Support to Local Health Economies - Southern Sector

Programme Board

24 June 2014

Agenda

- **Pre-meeting discussion with local organisations only – 30 mins**
- Welcome and introductions – 5 mins
- Review of minutes and outstanding actions from last meeting – 10 mins
- Review evaluation assessment and agree viable options – 1 hr, 45 mins
- Discuss high level implementation plans and communications and next steps – 30 mins

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  - Non-financial evaluation
  - Value for Money evaluation
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Revised list of Southern Sector reconfiguration options following assessment of elective activity

PRELIMINARY

CDM1: Emergency Ctr
CDM2: Emergency Med Ctr
CDM4: Elective Day Case
CDM5: Specialised
CDM3: Non-complex elective (may not include urology and T&O)

Site	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7
ECT	CDM3 OR CDM4	CDM2 / CDM3	CDM3 OR CDM4	CDM2 / CDM3	CDM3 OR CDM4	CDM2 / CDM3	CDM2 / CDM3
STFT	CDM1 / CDM3	CDM1 / CDM3	CDM1 / CDM3	CDM3	CDM2 / CDM3	CDM1 / CDM3	CDM2 / CDM3
UHSM[1]	CDM3 / CDM5	CDM3 / CDM5	CDM2 / CDM3 / CDM5	CDM1 / CDM3 / CDM5	CDM1 / CDM3 / CDM5	CDM2 / CDM3 / CDM5	CDM1 / CDM3 / CDM5
THFT	CDM3 OR CDM4	CDM3 OR CDM4	CDM3 OR CDM4	CDM3 OR CDM4	CDM3 OR CDM4	CDM3 OR CDM4	CDM3 OR CDM4

Clinical Board agreed to have a CDM6 on all sites under all options

Note: Consultant led obstetrics unit at STFT and UHSM in all options where either CDM 1, 2 or 5;
ECT to be modelled with and without Obstetrics when CDM2; all complex elective inpatients at CDM1
1 Hurdle criteria require that UHSM include a CDM5 in all options

We have confirmed a set of hurdle criteria

Hurdle criteria	Justification
1 No premises in new locations, existing NHS estate should be utilised[1]	▪ Timescale and cost of securing and developing new sites
2 Is aligned with commissioner plans and ensures commissioners are viable; this should include ensuring a viable provider landscape with identification of any proposed subsidies by commissioners required to maintain commissioner requested services[2]	▪ Must facilitate the whole system transformation set out in plans within the available resources
3 Is aligned with the specialised commissioning and other national strategies (e.g., major emergency centres)	▪ Specialised commissioning and other services being separately evaluated as part of national strategy
4 Aligns to commitments made in prior CCG consultations[2]	▪ Commissioners need to hold to the commitments made in regards to changing services in prior consultations
5 Allows delivery of the agreed minimum standards of care and care models	▪ Need sufficient clinical activity to fund the required minimum workforce essential for the delivery of safe services
6 Maximum number of points of delivery given the available workforce and activity need of the population	▪ To offer the maximum number of viable sites to optimise patient access across the system
7 Travel times for certain services (e.g., urgent care) will not be longer than a set maximum	▪ Travelling more than a set maximum time is not reasonable for patients and carers ▪ Requires blue light travel times of 45 minutes to a CDM1[3,4] ▪ Requires 90% of population within 20 mins access to an A&E and 100% of population within 30 mins access to an A&E with blue light travel times[4]

1 No completely new sites will be built; however, investment and expansion at existing sites is anticipated
2 CCGs have been asked to note any additional requirements that may alter shortlisted options by 3 June
3 Aligned with Healthier Together
4 Blue light travel times defined as 66% of peak private car travel times

Non-financial evaluation criteria (1/2)

Criteria	Sub-criteria	Proposed measurement
1 Quality of care[1]	▪ Clinical effectiveness and outcomes	▪ Mortality rates*
	▪ Patient experience	Patient experience data using CQC standardised scores for: ▪ How would you rate the care you received?* ▪ Did you feel you were treated with respect?* ▪ Were you involved as much as you wanted to be?*
	▪ Estate quality	Quality of estates, looking at: ▪ Area of not functionally suitable NHS space ▪ Estate dating post-1964 ▪ Estate dating post-1984 ▪ Number car parking spaces ▪ % of single (ensuite) rooms
	▪ Supports innovation*	
2 Access to care	▪ Distance and time to access services	▪ Blue light travel times (average and maximum) ▪ Private car – off peak travel times (average and maximum) ▪ Private car – peak travel times (average and maximum) ▪ Public transport – peak travel times (average and maximum) ▪ Each by total population and >75s
	▪ Patient choice	The reduction in the number of sites delivering: ▪ Emergency care ▪ Obstetrics ▪ Outpatients and diagnostics ▪ Elective care ▪ Paediatrics

* These analyses do not differentiate between options in future model
1 Patient safety is considered before this stage of evaluation in the hurdle criteria for options. All options must meet required patient safety standards
2 Costs of transitioning from the current to the proposed option
NOTE: Theatre estate (airflow) was proposed as an estate quality evaluation criteria but has not been included as it can be changed by capex investment and therefore will be part of costing of the options

Non-financial evaluation criteria (2/2)

Criteria	Sub-criteria	Proposed measurement
4 Deliverability	▪ Workforce/staffing	▪ Staff turnover rates* ▪ Staff sickness rates* ▪ Staff recommendation as a place to work or receive treatment* ▪ Staff job satisfaction* ▪ Staff satisfied with the quality of work and patient care*
	▪ Expected time to deliver	▪ The number of sites already delivering the services ▪ The new capacity required ▪ The volume of acute beds that would be moved ▪ The volume of maternity beds that would be moved ▪ The volume of paediatrics beds that would be moved
	▪ Co-dependencies with other strategies including primary care	▪ CCG strategies – flows across council and CCG boundaries ▪ Healthier Together ▪ National guidance
5 Research and education	▪ Conducive to clinical education ▪ Conducive to clinical research	▪ Research spend at non-major ED and non-specialist hospital sites ▪ Education spend at non-major ED and non-specialist hospital sites.

* These analyses do not differentiate between options in future model
1 Patient safety is considered before this stage of evaluation in the hurdle criteria for options. All options must meet required patient safety standards
2 Costs of transitioning from the current to the proposed option
NOTE: Number of staff likely to move site was proposed as a deliverability evaluation criteria but has not been included because this is covered by bed movements and transition costs.

Value for Money evaluation criteria

Criteria	Notes	Components
i Capital costs	▪ Upfront capital required to implement acute reconfiguration	▪ Capital costs to accommodate changes in estate ▪ Net receipts from selling land
ii Transition costs	▪ One-off costs (excluding capital build and receipts) to implement changes	▪ Workforce: training ▪ Workforce: redundancy ▪ Workforce: travel protection ▪ IT costs ▪ Implementation (programme team)
Viable provider land-scape[1] – iii Trust viability	▪ Assessment of the ongoing viability of individual hospital sites	▪ Number of sites below 1% surplus[3]
Viable provider land-scape[1] – iv Impact on provider I&E	▪ Income and expenditure (I&E) benefit across providers, delivered by proposals	▪ Sum of the income and expenditure changes across all providers in scope
v Net present value[2]	▪ Total value of each option incorporating future capital and revenue implications and compared on like-for-like basis	▪ Upfront capital and transition costs ▪ Recurrent income and expenditure changes due to proposals, across wider public sector ▪ NPV relative to 'base case' forecasts

1 Evaluation focuses on acute providers only
2 NPV is calculated in line with Treasury Green Book guidance
3 Assessment against "1% net surplus'" has been used as the minimum requirement, as a proxy for the minimum level for financial health of a provider when assessing income and expenditure only. However, Trusts may plan for higher surpluses, and also the full financial viability of a provider would require assessment of cash flow and balance sheet issues (e.g. Monitor risk assessment framework)

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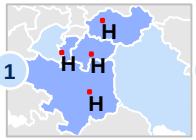
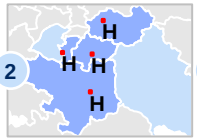
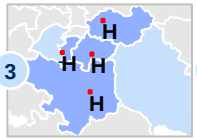
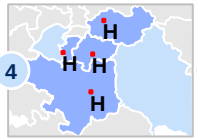
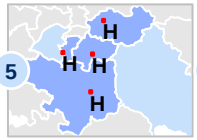
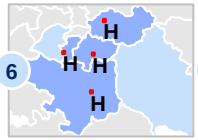
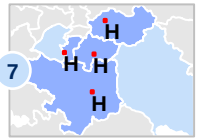
Summary of non-financial option evaluation

++ High evaluation
-- Low evaluation
/ Neutral evaluation

PROPOSED AT 17TH JUNE CLINICAL BOARD

		1	2	3	4	5	6	7
								
		Hospital / **CDM**	**Hospital** / **CDM**	**Hospital** / **CDM**	**Hospital** / **CDM**	**Hospital** / **CDM**	**Hospital** / **CDM**	**Hospital** / **CDM**
		▪ ECT ▪ 3 or 4 ▪ STFT ▪ 1/3 ▪ UHSM ▪ 3/5 ▪ THFT ▪ 4	▪ ECT ▪ 2/3 ▪ STFT ▪ 1/3 ▪ UHSM ▪ 3/5 ▪ THFT ▪ 4	▪ ECT ▪ 3 or 4 ▪ STFT ▪ 1/3 ▪ UHSM ▪ 2/3/5 ▪ THFT ▪ 4	▪ ECT ▪ 2/3 ▪ STFT ▪ 3 ▪ UHSM ▪ 1/3/5 ▪ THFT ▪ 4	▪ ECT ▪ 3 or 4 ▪ STFT ▪ 2/3 ▪ UHSM ▪ 1/3/5 ▪ THFT ▪ 4	▪ ECT ▪ 2/3 ▪ STFT ▪ 1/3 ▪ UHSM ▪ 2/3/5 ▪ THFT ▪ 4	▪ ECT ▪ 2/3 ▪ STFT ▪ 2/3 ▪ UHSM ▪ 1/3/5 ▪ THFT ▪ 4
Quality of care	**Clinical effectiveness and outcomes**	++	++	++	++	++	++	++
	Patient experience	++	++	++	++	++	++	++
	Estate quality	-	/	/	++	++	/	++
	Supports innovation	++	++	++	++	++	++	++
Access	**Time to access CDM1**	-	-	-	-	-	-	-
	Time to access CDM1/2	--	-	-	-	-	/	/
	Patient choice	--	-	-	-	-	-	-
Deliverability	**Workforce/staffing**	++	++	++	++	++	+	+
	Expected time to deliver	--	--	--	--	-	-	-
	Discharge flows	-	-	-	-	-	/	/
	Alignment with other strategies	+	+	+	++	++	/	+
Research & education	**Alignment**	/	/	+	+	+	+	+

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Key assumptions for financial reconfiguration modelling and evaluation

Intermediate case shown on following slides

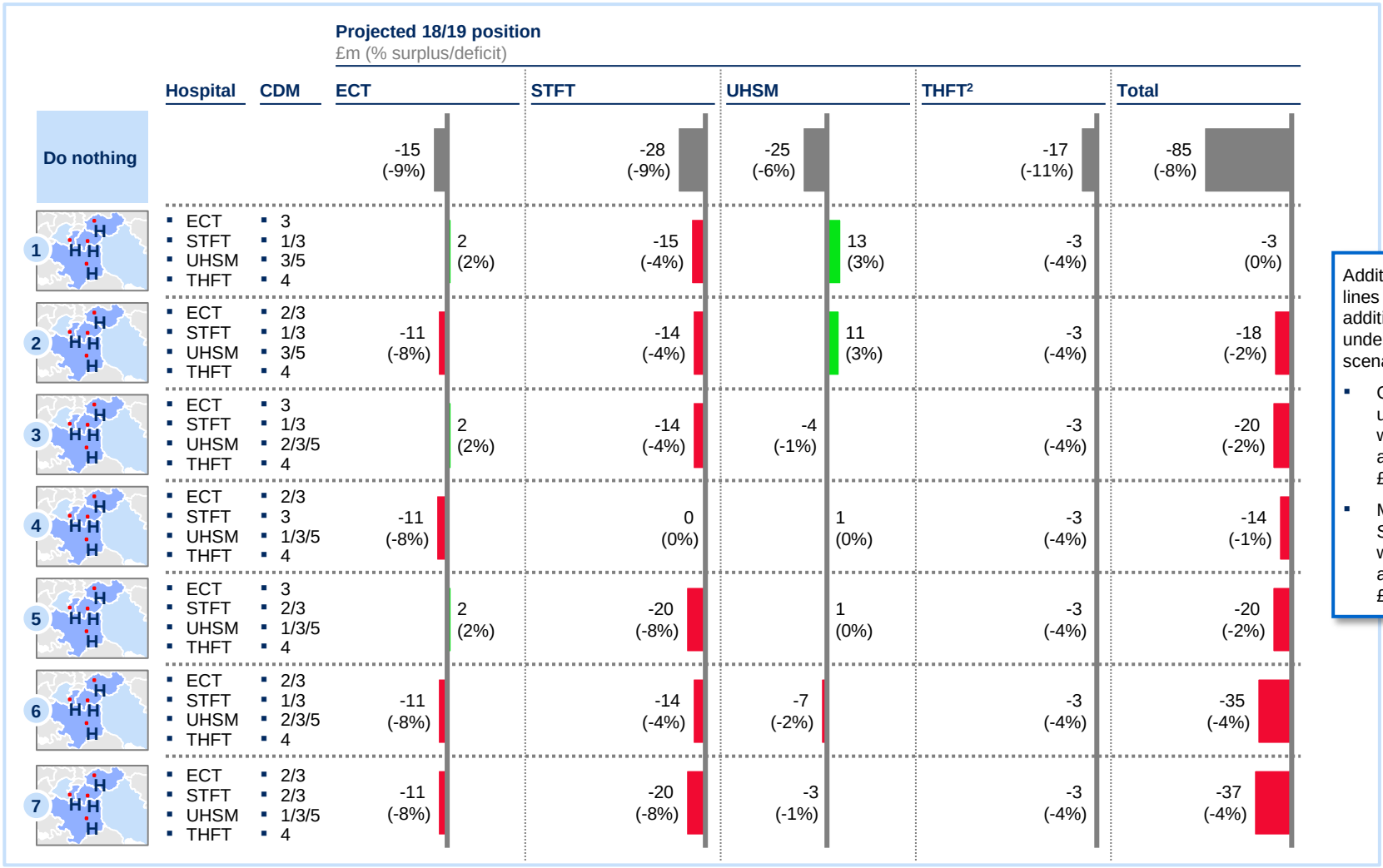
	Rationale for improved case	Worst case	Intermediate	Best case
Tariff efficiency for CCG services	▪ 4% CCG tariff efficiency may be reduced given it puts significant pressure on trusts; ▪ Effective reduction in prices may be less because of non-PbR prices and rebasing tariff using reference costs	4%	3.5%	3%
Cost of new build	▪ Cost of new build may be reduced if – Ability to absorb more activity through increased throughput in A&E, theatres and outpatient space[1] – Opportunity for refurbishment rather than new build	£700-1000k per bed	£300-750k per bed	£200-500k per bed[2]
Spare capacity	▪ Some existing excess capacity at non-SS trusts may be used for new SS activity ▪ Potential for LOS reduction opportunities outside SS (further to HT assumption)	0 beds	100 beds[3]	200 beds[4]
Service swaps	▪ Opportunity to reduce build outside SS if elective activity can be diverted from sites receiving new emergency activity	0 beds	50 beds[5]	100 beds

1 Increased productivity already assumed through 15% LOS reduction in bed activity
2 As per original assumptions; intermediate case adds 50% to these costs
4 Assumes additional 100 beds at CMFT can be utilised (~160 current capacity after HT)
3 Assumes additional ~1% ALOS in addition to HT assumptions; releases additional 100 beds at CMFT, Oldham and Salford
5 Assumes ~10% of elective activity at CMFT, Oldham and Salford could be diverted to SS Trusts; note service swaps are assumed not to affect trust I&E given site retains the activity put it is reprovided on another side (e.g., fixed costs covered through rental payments to host site)

‘Intermediate Case’ Forecast trust level I&E under each option

PRELIMINARY

£m



Additional service lines may add additional deficit under certain scenarios, e.g.,

- Obstetrics unit at ECT would cost additional £1-1.5m[1]
- MLU and Step Up beds would cost additional £0.5-1m

1 In each option where ECT is CDM2 it is currently assume to include Obstetrics activity
2 THFT is being finalised to align with Care Together work; difference shown is due to 3.5% tariff deflator

SOURCE: LHE SS reconfiguration model; Trust baseline data

Trust I&E forecast suggests that Options 6 and 7 are no longer viable

- Options 6 and 7 run a ~£35m deficit and would require a 4% subsidy across the CCGs
- Even if all benefits from organisational form were achieved, this would still leave a deficit of ~£20-25m and would require a >2% subsidy across the CCGs
- As per the agreed hurdle criteria, in order for commissioners to meet current plans these options would no longer be viable

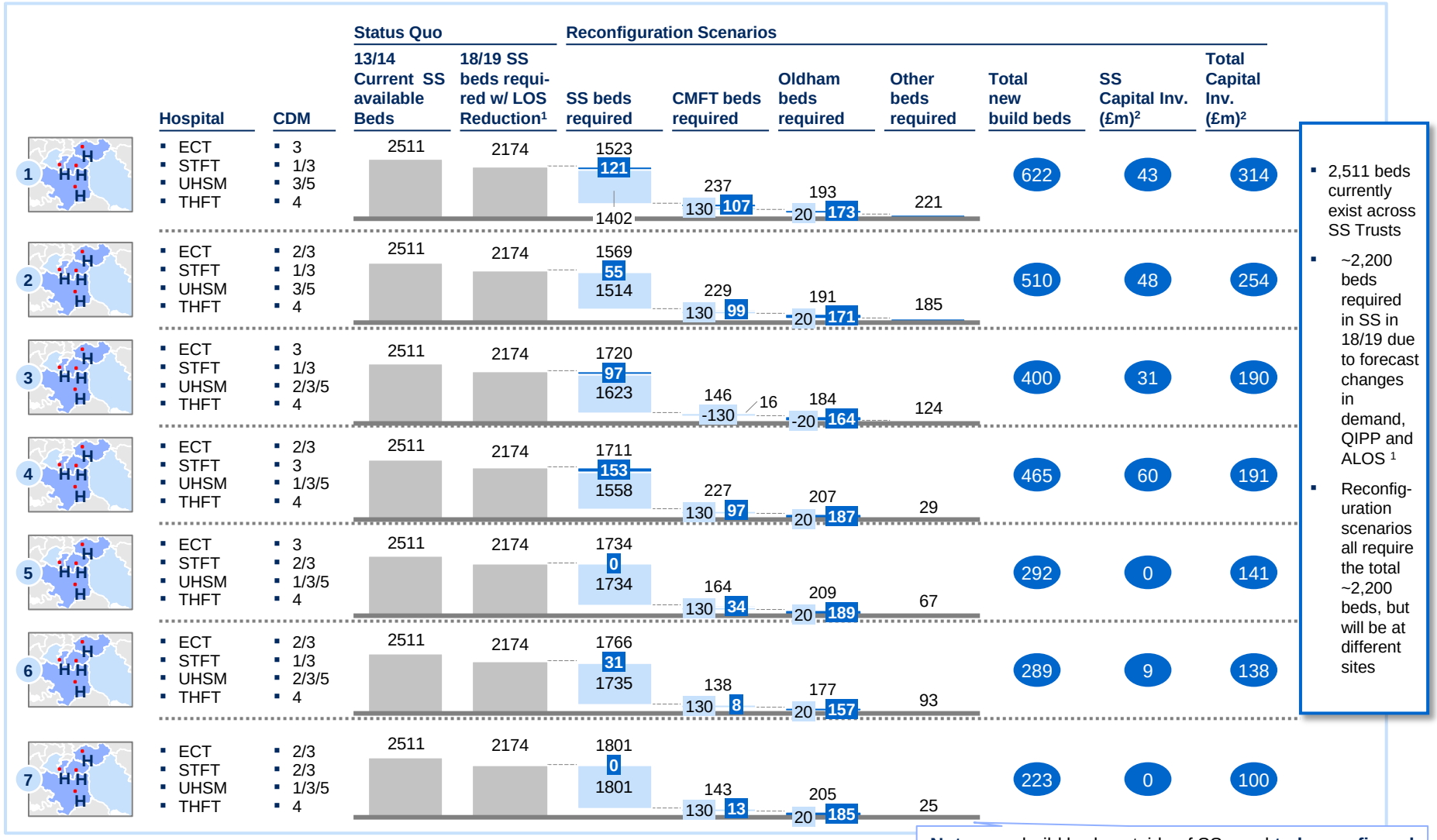
‘Intermediate Case’ Incremental change in I&E under each option PRELIMINARY

£m

SOURCE: LHE SS reconfiguration model; Trust baseline data

‘Intermediate Case’ Changes in beds by option, and associated capital costs

PRELIMINARY



- 2,511 beds currently exist across SS Trusts
- ~2,200 beds required in SS in 18/19 due to forecast changes in demand, QIPP and ALOS [1]
- Reconfig-uration scenarios all require the total ~2,200 beds, but will be at different sites

Note: new build beds outside of SS need **to be confirmed**

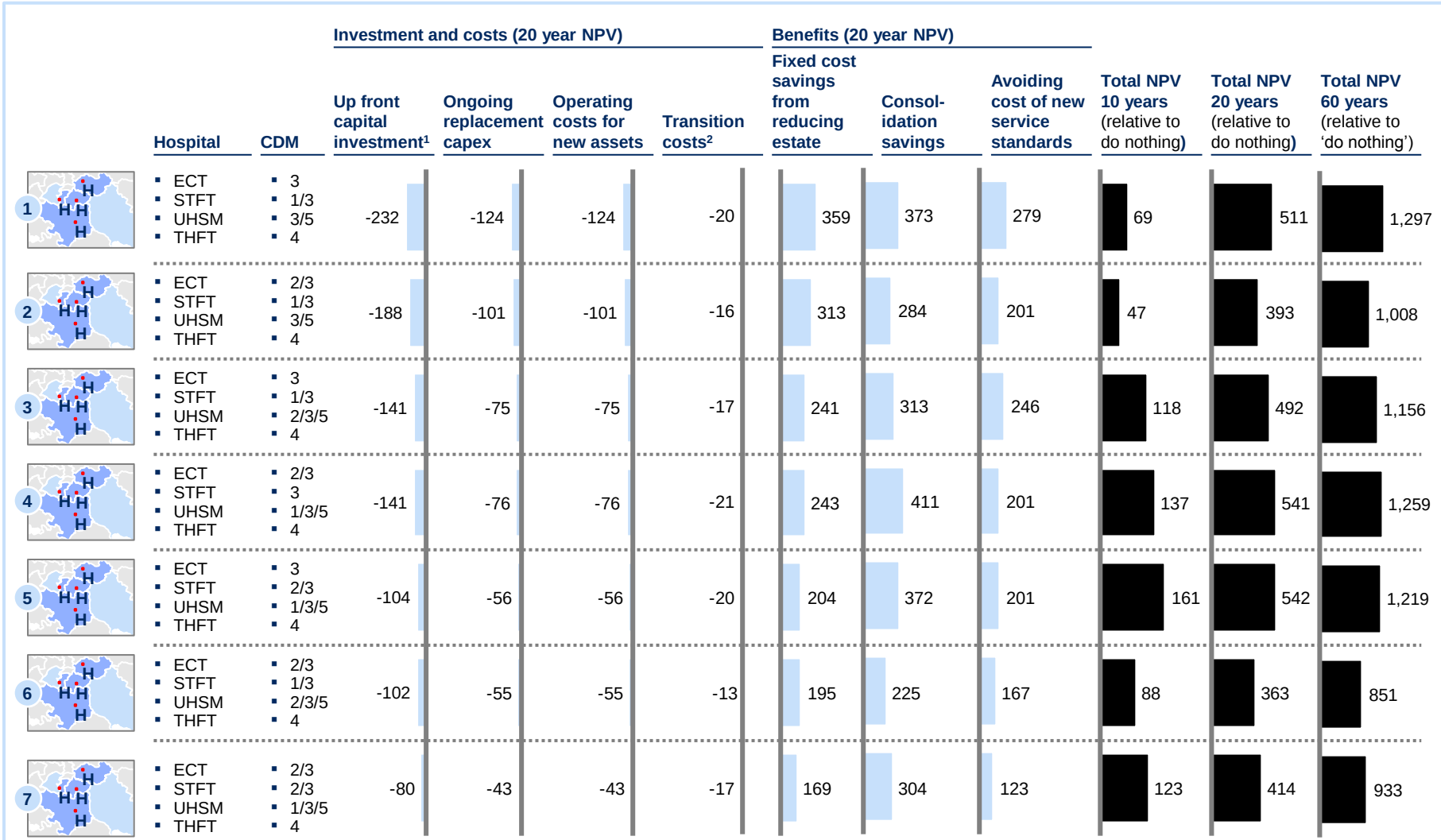
1 3% pa for ALOS reduction in general adult beds; no change in paediatrics, maternity or critical care ALOS
2 Total beds/capital cost across Southern Sector, CMFT and Other Trusts

SOURCE: LHE SS reconfiguration model; Trust baseline data

‘Intermediate Case’ Evaluation of ‘NPV’ of acute reconfiguration

PRELIMINARY

Net present value (£m) relative to ‘do nothing’



1: Up front capital investment excludes PDC and VAT as per government guidance

2: Transitions costs include the ongoing price of an additional ambulance all other costs are one off, excludes redundancy payments

SOURCE: LHE SS reconfiguration model; Trust baseline data

Thresholds for scoring Value for Money evaluation criteria

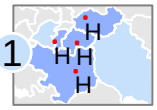
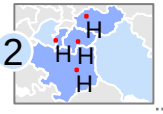
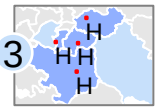
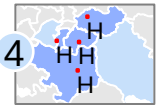
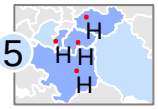
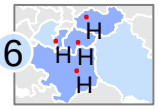
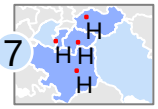
Difference compared to base case

	++	+	/	-	- -
i. Net capital costs	▪ >£200m less	▪ £5m-£200m less	▪ +/-£5m of 'base case'	▪ £5-£200m more	▪ >£200m more
ii. Transition costs	▪ N/A	▪ N/A	▪ Within +/-£5m of 'base case'	▪ £5-£30m above 'base case'	▪ >£30m above 'base case'
iii. Trust viability	▪ All Trusts above 1% net surplus	▪ Half of the Trusts below 1% net surplus in 'base case' now exceed 1%	▪ No change from 'base case'	▪ N/A	▪ Trusts above 1% net surplus in 'base case' drop below 1%
iv. Incremental impact on provider I&E	▪ >£75m improvement in total I&E vs. 'base case'	▪ £5m-£75m improvement in I&E vs. 'base case'	▪ Within +/-£5m of 'base case'	▪ £5m-£75m reduction in I&E vs. 'base case'	▪ >£75m reduction in I&E vs. 'base case'

'Base case' is the set of 2018/19 forecasts for Income & Expenditure at Trusts before the incremental impact of proposed changes

‘Intermediate Case’ Value for Money analysis and scoring

PRELIMINARY

Option:	Hospital	CDM	Total capital costs (£m)		Transition costs (£m)		Trust viability (number of Trusts in deficit)		Total incremental impact on provider I&E (£m)		Net Present Value[1] (£m) 10 yr	20 yr
1 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 3/5 ▪ 4	314	--	40	--	2	+	88	++	69	511
2 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 3/5 ▪ 4	254	--	30	--	3	/	72	+	47	393
3 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 2/3/5 ▪ 4	190	-	33	--	3	/	79	++	118	492
4 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 3 ▪ 1/3/5 ▪ 4	191	-	44	--	4	/	91	++	137	541
5 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 2/3 ▪ 1/3/5 ▪ 4	141	-	39	--	3	/	85	++	161	542
6 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 2/3/5 ▪ 4	138	-	24	-	4	/	62	+	88	363
7 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 2/3 ▪ 1/3/5 ▪ 4	100	-	30	--	4	/	67	+	123	414

Note: Thresholds have been purposefully selected to differentiate between options, although the differences between options may be marginal and within the margin of error for forecasting

1 NPV relative to base case, calculated in line with Green Book guidance (3.5% discount rate years 1-30)

SOURCE: Reconfiguration modelling – see assumptions and scoring thresholds

‘Best Case’ Value for Money analysis and scoring

PRELIMINARY

Option:	Hosp-ital	CDM	Total capital costs (£m)		Transition costs (£m)		Trust viability (number of Trusts in deficit)		Total incremental impact on provider I&E (£m)		Net Present Value[1] (£m) 10 yr	20 yr
1	ECT STFT UHSM THFT	3 1/3 3/5 4	180	-	40	--	2	+	104	++	218	716
2	ECT STFT UHSM THFT	2/3 1/3 3/5 4	144	-	30	--	3	/	85	++	171	563
3	ECT STFT UHSM THFT	3 1/3 2/3/5 4	119	-	33	--	3	/	87	++	198	602
4	ECT STFT UHSM THFT	2/3 3 1/3/5 4	102	-	44	--	2	+	101	++	236	678
5	ECT STFT UHSM THFT	3 2/3 1/3/5 4	82	-	39	--	2	+	92	++	236	678
6	ECT STFT UHSM THFT	2/3 1/3 2/3/5 4	86	-	24	-	4	/	68	+	147	444
7	ECT STFT UHSM THFT	2/3 2/3 1/3/5 4	59	-	30	--	4	/	72	+	165	460

Note: Thresholds have been purposefully selected to differentiate between options, although the differences between options may be marginal and within the margin of error for forecasting

1 NPV relative to base case, calculated in line with Green Book guidance (20-year NPV, 3.5% discount rate years 1-30, 3.0% discount rate years 31-60)

SOURCE: Reconfiguration modelling – see assumptions and scoring thresholds

‘Worst Case’ Value for Money analysis and scoring

PRELIMINARY

Option:	Hosp-ital	CDM	Total capital costs (£m)		Transition costs (£m)		Trust viability (number of Trusts in deficit)		Total incremental impact on provider I&E (£m)		Net Present Value[1] (£m) 10 yr	20 yr
1	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 3/5 ▪ 4	607	--	40	--	3	/	56	+	-251	77
2	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 3/5 ▪ 4	509	--	30	--	3	/	44	+	-228	23
3	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 2/3/5 ▪ 4	430	--	33	--	4	/	54	+	-139	148
4	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 3 ▪ 1/3/5 ▪ 4	458	--	44	--	4	/	62	+	-152	152
5	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 2/3 ▪ 1/3/5 ▪ 4	331	--	39	--	4	/	65	+	-41	275
6	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 2/3/5 ▪ 4	340	--	24	-	4	/	41	+	-125	81
7	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 2/3 ▪ 1/3/5 ▪ 4	276	--	30	--	4	/	50	+	-65	157

Note: Thresholds have been purposefully selected to differentiate between options, although the differences between options may be marginal and within the margin of error for forecasting

1 NPV relative to base case, calculated in line with Green Book guidance (20-year NPV, 3.5% discount rate years 1-30, 3.0% discount rate years 31-60)

SOURCE: Reconfiguration modelling – see assumptions and scoring thresholds

Sensitivity analysis for how changes in modelling variables impact CCG and providers forecasts, and Net Present Value calculation

PRELIMINARY

£m

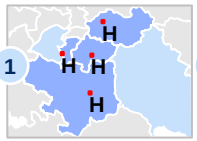
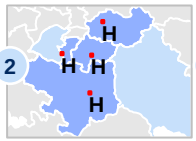
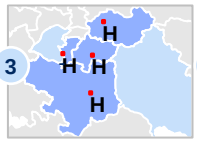
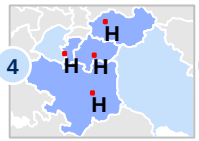
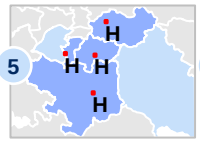
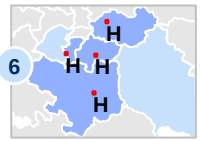
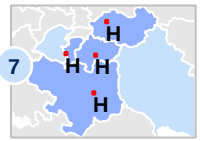
Variables	Description of sensitivity test	CCG viability	Trust 'base case' forecast	Incremental I&E impact on all Trusts	20 year Net Present Value
Net change in activity (demand growth and QIPP delivery)	▪ 20% higher/lower net change in activity	5-10 / n/a	5-10 / 10-20	0-5	0-100
	Trusts are/are not reimbursed[1]				
CIP delivery	▪ 20% increase/decrease of productivity opportunity is delivered	✗	25-35	0-5	0-100
Patient flow out of Southern sector	▪ 20% increase/decrease in activity loss outside of Southern sector	✗	✗	5-10	100-200
Costs to meet new clinical service standards	▪ 20% increase/decrease in costs to meet new clinical service standards	✗	15-25	15-25[3]	300-500
Economies of scale due to consolidation of services	▪ 20% increase/decrease in economies of scale	✗	✗	5-10	100-200

1 When Trusts are reimbursed for additional activity, CCGs incur additional costs and Trusts receive additional margin for services performed. When Trusts are not reimbursed, there is no effect on CCGs and Trusts incur additional (marginal) costs
2 Assumes 15% LOS reduction outside of SS
3 Avoidance of some costs to meet new clinical service standards , under reconfiguration options, is assumed to be proportional to costs incurred by Trusts to meet those standards

Summary of option evaluation

++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY

		1	2	3	4	5	6	7
								
		Hospital ▪ ECT ▪ STFT ▪ UHSM ▪ THFT **CDM** ▪ 3 or 4 ▪ 1/3 ▪ 3/5 ▪ 4	**Hospital** ▪ ECT ▪ STFT ▪ UHSM ▪ THFT **CDM** ▪ 2/3 ▪ 1/3 ▪ 3/5 ▪ 4	**Hospital** ▪ ECT ▪ STFT ▪ UHSM ▪ THFT **CDM** ▪ 3 or 4 ▪ 1/3 ▪ 2/3/5 ▪ 4	**Hospital** ▪ ECT ▪ STFT ▪ UHSM ▪ THFT **CDM** ▪ 2/3 ▪ 3 ▪ 1/3/5 ▪ 4	**Hospital** ▪ ECT ▪ STFT ▪ UHSM ▪ THFT **CDM** ▪ 3 or 4 ▪ 2/3 ▪ 1/3/5 ▪ 4	**Hospital** ▪ ECT ▪ STFT ▪ UHSM ▪ THFT **CDM** ▪ 2/3 ▪ 1/3 ▪ 2/3/5 ▪ 4	**Hospital** ▪ ECT ▪ STFT ▪ UHSM ▪ THFT **CDM** ▪ 2/3 ▪ 2/3 ▪ 1/3/5 ▪ 4
Quality of care	Clinical effectiveness and outcomes	++	++	++	++	++	++	++
	Patient experience	++	++	++	++	++	++	++
	Estate quality	-	/	/	++	++	/	++
	Supports innovation	++	++	++	++	++	++	++
Access	Time to access CDM1	-	-	-	-	-	-	-
	Time to access CDM1/2	--	-	-	-	-	/	/
	Patient choice	--	-	-	-	-	-	-
Affordability value for money	Capital cost to the system	--	--	-	-	-	-	-
	Transition costs	--	--	--	--	--	-	--
	Viable trusts and sites	+	/	/	/	/	/	/
	Surplus for acute sector	++	+	++	++	++	+	+
Deliverability	Workforce/staffing	++	++	++	++	++	+	+
	Expected time to deliver	--	--	--	--	-	-	-
	Discharge flows	-	-	-	-	-	/	/
	Alignment with other strategies	+	+	+	++	++	/	+
Research & education	Alignment	/	/	+	+	+	+	+

Agenda

- Pre-meeting discussion with local organisations only – 30 mins
- Welcome and introductions – 5 mins
- Review of minutes and outstanding actions from last meeting – 10 mins
- **Review evaluation assessment and agree viable options – 1 hr, 45 mins**
  - Review options and criteria
  - Non-financial evaluation
  - Value for Money evaluation
  - **Discuss additional savings from organisational options**
- Discuss high level implementation plans and communications and next steps – 30 mins

Potential savings opportunities

PRELIMINARY

	Description	Potential additional savings estimate, £m[1]
Elective (T&O and Urology)	▪ CDM3, CDM4 and CDM5 can be established as a joint venture for selected specialties such as T&O and Urology	1-2
Emergency Care	▪ CDM1 and CDM2 can be established as a joint venture for emergency care with clinical and financial economies of scale	1
Obstetrics	▪ CDM1 and CDM2/5 can be established as a joint venture for consultant-led obstetrics at those sites	1-2
M&A	▪ Acquisition of trusts which includes single governance, integration of back-office support and capability transfer from the acquirer	10
Total		13-15

NOTE: Assumed 3% savings on semi-variable costs for EL, NEL and obstetrics and 10% reduction in beds due to lower ALOS for ELIP, NEL and Obstetrics; Assumed 1.0% savings off total cost base for M&A option

1 Savings calculated for reconfiguration option 4

SOURCE: HES 2012/13; Reconfiguration model

Assumptions for financial benefit of organisational choices

PRELIMINARY

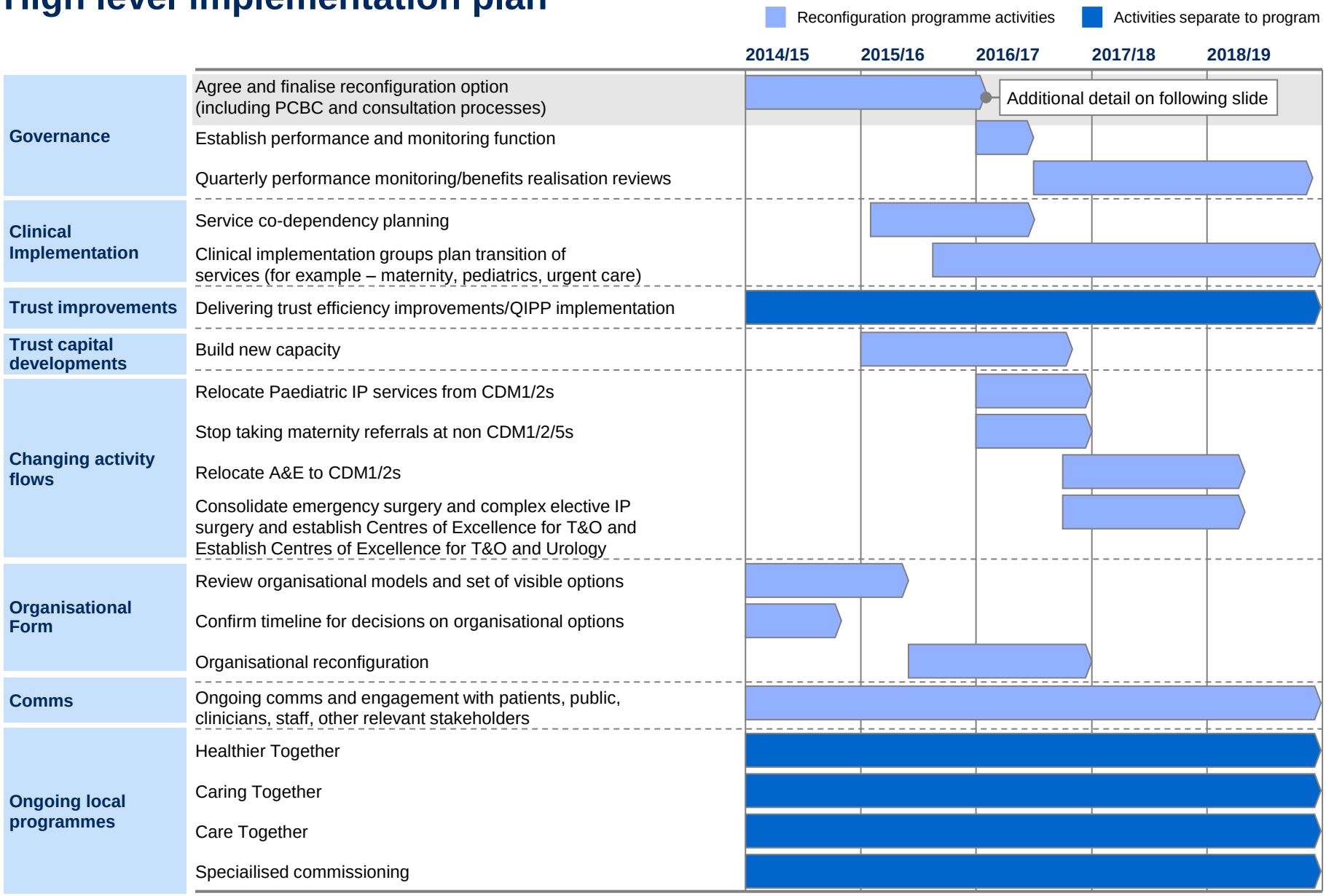
Option	Sources of benefit	Baseline	Savings calculation
JV for elective activity	▪ Best practice sharing driving down ALOS ▪ Better staff and capacity utilisation through coordination	▪ Day case and non-elective inpatients (surgery and medicine) ▪ Excludes obstetrics and pediatrics	▪ Extra 10% reduction in ALOS (8% fixed cost reduction) ▪ Extra 3% reduction in semi-variable costs
JV for Emergency Care	▪ Better staff and capacity utilisation through coordination	▪ All admissions ▪ Standard and major non-admitted attendances	▪ Extra 3% reduction in semi-variable costs
JV for obstetrics	▪ Best practice sharing driving down ALOS ▪ Better staff and capacity utilisation through coordination	▪ All complex and non-complex obstetric activity	▪ Extra 10% reduction in ALOS (8% fixed cost reduction) ▪ Extra 3% reduction in semi-variable costs
M&A	▪ Reduction in back-office costs and Board costs ▪ Better sharing of best practices ▪ Increased ability to provide reconfiguration	▪ Individual Trusts as per status quo	▪ 1.0% cost reduction for merged organisations

SOURCE: Team analysis; external research

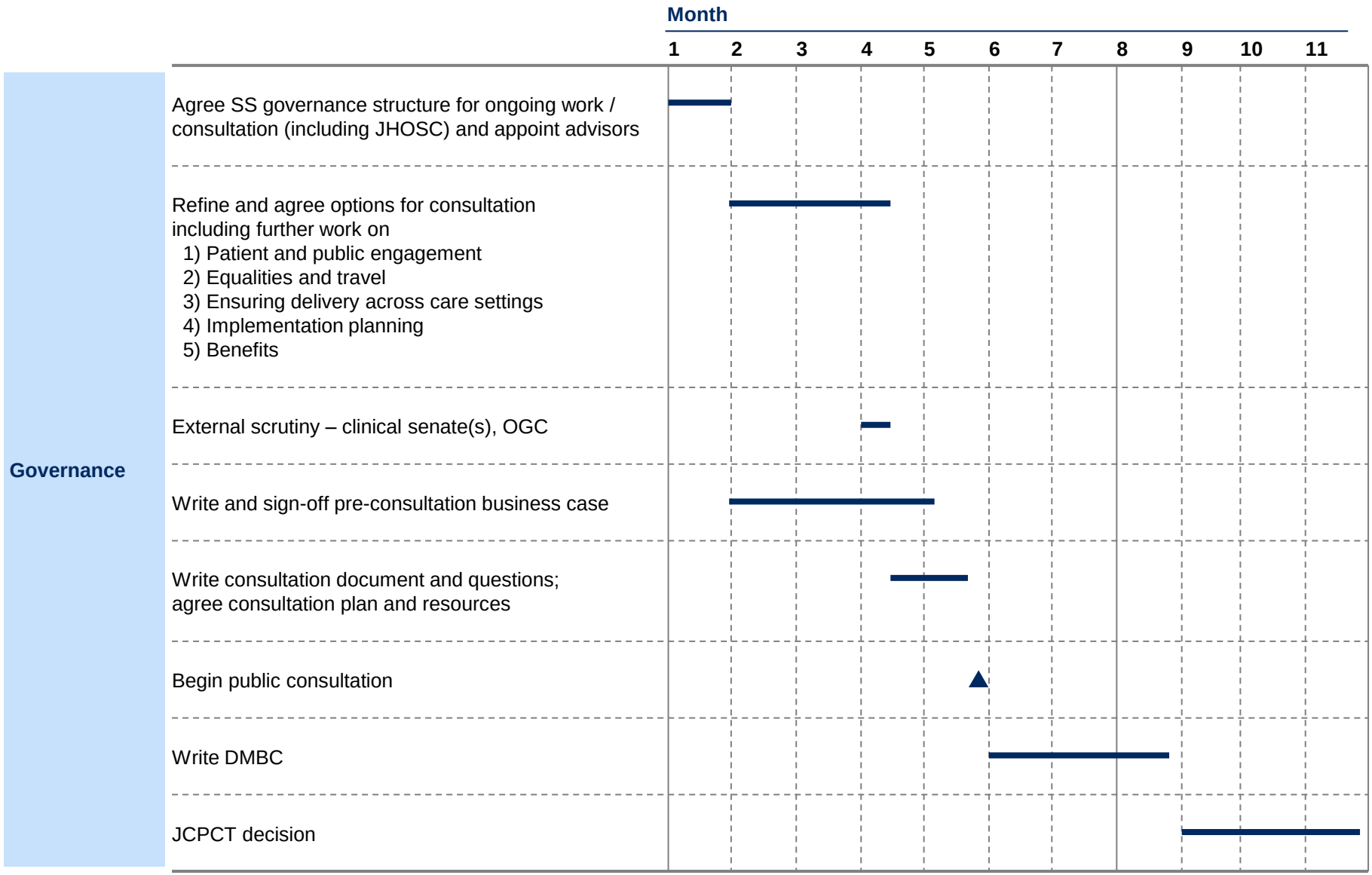
Agenda

- Pre-meeting discussion with local organisations only – 30 mins
- Welcome and introductions – 5 mins
- Review of minutes and outstanding actions from last meeting – 10 mins
- Review evaluation assessment and agree viable options – 1 hr, 45 mins
- **Discuss high level implementation plans and communications and next steps – 30 mins**

High level implementation plan



Key activities over upcoming months

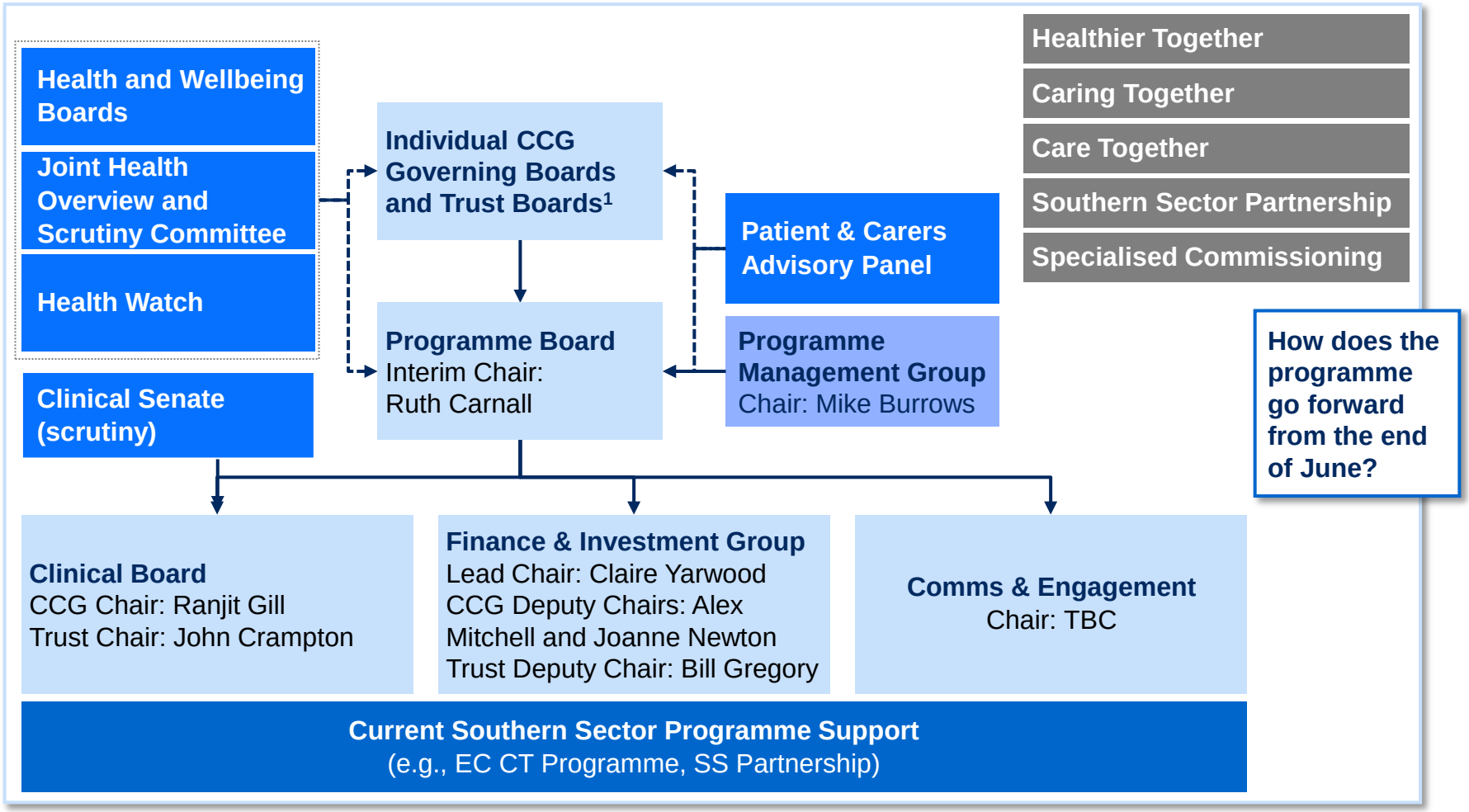


Potential governance for taking work forward

FOR DISCUSSION

Key

- Governance meeting/workstream
- Coordinating administrative processes
- Ongoing local area programmes
- Coordinating administrative processes



1 For Eastern Cheshire, this also includes the Caring Together Executive Board

Addendum

Monitor guidance of submission of financial plans

It is recommended that the Trusts:

- Put their base case numbers through the detailed financial template
- Present the impact of the options still under consideration in the narrative document which accompanies the financial plan
- For each of the options still under consideration, the Trusts should:
  - Present a high level 5 year I&E reflecting the financial impact of the option on their Trust along with supporting narrative (setting out the clinical and financial implications)
  - Number any options they present in the same way that the options have been numbered in the Challenged Health Economy work to avoid confusion

It is assumed that the primary financial impact will be on the I&E however if any of the option has significant implications for either the balance sheet or cashflow (due to capital requirements etc) a high level summary of these should also be presented

Non-financial option evaluation – from 17th June Clinical Board

1 Quality of care: Quality of estate

Low | Medium | High

PRELIMINARY

Quality of Estate

	Not functionally suitable – Occupied floor space[1] %	Estate dating post -1964 %	Estate dating post -1984 %	Total parking spaces available[2]	Single bed-rooms for patients with en-suite facilities	Estate quality
Macclesfield District General hospital	9	87	33	987	32	Medium
Wythenshawe Hospital	0	89	49	3,454	231	High
Stepping Hill Hospital	17	78	38	1,703	56	Medium
Tameside General Hospital	2	91	70	1,326	55	High
SS acute average	7	86	48	1,868	94	

1 Percentage of occupied floor area that is below Estate-code Condition B for functional suitability (i.e. below an acceptable standard, or unacceptable in its present condition, or so below standard that nothing but a total rebuild will suffice)

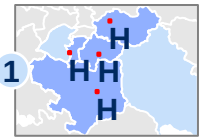
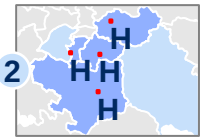
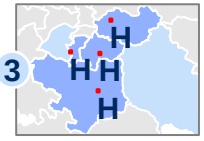
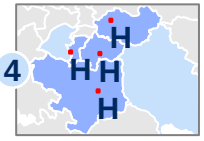
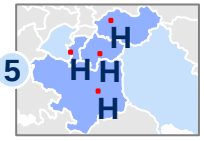
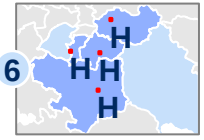
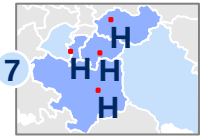
2 Total parking spaces available for both patients/visitors and staff; Parking spaces available for patients/visitors are 356, 903, 511 and 889 for ECT, UHSM, STFT and THFT respectively

SOURCE: HEFS 2012

1 Quality of care: Estate quality evaluation

++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY

	Hospital	CDM	Evaluation
1 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 3/5 ▪ 4	-
2 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 3/5 ▪ 4	/
3 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 2/3/5 ▪ 4	/
4 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 3 ▪ 1/3/5 ▪ 4	++
5 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 2/3 ▪ 1/3/5 ▪ 4	++
6 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 2/3/5 ▪ 4	/
7 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 2/3 ▪ 1/3/5 ▪ 4	++

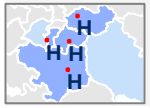
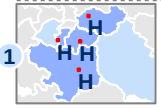
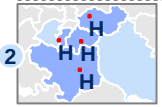
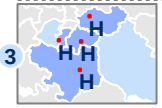
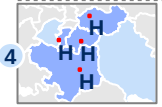
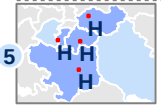
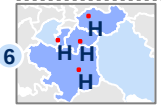
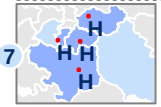
Rationale

- Options with UHSM as the CDM1 and one or two other CDM2s have been rated positively
- Options with STFT as the CDM1 and one or two other CDM2s have been rated neutrally
- Options with STFT as a CDM1 and no CDM2s have been rated lower than other options
- THFT has had no impact on differentiating between options since it the same in all instances

2 Access to care: Time to access a CDM 1 for entire catchment population

Present situation
++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY

Proposed Option			Blue Light[1,2] (mins)		Private Car – off peak[1] (mins)		Private Car – peak[1] (mins)		Public Transport[1] (mins)		
	Hospital	CDM	Avg	Max	Avg	Max	Avg	Max	Avg	Max	Evaluation
	▪ ECT ▪ STFT ▪ UHSM ▪ THFT		8.4	26.2	11.2	36.8	12.8	39.7	37.3	147.1	
1 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 3/5 ▪ 4	12.8	30.6	16.5	41.3	19.4	46.3	53.1	158.4	–
2 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 3/5 ▪ 4	12.8	30.6	16.5	41.3	19.4	46.3	53.1	158.4	–
3 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 2/3/5 ▪ 4	12.8	30.6	16.5	41.3	19.4	46.3	53.1	158.4	–
4 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 3 ▪ 1/3/5 ▪ 4	13.2	31.4	17.2	45.1	20.0	47.5	57.3	159.2	–
5 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 2/3 ▪ 1/3/5 ▪ 4	13.2	31.4	17.2	45.1	20.0	47.5	57.3	159.2	–
6 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 2/3/5 ▪ 4	12.8	30.6	16.5	41.3	19.4	46.3	53.1	158.4	–
7 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 2/3 ▪ 1/3/5 ▪ 4	13.2	31.4	17.2	45.1	20.0	47.5	57.3	159.2	–

- All options have been rated lower than present situation
- Other important factors for access (e.g., opening times and translation services) can be delivered from any of the options

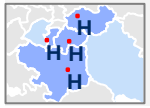
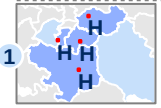
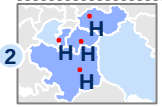
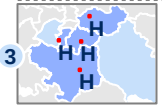
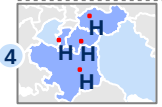
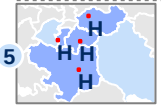
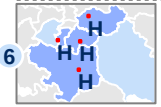
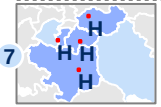
1 Population Weighted average travel time to nearest proposed CDM1 within SS; population weighted travel times by postcode area (LSOA)
2 Blue Light travel time estimated as 66% of peak private car
NOTE: Times are calculated for the entire catchment population of ~850k

SOURCE: Steer Davies Gleave Travel Time Data April 2014

2 Access to care: Time to access a CDM 1 or 2 for entire catchment population

Present situation
++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY

Proposed Option			Blue Light[1,2] (mins)		Private Car – off peak[1] (mins)		Private Car – peak[1] (mins)		Public Transport[1] (mins)		
	Hospital	CDM	Avg	Max	Avg	Max	Avg	Max	Avg	Max	Evaluation
	▪ ECT ▪ STFT ▪ UHSM ▪ THFT		8.4	26.2	11.2	36.8	12.8	39.7	37.3	147.1	
1 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 3/5 ▪ 4	12.8	30.6	16.5	41.3	19.4	46.3	53.1	158.4	--
2 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 3/5 ▪ 4	11.1	26.2	14.2	36.8	16.8	39.7	45.0	147.1	-
3 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 2/3/5 ▪ 4	10.3	30.6	13.6	41.3	15.6	46.3	45.8	158.4	-
4 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 3 ▪ 1/3/5 ▪ 4	10.7	28.5	14.0	39.2	16.3	43.2	46.3	147.7	-
5 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 2/3 ▪ 1/3/5 ▪ 4	10.3	30.6	13.6	41.3	15.6	46.3	45.8	158.4	-
6 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 2/3/5 ▪ 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/
7 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 2/3 ▪ 1/3/5 ▪ 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/

- All options have been rated lower than present situation, except options 6 and 7 which are only very marginally higher than the status quo
- Option 1 has been rated lower than options 2 to 5 because of the significant increase in travel time
- Other important factors for access (e.g., opening times and translation services) can be delivered from any of the options

1 Population Weighted average travel time to nearest proposed CDM1 or 2 within SS; population weighted travel times by postcode area (LSOA)
2 Blue Light travel time estimated as 66% of peak private car
NOTE: Times are calculated for the entire catchment population of ~850k

SOURCE: Steer Davies Gleave Travel Time Data April 2014

2 Access to care: Time to access a CDM 1 or 2 for over 75s

Present situation
++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY

Proposed Option	Hospital	CDM	Blue Light[1,2] (mins) Avg	Blue Light[1,2] (mins) Max	Private Car – off peak[1] (mins) Avg	Private Car – off peak[1] (mins) Max	Private Car – peak[1] (mins) Avg	Private Car – peak[1] (mins) Max	Public Transport[1] (mins) Avg	Public Transport[1] (mins) Max	Evaluation
	▪ ECT ▪ STFT ▪ UHSM ▪ THFT		8.6	26.2	11.4	36.8	13.0	39.7	38.0	147.1	
1	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 3/5 ▪ 4	12.9	30.6	16.6	41.3	19.5	46.3	54.3	158.4	--
2	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 3/5 ▪ 4	11.0	26.2	14.2	36.8	16.6	39.7	44.9	147.1	-
3	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 2/3/5 ▪ 4	10.5	30.6	13.9	41.3	15.9	46.3	47.6	158.4	-
4	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 3 ▪ 1/3/5 ▪ 4	11.0	28.5	14.4	39.2	16.7	43.2	47.3	147.7	-
5	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 2/3 ▪ 1/3/5 ▪ 4	10.5	30.6	13.9	41.3	15.9	46.3	47.6	158.4	-
6	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 2/3/5 ▪ 4	8.7	26.2	11.7	36.8	13.2	39.7	38.5	147.1	/
7	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 2/3 ▪ 1/3/5 ▪ 4	8.7	26.2	11.7	36.8	13.2	39.7	38.5	147.1	/

- All options have been rated lower than present situation, except options 6 and 7 which are only very marginally higher than the status quo
- Option 1 has been rated lower than options 2 to 5 because of the significant increase in travel time
- Other important factors for access (e.g., opening times and translation services) can be delivered from any of the options

- **Access times for over 75s do not vary significantly from the whole of the catchment population and therefore it is proposed it is not used in the evaluation of the options**

1 Population Weighted average travel time to nearest proposed CDM1 or 2 within SS; population weighted travel times by postcode area (LSOA)
2 Blue Light travel time estimated as 66% of peak private car
NOTE: Times are calculated for the entire >75 catchment population

SOURCE: Steer Davies Gleave Travel Time Data April 2014

2 Access to care: Time to access a CDM 3 for entire catchment population

Present situation
++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY

Proposed Option			Blue Light[1,2] (mins)		Private Car – off peak[1] (mins)		Private Car – peak[1] (mins)		Public Transport[1] (mins)		
	Hospital	CDM	Avg	Max	Avg	Max	Avg	Max	Avg	Max	Evaluation
	ECT STFT UHSM THFT		8.4	26.2	11.2	36.8	12.8	39.7	37.3	147.1	
1	ECT STFT UHSM THFT	3 1/3 3/5 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/
2	ECT STFT UHSM THFT	2/3 1/3 3/5 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/
3	ECT STFT UHSM THFT	3 1/3 2/3/5 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/
4	ECT STFT UHSM THFT	2/3 3 1/3/5 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/
5	ECT STFT UHSM THFT	3 2/3 1/3/5 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/
6	ECT STFT UHSM THFT	2/3 1/3 2/3/5 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/
7	ECT STFT UHSM THFT	2/3 2/3 1/3/5 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/

- All options have been rated neutrally as access times are largely unchanged from the status quo

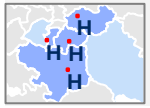
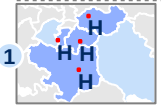
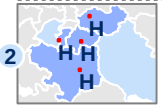
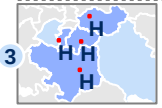
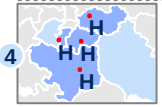
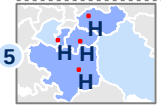
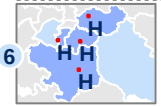
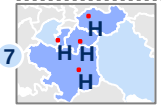
1 Population Weighted average travel time to nearest proposed CDM3 within SS; population weighted travel times by postcode area (LSOA)
2 Blue Light travel time estimated as 66% of peak private car
NOTE: Times are calculated for the entire catchment population of ~850k

SOURCE: Steer Davies Gleave Travel Time Data April 2014

2 Access to care: Time to access a CDM 3 for entire catchment population (ECT is CDM4 in op 1,3,5)

Present situation
++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY

Proposed Option		Hospital	CDM	Blue Light[1,2] (mins) Avg	Blue Light[1,2] (mins) Max	Private Car – off peak[1] (mins) Avg	Private Car – off peak[1] (mins) Max	Private Car – peak[1] (mins) Avg	Private Car – peak[1] (mins) Max	Public Transport[1] (mins) Avg	Public Transport[1] (mins) Max	Evaluation
		▪ ECT ▪ STFT ▪ UHSM ▪ THFT		8.4	26.2	11.2	36.8	12.8	39.7	37.3	147.1	
1		▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 4 ▪ 1/3 ▪ 3/5 ▪ 4	10.3	30.6	13.6	41.3	20.0	46.3	45.8	158.4	-
2		▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 3/5 ▪ 4	8.7	26.2	11.5	36.8	16.3	39.7	38.0	147.1	/
3		▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 4 ▪ 1/3 ▪ 2/3/5 ▪ 4	10.3	30.6	13.6	41.3	15.6	46.3	45.8	158.4	-
4		▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 3 ▪ 1/3/5 ▪ 4	8.7	26.2	11.5	36.8	16.8	39.7	38.0	147.1	/
5		▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 4 ▪ 2/3 ▪ 1/3/5 ▪ 4	10.3	30.6	13.6	41.3	15.6	46.3	45.8	158.4	-
6		▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 2/3/5 ▪ 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/
7		▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 2/3 ▪ 1/3/5 ▪ 4	8.7	26.2	11.5	36.8	13.1	39.7	38.0	147.1	/

- Time to access a CDM 3 for options 2,4, 6 and 7 are only very marginally higher than the status quo and hence have been rated neutrally
- Options 1, 3 and 5 have been rated lower than other options because of the increased difference from status quo

1 Population Weighted average travel time to nearest proposed CDM3 within SS; population weighted travel times by postcode area (LSOA)
2 Blue Light travel time estimated as 66% of peak private car
NOTE: Times are calculated for the entire catchment population of ~850k

SOURCE: Steer Davies Gleave Travel Time Data April 2014

2 Access to care: Patient choice

++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY

Proposed Option			Reduction in # of sites delivering …							
	Hospital	CDM	Emergency medical care	Emergency surgery and complex elective IP	Non-complex elective IP	Consultant-led obstetrics[1]	Paediatric IP[2]	Outpatients/ diagnostics	Evaluation	Rationale
1	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 or 4 ▪ 1/3 ▪ 3/5 ▪ 4	3	3	1-2	2	3	0	--	▪ All options are expected to reduce access due to the decrease in number of sites offering services ▪ Options where the reduction in number of sites offering emergency medical care is 3 or more have been rated lower
2	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 3/5 ▪ 4	2	3	1	1-2	3	0	-	
3	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 or 4 ▪ 1/3 ▪ 2/3/5 ▪ 4	2	3	1-2	2	3	0	-	
4	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 3 ▪ 1/3/5 ▪ 4	2	3	1	2-3	3	0	-	
5	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 or 4 ▪ 2/3 ▪ 1/3/5 ▪ 4	2	3	1-2	2	3	0	-	
6	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 2/3/5 ▪ 4	1	3	1	1-2	3	0	-	
7	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 2/3 ▪ 1/3/5 ▪ 4	1	3	1	1-2	3	0	-	

1 Complex and non-complex
2 Short stay and long stay

SOURCE: Team analysis

4 Deliverability: Time to deliver

SS | Oldham | ++ High evaluation
CMUH | Other | -- Low evaluation
/ Neutral evaluation

PRELIMINARY

Ease of delivering option in 3-5 years

	Hospital	CDM	New capacity required (beds)[1,2]	Movement of acute beds[3]	Movement of maternity beds	Evaluation	Rationale
1	ECT STFT UHSM THFT	3 1/3 3/5 4	121 + 173 + 221 + 107 = 622	107 + 221 + 196 + 173 = 697	49	--	Options moving less beds and requiring less new capacity rated higher
2	ECT STFT UHSM THFT	2/3 1/3 3/5 4	99 + 185 + 55 + 171 = 510	99 + 185 + 127 + 171 = 582	28	--	
3	ECT STFT UHSM THFT	3 1/3 2/3/5 4	16 + 124 + 164 + 97 = 401	16 + 124 + 172 + 164 = 476	49	--	
4	ECT STFT UHSM THFT	2/3 3 1/3/5 4	97 + 29 + 153 + 187 = 466	331 + 97 + 29 + 187 = 644	59	--	
5	ECT STFT UHSM THFT	3 2/3 1/3/5 4	34 + 67 + 189 + 0 = 290	34 + 67 + 183 + 189 = 473	49	-	
6	ECT STFT UHSM THFT	2/3 1/3 2/3/5 4	8 + 93 + 157 + 31 = 289	8 + 93 + 157 + 102 = 360	28	-	
7	ECT STFT UHSM THFT	2/3 2/3 1/3/5 4	13 + 25 + 185 + 0 = 223	13 + 25 + 185 + 134 = 357	28	-	

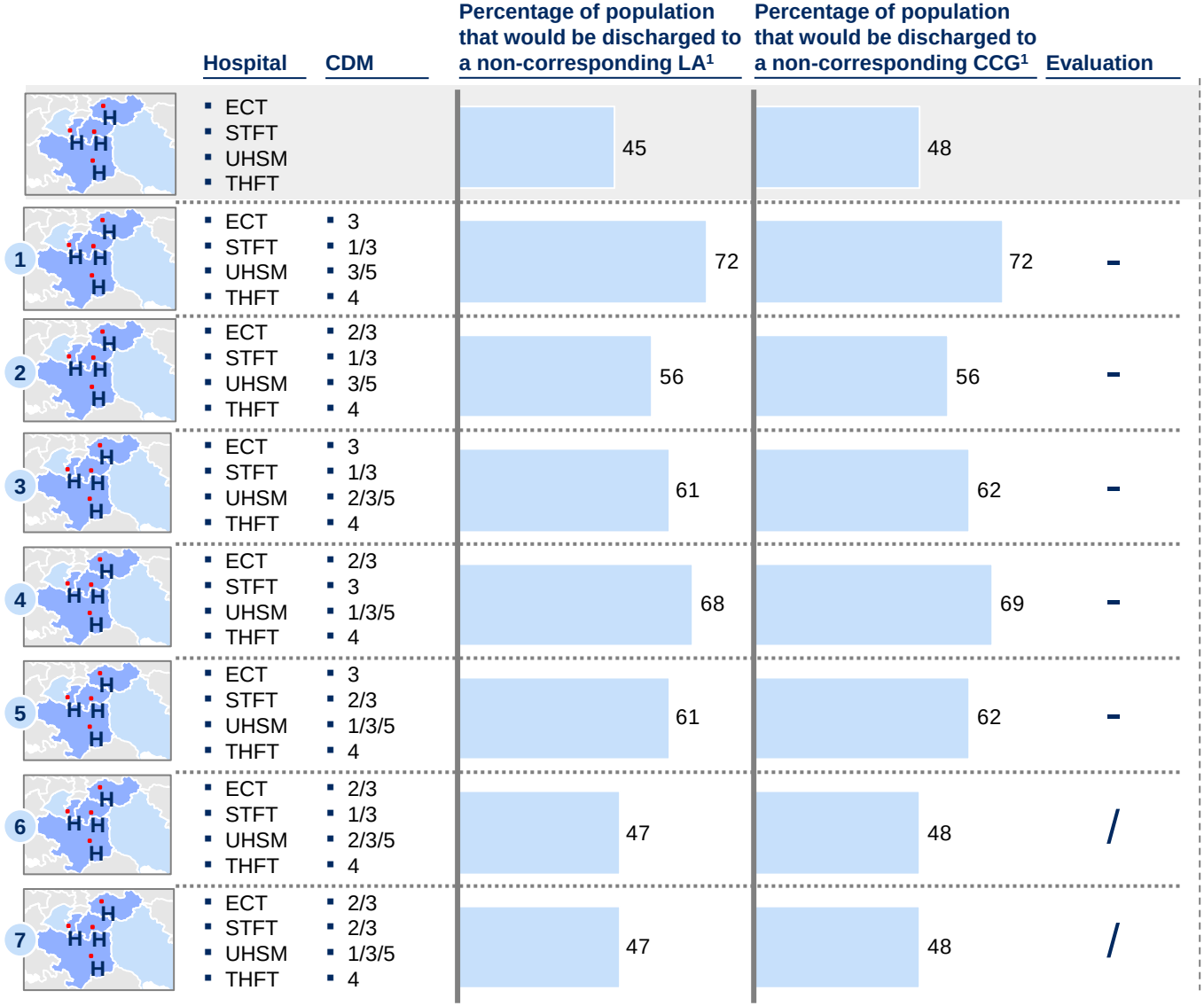
NOTE: Current number of acute beds excluding rehab beds is 293, 742, 958 and 518 for ECT, STFT, UHSM and THFT respectively
1 Based on intermediate case assumptions; 2 Excludes rehabilitation beds; 3 Includes obstetrics

SOURCE: Reconfiguration model

4 Deliverability: CDM1 or 2 discharge flows

Present situation
++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY



Rationale

- The higher the percentage that would be discharged to a non-corresponding LA/CCG the lower the evaluation as it would be harder to discharge these patients from hospital
- Options 6 and 7 have been rated neutrally because they do not change significantly from the status quo
- All other options have been evaluated lower than present situation but equally as the status quo is already quite high and the infrastructure is therefore in place to support cross-border flows

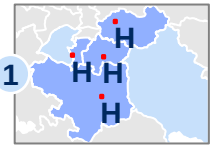
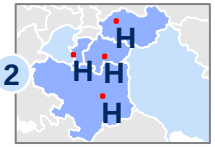
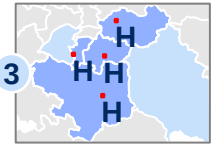
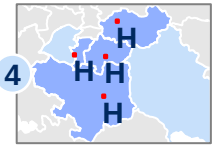
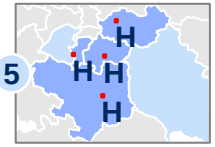
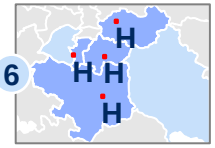
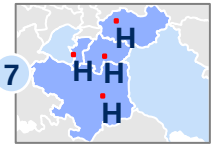
1 Used ~850k catchment population

SOURCE: Steer Davies Gleave Travel Time Data April 2014

4 Deliverability: Co-dependencies with other strategies

++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY

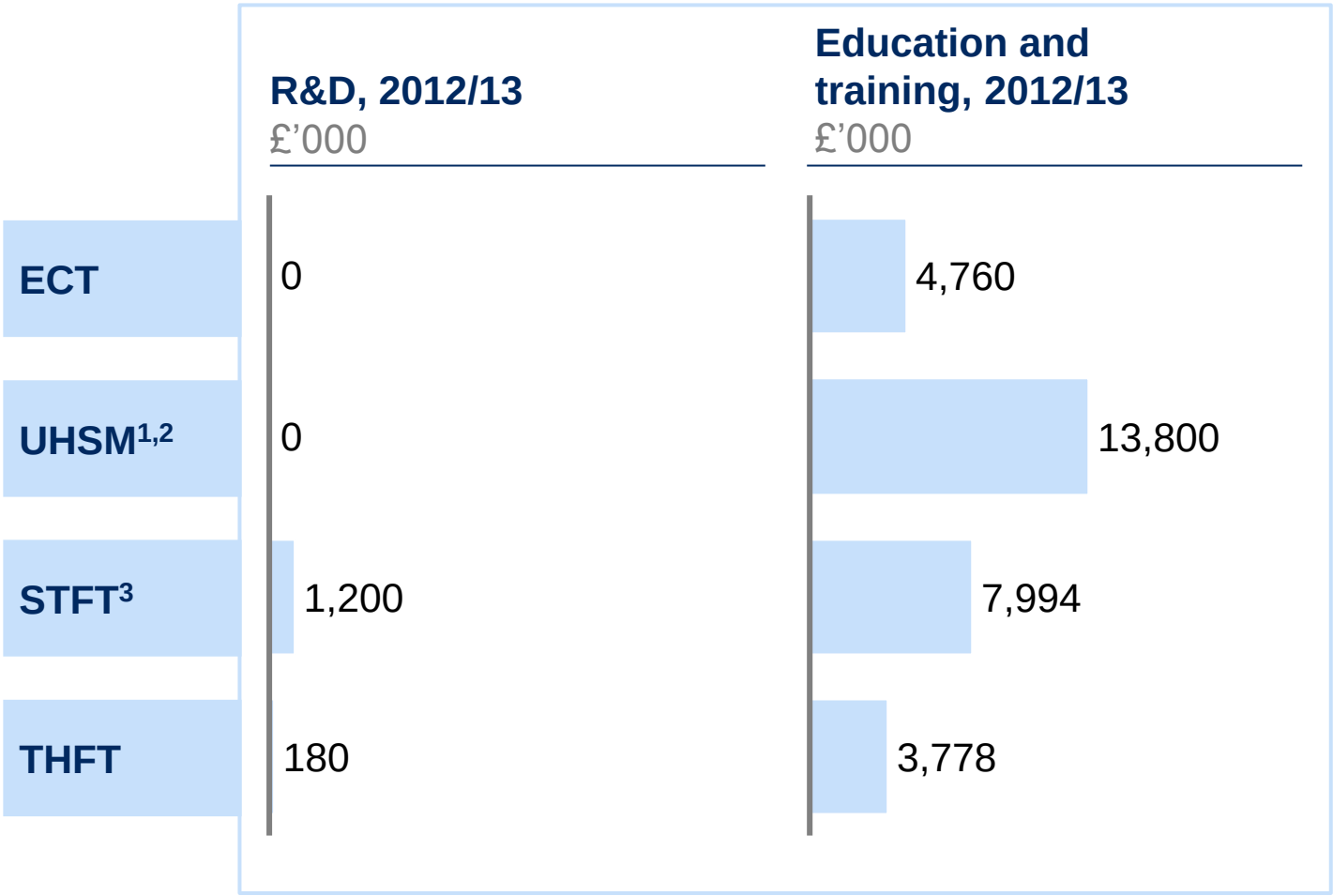
	Hospital	CDM	Evaluation
1 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 3/5 ▪ 4	+
2 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 3/5 ▪ 4	+
3 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 1/3 ▪ 2/3/5 ▪ 4	+
4 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 3 ▪ 1/3/5 ▪ 4	++
5 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 3 ▪ 2/3 ▪ 1/3/5 ▪ 4	++
6 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 1/3 ▪ 2/3/5 ▪ 4	/
7 	▪ ECT ▪ STFT ▪ UHSM ▪ THFT	▪ 2/3 ▪ 2/3 ▪ 1/3/5 ▪ 4	+

Rationale

- CCG strategies
  - CCG strategies seek to invest in primary and community services to deliver care closer to home and improve outcomes. These strategies are best supported by options 1-5 where there is more flexibility and resource for this investment. Therefore options with 2 CDM2s have been rated neutrally whilst options with no or one CDM2s have been rated positively.
- Emerging guidance on Major Emergency Centres (MECs)
  - Emerging guidance on MECs suggests they will need co-location with two specialised services. Within Southern Sector, only UHSM would meet this requirement. Options with UHSM as CDM1 have been rated positively and those with STFT as CDM1 have been rated neutrally.
- Healthier Together
  - The Healthier Together options have either no CDM1 in Southern Sector or a CDM1 at either STFT or UHSM. All the options therefore align with Healthier Together options
- It is assumed that the following will not be, or will be equally, impacted under each of the options
  - National Initiatives: short-term Trust CIPs
  - Broader North West Initiatives: Trafford reconfiguration, Care Together (Tameside)
  - Local Strategies in place or in development: mental health plans, ongoing work by networks e.g. cancer network

5 Research and Education: Income

PRELIMINARY



1 UHSMFT acts as a host, on behalf of a number of NHS trusts and foundation trusts across Greater Manchester, for clinical research funding from the Department of Health. The gross funding figures for R&D and education and training are ~£21m and ~£63m respectively. ~£15m of the R&D income relates to GM CLRN of which UHSM retained ~£2m. The remaining ~£8m of this is all specialised.

2 UHSM also hosted the National Leadership Academy with a budget of ~£40m which was largely spent with training bodies external to the NHS who are commissioned to develop and run leadership development courses for the NHS. The remaining income of ~£23m is split 60/40 non-specialised/specialised in proportion to the Trust's income

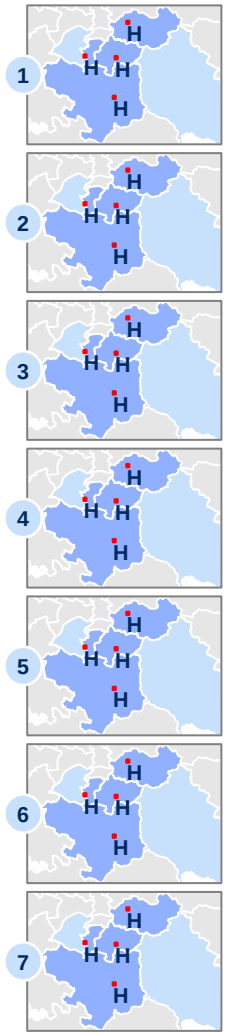
3 Includes £0.5m from UHSM in relation to GM CLRN

SOURCE: FIMS 2012/13; Trust annual reports 2012/13

5 Research and Education: Alignment

++ High evaluation
-- Low evaluation
/ Neutral evaluation

PRELIMINARY



Disruption to research and education

Hospital	CDM	Research income at hospitals other than CDM1 or 2 £m, 2012/13	Education income at hospitals other than CDM1 or 2 £m, 2012/13	Evaluation
ECT STFT UHSM THFT	3 1/3 3/5 4	0.2	22.3	/
ECT STFT UHSM THFT	2/3 1/3 3/5 4	0.2	17.6	/
ECT STFT UHSM THFT	3 1/3 2/3/5 4	0.2	8.5	+
ECT STFT UHSM THFT	2/3 3 1/3/5 4	1.4	11.8	+
ECT STFT UHSM THFT	3 2/3 1/3/5 4	0.2	8.5	+
ECT STFT UHSM THFT	2/3 1/3 2/3/5 4	0.2	3.8	+
ECT STFT UHSM THFT	2/3 2/3 1/3/5 4	0.2	3.8	+

Rationale

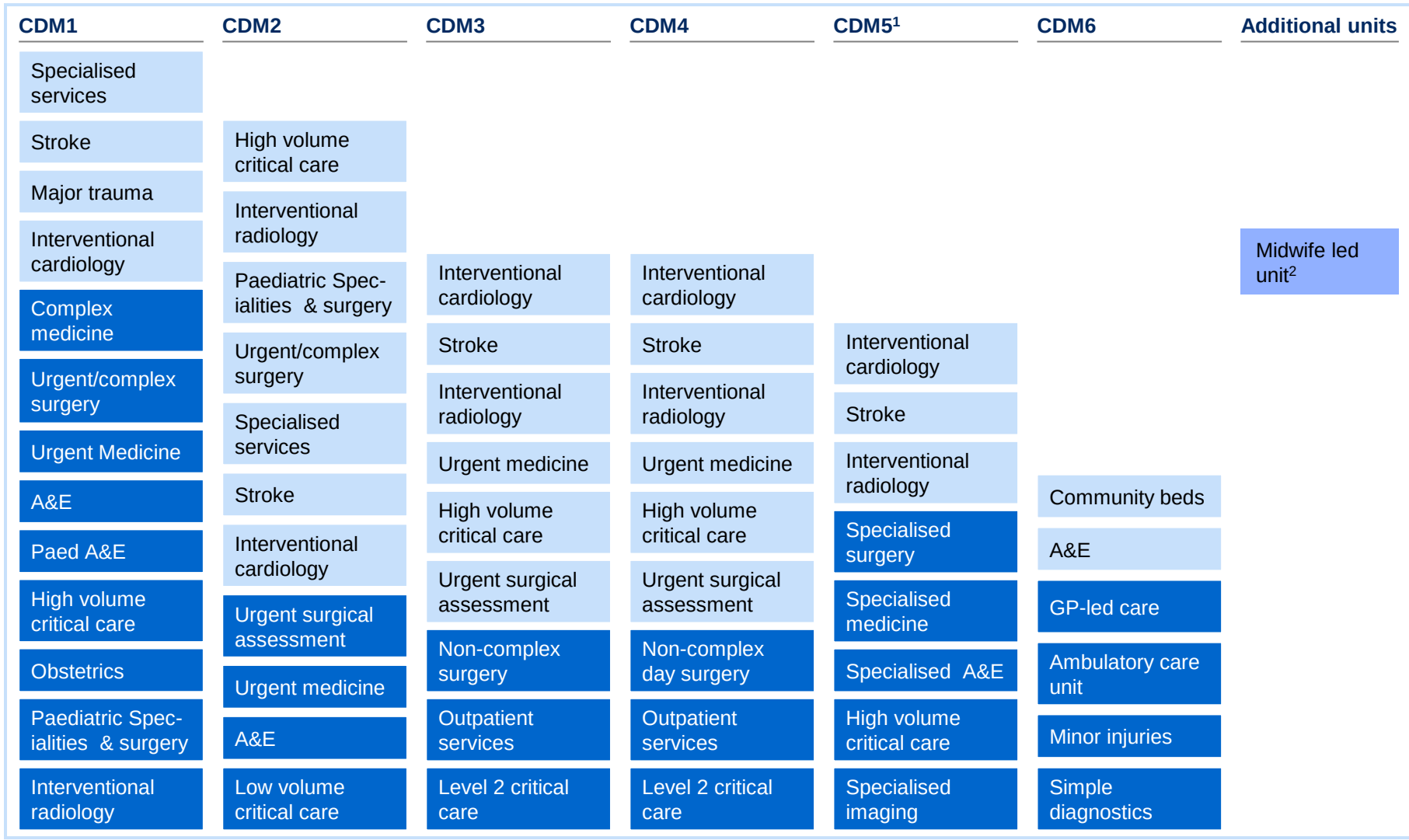
- All options have been rated positively for R&D as all options offer equal opportunity for attracting more R&D due to greater collaboration and consolidation of services
- Options where UHSM is not a CDM1 or CDM2 have been rated lower as UHSM is the centre for R&D in south sector and not being a CDM1 or CDM2 would hamper its ability to do this role
- Education can move with clinical activity, and therefore there would be no difference between options in the ability to develop teaching

SOURCE: FIMS 2012/13; Trust annual reports 2012/13

Additional back-up

TO BE FINALSED

Care Delivery Models for the Southern Sector



1 Specialised services which are either not dependent on co-location with other specialties for high quality/safe care (e.g., ophthalmology), or which can be operated at scale to sustain dedicated co-located services (e.g., stand-alone cancer hospital)

2 Can be co-located with any unit that has 24/7 access to obstetrics and neonatal care, although not necessarily co-located

Revised list of Southern Sector reconfiguration options and key services (current modelling inputs)

CDM1: Emergency Centre
CDM2: Emergency Medical
CDM3: Non-complex elective
CDM4: Elective Day Case

Site	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7
ECT[1]	▪ Non-complex elective (day) surgery ▪ Outpatient services ▪ L2 critical care ▪ UCC	▪ Urgent surgical assessment ▪ Urgent medicine ▪ A&E ▪ Non-complex elective surgery ▪ Outpatient services ▪ L2 and low volume critical care ▪ Obstetrics	▪ Non-complex elective (day) surgery ▪ Outpatient services ▪ L2 critical care ▪ UCC	▪ Urgent surgical assessment ▪ Urgent medicine ▪ A&E ▪ Non-complex ELIP ▪ Outpatient services ▪ L2 and low volume critical care ▪ Obstetrics	▪ Non-complex elective (day) surgery ▪ Outpatient services ▪ L2 critical care ▪ UCC	▪ Urgent surgical assessment ▪ Urgent medicine ▪ A&E ▪ Non-complex ELIP ▪ Outpatient services ▪ L2 and low volume critical care ▪ Obstetrics	▪ Urgent surgical assessment ▪ Urgent medicine ▪ A&E ▪ Non-complex elective surgery ▪ OP services ▪ L2 and low volume CC ▪ Obstetrics
STFT	▪ Urgent and complex surgery and medicine ▪ A&E inc paed ▪ High volume CC ▪ Obstetrics ▪ Complex and non-complex elective ▪ Paediatric IP	▪ Urgent and complex surgery and medicine ▪ A&E inc paed ▪ High volume CC ▪ Obstetrics ▪ Complex and non-complex elective ▪ Paediatric IP	▪ Urgent and complex surgery and medicine ▪ A&E inc paed ▪ High volume CC ▪ Obstetrics ▪ Complex and non-complex elective ▪ Paediatric IP	▪ Non-complex elective surgery ▪ Outpatient services ▪ L2 critical care ▪ UCC	▪ Urgent surgical assessment ▪ Urgent medicine ▪ A&E ▪ Non-complex elective surgery ▪ Outpatient services ▪ L2 and low volume critical care	▪ Urgent and complex surgery and medicine ▪ A&E inc paed ▪ High volume CC ▪ Obstetrics ▪ Complex and non-complex elective ▪ Paediatric IP	▪ Urgent surgical assessment ▪ Urgent medicine ▪ A&E ▪ Non-complex elective surgery ▪ OP services ▪ L2 and low volume CC
UHSM[2]	▪ Non-complex elective surgery ▪ Outpatient services ▪ L2 critical care ▪ Specialised services ▪ Obstetrics ▪ UCC	▪ Non-complex elective surgery ▪ Outpatient services ▪ L2 critical care ▪ Specialised services ▪ Obstetrics ▪ UCC	▪ Urgent surgical assessment and medicine ▪ A&E ▪ Non-complex ELIP Outpatient services ▪ L2 critical care ▪ Specialised services ▪ Obstetrics	▪ Urgent and complex surgery and medicine ▪ A&E inc paed ▪ High volume CC ▪ Obstetrics ▪ Complex and non-complex elective ▪ Specialised services ▪ Obstetrics ▪ Paediatric IP	▪ Urgent and complex surgery and medicine ▪ A&E inc paed ▪ High volume CC ▪ Obstetrics ▪ Complex and non-complex elective ▪ Specialised services ▪ Obstetrics ▪ Paediatric IP	▪ Urgent surgical assessment ▪ Urgent medicine ▪ A&E ▪ Non-complex ELIP ▪ Outpatient services ▪ L2 critical care ▪ Specialised services ▪ Obstetrics ▪ *+CDM3*	▪ Urgent /complex surgery + medicine ▪ A&E inc paed ▪ High volume CC ▪ Obstetrics ▪ Complex and non-complex elective ▪ Specialised svcs ▪ Obstetrics ▪ Paediatric IP
THFT[3]	▪ Non-complex elective day surgery (current modelling; may also have IP) ▪ Outpatient services ▪ L2 critical care ▪ UCC	▪ Non-complex elective day surgery (current modelling; may also have IP)) ▪ Outpatient services ▪ L2 critical care ▪ UCC	▪ Non-complex elective day surgery (current modelling; may also have IP) ▪ Outpatient services ▪ L2 critical care ▪ UCC	▪ Non-complex elective day surgery (current modelling; may also have IP) ▪ Outpatient services ▪ L2 critical care ▪ UCC	▪ Non-complex elective day surgery (current modelling; may also have IP) ▪ Outpatient services ▪ L2 critical care ▪ UCC	▪ Non-complex elective day surgery (current modelling; may also have IP) ▪ Outpatient services ▪ L2 critical care ▪ UCC	▪ Non-complex elective day surgery (current modelling; may also have IP) ▪ Outpatient services ▪ L2 critical care ▪ UCC

1 ECT has been assumed to be a CDM3 in options where it could be CDM3 or 4 (options 1, 3 and 5)
2 Hurdle criteria require that UHSM include a CDM5 in all options
3 THFT has been assumed to be a CDM4 in all options; noting it may still be a CDM3 with IP activity
Note: Consultant led obstetrics unit at STFT and UHSM and ECT in all options where it is a CDM1, 2 or 5

Modelling assumptions (1 of 2)

REVISED AFTER
5 JUNE F&I GROUP

BASELINE

Activity growth	▪ Activity forecasts based on commissioner plans (CCG and NHSE Specialised Commissioning, including – Demand growth from demographic and non-demographic pressures – Demand management through QIPP
Tariff	▪ -4% Tariff on non-specialised acute income ▪ -3% Tariff on community income (as a proxy for higher productivity) ▪ -3% Tariff on specialised income (as we think 4% is unrealistic given past performance)
Cost inflation	▪ 14/15 2.8%, 15/16 2.9%, 16/17 4.4%, 17/18 3.4% 18/19 3.3%
CIP	▪ Potential savings modelled if Trust closed productivity gap to top-quartile peer – or average of top 3 peers if Trust already at top quartile – assuming that peers reduced costs by 2% p.a. ▪ Medical & nursing productivity excluded if benchmarking suggested investment required ▪ Cap of 20% reduction in total cost base over 4 years set as maximum sustainable improvement

RECONFIGURATION (cont. on next page)

Profitability of service lines	▪ Elective activity made 1% more profitable with aggregate position staying the same and cost passed to non-elective ▪ Specialised activity made 2% more profitable with aggregate position staying the same and cost passed to non-specialised
Marginal tariff	▪ Emergency activity moving between trusts is rebased so that all is paid at full tariff rather than a percentage at marginal 30% tariff

1 Pending further information from work with IBI

Modelling assumptions (2 of 2)

REVISED AFTER 5 JUNE F&I GROUP

Activity and income	▪ Activity moves to the alternative Trust based on shortest travel time[2] (A&E and non-elective) or 50:50 combination of shortest travel time and current patient flows (elective and maternity) ▪ Clinical income follows activity, adjusted for differences in Market Forces Factor ▪ Non-clinical income retained at current site
Variable costs	▪ Comprises of drug costs, supplies and services and other operating costs ▪ 100% of variable costs associated with the service is transferred from the divesting to the receiving site .
Semi variable costs	▪ 100% of semi-variable costs associated with the service removed from divesting site ▪ 80% of these costs transferred to receiving site ▪ 20% difference represents savings from consolidating services (e.g. removing duplication, economies of scale)
Capacity	▪ Beds used as a proxy for overall capacity requirements and availability ▪ Future capacity requirements based on activity changes and length of stay reduction (3%pa for ALOS in general adult beds no change in paediatrics, maternity or critical care ALOS)
Fixed costs (divesting sites)[2]	▪ Comprises of establishment, premises and fixed plant, PFI operating costs, PDC, depreciation, interest (PFI & other), other non-operating costs ▪ Fixed costs scale at 80% with change in beds (i.e. 100% reduction in beds modellled as 80% reduction in fixed costs; 50% reduction in beds modelled as 40% reduction in fixed costs) ▪ Assumes PFI capacity cannot be removed
Cost of new capacity (receiving sites)	▪ Additional bed requirement is after ALOS reduction ▪ Capex costed at £200k/bed for <=90 beds, £350k/bed for 91-180, then £500k/bed >180[3] ▪ I&E impact equal to 11.5% pa of capex (3.5% PDC, 4% depreciation, 4% premises cost)
Cost of new service standards	▪ Under current service configuration, Trusts will incur additional costs to meet new service standards, e.g. consultant 24x7 cover (now added to baseline forecasts) ▪ CDM1 avoids the cost of new service standards through increased activity; CDM 3-6 as they no longer provide the service CDM2 requires the cost of new standards except where explicitly stated e.g. +/- maternity

1 Off peak travel time from patient home to hospital site
2Pending further information from work with IBI
3 When number of beds exceed threshold, all beds are modelled at the higher price – e.g. 95 additional beds are all modelled at £350k per beds. This reflects the step change in additional clinical and non-clinical space required

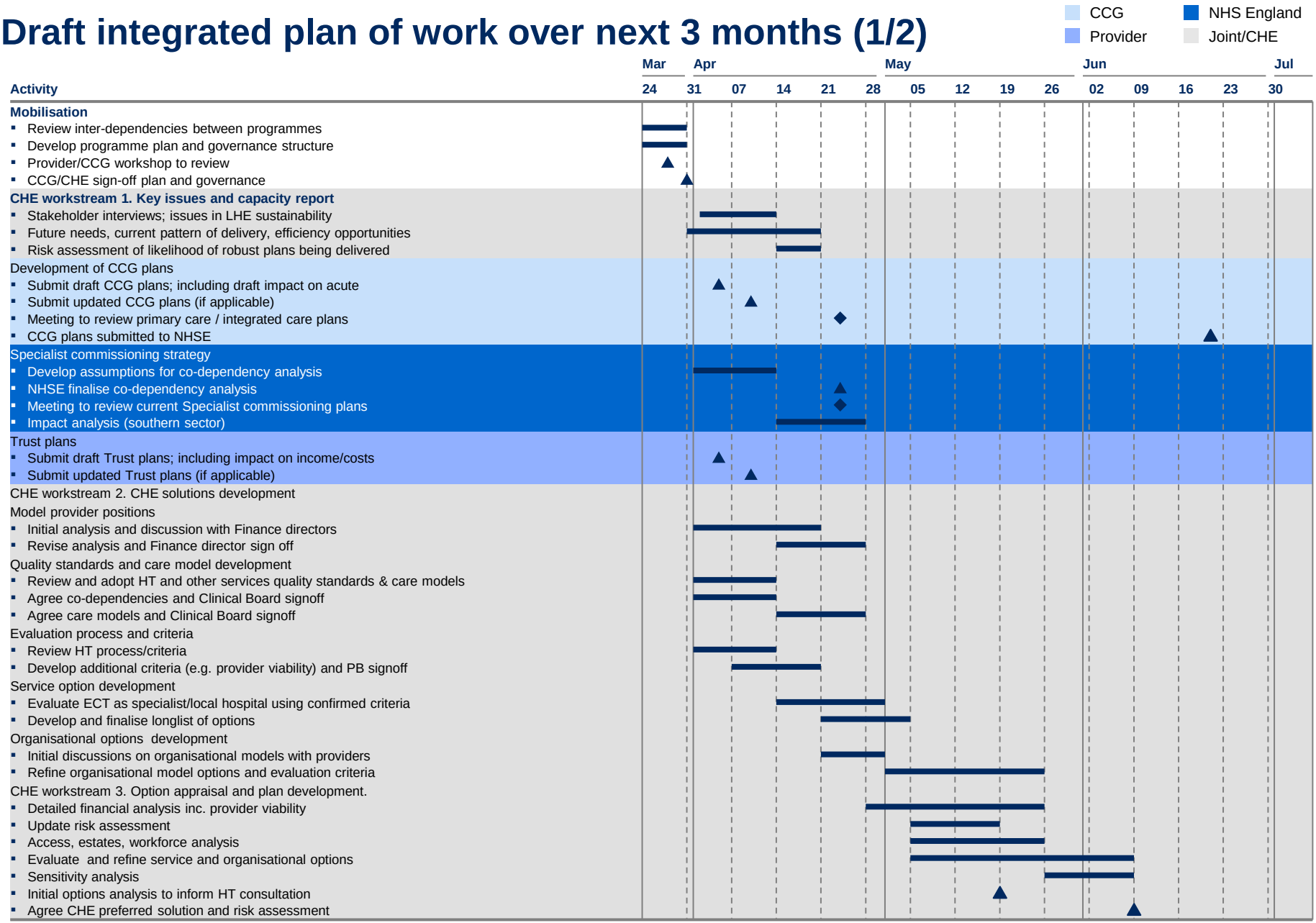
NPV methodology

✓ Included ✗ Excluded

Description	"Expanded NPV" for overall evaluation Wider focus on UK economy, in line with HMT Green Book guidance
Capital investment	
▪ SS hospitals	✓ Excludes VAT as transfer in public sector
▪ Outside SS major hospitals	✓
▪ OOH hubs & GP practices	✗ Required in "do nothing"
Revenue impact of new build at Major and Local Hospitals	
▪ Operating costs	✓
▪ Ongoing capex[1]	✓
▪ PDC	✗ Avoid double counting capital charges and capital investment
Revenue impact of removing assets at Local Hospitals	
▪ Operating costs	✓
▪ Ongoing capex[2]	✓
▪ PDC	✗ Transfer between NHS and HMT
Land receipts	✓
Impairments	✗ No cash flow effect
Changes in pay costs	
▪ Consolidation savings	✓
▪ Avoiding cost of new service standards[2]	✓ Benefit compared to 'do nothing' situation
Transition costs	✓ Excludes redundancy as transfer payment
Period	10, 20 years and 60 years
Discount rate	3.5% p.a. y1-30; 3.0% y31-60 (to end of 12/13)

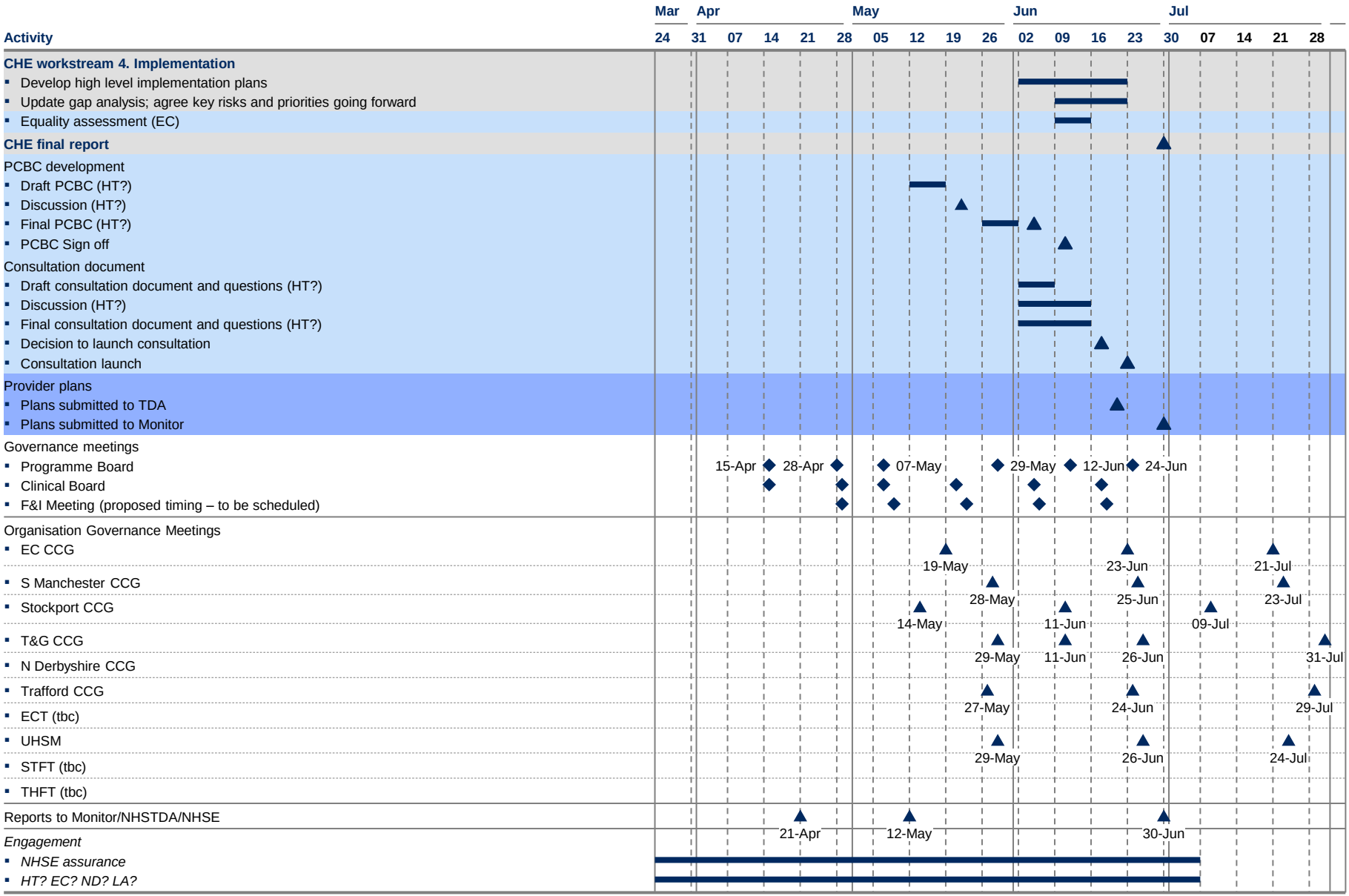
1 Assumption that the additional costs required to meet new service standards (e.g. through increased staffing levels) estimated can be met to varying degrees via the consolidation of services and staff in different reconfiguration options
2 Ongoing capital expenditure to replace assets, assumed to be spread evenly over 25 years (4% of asset value per year)

Draft integrated plan of work over next 3 months (1/2)



Draft integrated plan of work over next 3 months (2/2)

CCG · NHS England · Provider · Joint/CHE



Summary of key risks and mitigating actions

Risk	RAG	Mitigating actions
1. Differences between CCG and trust activity assumptions, which need to be reconciled. This potentially impacts both I&E and capital requirements sector		We have had 1-1 discussions with each organisation to review assumptions and ensure baseline is agreed and have had the F&I and Prog Bd review and sign off on the plans; we continue to work ongoing with FDs to understand the underpinning assumptions and will ultimately assign a risk rating to the plans in the critical friend role
2. Level of deliverability of both CCG demand management and Trust CIP assumptions		We are reaching out to all Finance Directors to review and sensitivity test these assumptions using benchmarks; 2nd Primary Care workshop today to review demand management strategies
3. Uncertainty over the recommendations of Healthier Together for trusts together with potentially different assumptions between HT PCBC for services in scope and the CHE project assumptions for other services		We are addressing this through ongoing dialogue with the Healthier Together team
4. Differential timetable for Tameside FT's recovery plan, potentially cutting across the CHE timetable		We are aligning milestones as possible and focusing on an aligned diagnostic for each core provider, while not duplicating option and appraisal work underway at THFT
5. Need to develop scenarios for specialised commissioning with NHSE, which will particularly impact the position of UHSM and is currently on a different and slower national timetable than the CHE programme		We are engaging in frequent dialogue with NHSE to review their current plans and agree a set of 'most likely' scenarios to build into our models; prioritising meeting with key stakeholders for next week of 2 June
6. Potential confusion in the LHE between service redesign options and organisational form		These are kept as distinct work with commissioner driven service redesign taking precedence; different evaluation criteria are also being developed for each
7. Governance and process complexity resulting from the large number of organisations involved and varying levels of cross-area flows and collaboration		We are addressing through clear governance structures and work programme
8. BCF allocations not fully understood		We are holding 1-1s with FDs to work through these assumptions and discuss at F&I group
9. Risk of CCGs/Trusts not adopting this work into 5 year plans		Needs to be discussed regularly as part of Programme Board
10. Need leadership and engagement going forward to ensure sustainability of work post June		Needs to be discussed regularly as part of Programme Board
11. Accounting for impact of options on CMFT		We are incorporating CMFT patient inflows into our reconfiguration model and will share these results with both the Programme Board and discuss with CMFT
12. Ensuring sufficient local engagement with LAs and patients		We are meeting with the GM LA and agreed plan to ensure linkage between Programme Board and GM LA teadership; 2nd meetingwith Patient and Carer leads on 12 June
13. Ensuring options are fully aligned with CCG plans		We are meeting with each CCG that is concerned to understand the requirements and implications; however, also agreed that ultimately the Trusts must be financially viable in addition to the CCGs, so we have to assess options with this in mind as well