that low level paediatric outpatient clinics would move into Stanley Primary Care Centre but this has not yet been decided.

35. Postcode travel analysis is being undertaken to understand the distances between locality postcodes and other health facilities. To fully understand all factors a Northerly, Southerly, Easterly, Westerly and central postcode will be used from the Stanley and Consett areas to get an appropriate average. This will help us build a consistent picture to determine what can be considered a fair travel distance for users of health services, taking into account public transportation.

Issues for Resolution and Possible Outcomes

Beds

36. Current activity data suggests that there is a clinical need for patient beds in the Consett area. We know that a high proportion of patients from the area go to Weardale Hospital and we are doing some further analysis to understand what their health needs are so we can consider what might be better offered closer to home. The CCG have no control over which patients are directed to which hospital and decision making by our main provider CDDFT is based on clinical need and available beds at that point in time.

37. We know that as part of our community contract with CDDFT they are looking at reducing the patient length of stay which is expected to have an impact on the number of beds required across the whole health estate for that provider. We are meeting with them to get a better understanding of this work to help inform our decision making on beds.

38. The Healthcare planning process has indicated that anything less than a 24-bedded ward is not cost effective in the longer term due to the additional services required to support the facilities. This was confirmed by our independent healthcare planner. The Carter Review, which looked at achieving cost efficiencies across healthcare, concluded that 16 beds was the minimum possible bed number to achieve efficiency. This project would be unable to support either of these numbers because the need is not there.

39. An 8-bedded ward is being considered however, this would go against both sets of advice and guidance around cost effective hospitals and would leave us with uncertainty about the future sustainability of this facility. Current evidence would suggest that an 8-bedded ward is not cost effective or sustainable.

40. We are looking at alternative options for bed provision with the independent sector in the area, as well as with the Willowburn Hospice to get a fuller understanding of what is available and what we may be able to do differently in future.

Theatres

41. Darlington and UHND – CDDFT have confirmed that they are not supportive of delivering surgical services (including endoscopy) at locations other than their main sites for patient safety reasons. The Trust feel that they need the appropriate back up services in place on the same site as the surgery that is taking place. This means that delivering surgery from Shotley Bridge/Consett in future is unlikely.

42. At this stage and with this knowledge in mind, the CCG would not be able to support the building of a new theatre suite for it to stand empty due to the Trust's future clinical plans. This would not be value for money for the taxpayer.

43. It would be inappropriate for the CCG to proceed to build theatres knowing that their main provider had no use for it clinically and no intention of using it. The ultimate result of doing this would be further cost to the taxpayer for expensive, empty space.

44. Aside from these issues, the activity data for these services is low and potentially not large enough to warrant its own facility in any event.

Chemotherapy

45. We are aware that the Trust has plans to refurbish their chemotherapy ward so that it can provide a better patient environment. The Trust also has the option to extend their beds so that the current activity at Shotley Bridge can be absorbed to the main site. We know that these plans rely heavily on Macmillan funding.

46. The CCG have met with Macmillan, who confirmed one of their strategic priorities is care closer to home and that our plans for Consett may impact their thoughts around what they fund within UHND. Both the CCG and Macmillan will separately meet with the Trust's service manager to establish whether or not there is any merit in approaching this jointly and so we can better understand the Trust's plans for chemotherapy in future.

47. Again, if the Trust were intending on absorbing activity from Shotley Bridge into their main site, it would not represent value for the taxpayer if the CCG were then to build a new unit, for it to be unstaffed by the main service provider and standing empty.

Urgent Care

48. A recent review of urgent care has recommended between the hours of 1200 midnight and 0800am there is very little activity through any of North Durham's urgent care centres.

49. As such it is recommended that if an urgent care facility was provided in future, it would open only during the hours of 0800am and 1200 midnight.

Outpatients

50. The options developed suggest there is enough activity to support the continued delivery of some community outpatient services from the Consett area.

Stanley

51. We are working with the General Manager for Paediatrics at CDDFT. They and the Paediatricians from the Trust are keen on Stanley as a children's services centre having delivered from the site before.

52. Stanley's proximity to Consett means that patients from both Consett and Stanley would not be at a disadvantage from this move travel wise. The service manager was keen in particular for disabled children in the area to have good access to facilities which Stanley can provide for well. This would also make better use of the currently unused audiology suite at Stanley and negate the need for the CCG to build a new one, which would be expensive.

53. Activity levels for these services are low and as they do not depend on being located next to other services, can be safely moved.

54. This opens up the possibility for additional paediatric services to work out of Stanley in future, through further discussion between the Trust and the CCG. This would also bring the facility back into its intended original use and reduce some of the CCG's void costs there.

55. We are also running a 12 month Children's Autism Diagnostic service pilot with Tees, Esk and Wear Valleys (TEWV) Mental Health Foundation Trust.

Other Public Services

56. An initial meeting has taken place between the CCG and representatives at Durham County Council who are leading on the One Public Estate agenda. This looks at the potential for co-locating health and social care services and sharing of facilities.

57. Durham County Council (DCC) have the service data from Shotley Bridge and are working with their social care teams to establish whether or not any services have the potential to be co-located well together out of any potential new building. DCC reps will also explore possible interest from the ambulance service, fire service and others as part of this exploratory work.

58. If any of this were likely to be developed within project timescales it would have the potential to offer some income to the project and make it health and social care funded – benefitting both public sector organisations.

59. DCC are also looking at potential income for health from the Genesis project at the old steelworks in Consett.

Mental Health

60. TEWV plans outline a significant requirement for administration space within the healthcare planner's space calculation which moves the project away from being a healthcare setting and more of an administration/office space.

61. It is unlikely therefore that the CCG would pursue this as part of the project as there is other empty space that could be used within the estate for this purpose. It would not be cost effective to invest in building more property for administrative services.

Procurement Issues

62. To date the CCG have worked alongside NHS Property services with their healthcare planner and surveyor to establish space requirements and outline costs.

63. The CCG do have the opportunity to work with an alternative developer for this project however; this would require a full procurement exercise to establish a preferred bidder.

64. We are in the process of working through the benefits and disadvantages of working with NHS Property Services or an alternative provider and will need to make a decision soon on which offers the best value for money and poses the least risk to the CCG.

Where to Build

65. The existing hospital is being built around with houses and does not represent the best site accessibility wise for patients and the public.

66. We will look at current and other sites as part of our work to establish what is most accessible and most affordable. These locations may form part of our options for public engagement.

Decision Making in Health Care – Notes and Guidance

67. The NHS Constitution in England gives CCGs the power to make decisions about the commissioning of health care services. GPs and other local health professionals (such as those within a CCG) commission most NHS services and are responsible for ensuring that all health services delivered meet clinical need (NHS Constitution).

68. Upper tier and unitary local authorities in England have, by law, powers to review and scrutinise any matter relating to the planning, provision and operation of the health service (including public health) in its area. This enables scrutiny of the quality of services provided locally, and the CCG fulfil this obligation by ensuring that any CCG decisions to change services are taken through the Health Overview and Scrutiny Committee at appropriate stages for their views (NHS Constitution).

69. The CCG are also obliged by the NHS Constitution to involve people early in the service change process and we have done this by engaging with stakeholders through a series of workshops and then subsequently setting up steering and project groups which include patient representatives, public representatives (local councillors), providers of services and CCG managerial staff.

70. The CCG will continue to be open and transparent throughout the project and will continue to involve these parties.

71. It is important to clarify that no decisions have been made about the future delivery of services within Shotley Bridge and that the project is in its early stages, assessing clinical need so that options for future delivery of care can be properly evaluated.

72. Ultimately the CCG decides whether or not changes to services are required and what they may look like in future but thorough decision making principles are

applied including the involvement of key stakeholders and the use of clinical data and information to ascertain clinical need. Any service changes also must be 'future-proofed' and in order for this to be successful, we need to work across the healthcare system with our providers so that our efforts are aligned to their strategic direction and regional/national expectations around the future provision of health and social care services.

73. If NHS Property Services were to sell the site and redevelop elsewhere, the funds from the sale would return to the Department of Health to recycle into the NHS via the standard business case approval processes. There is no commitment to reuse the funds locally. This is current DoH policy and has been consistent since 2013. In its response to the Naylor Report DoH have confirmed this position.

Next Steps

74.

- Outline business case to NHS England end 2018
- Public consultation early 2019
- Full business case Spring-Summer 2019
- Construction later 2019

All timescales are approximate and subject to change.

Recommendations

75. The Adults Wellbeing and Health Overview and Scrutiny Committee is recommended to accept this report for information.

Appendix A – Healthcare Planner Options

- Do nothing
- Close and do not replace
- Do minimum – provide at other sites
- Outpatients facility for chronic and continuing care
- Outpatients facility for chronic and continuing care, urgent care and imaging
- Outpatients facility for chronic and continuing care, urgent care, imaging and chemotherapy
- Outpatients facility for chronic and continuing care, urgent care, imaging, chemotherapy, surgery and endoscopy
- Outpatients facility for chronic and continuing care, urgent care, imaging, chemotherapy, surgery, endoscopy and inpatient ward