NHS
Halton and St Helens

Business case for a Halton Health Care Resource Centre

April 2011

finnamore

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1 Executive Summary

1.1 Introduction

This document sets out the options and presents a business case to assist the PCT Board in considering the proposed future use of the Cheshire and Merseyside NHS Treatment Centre (CMTC) as a multi-purpose health care resource centre.

The CMTC is located on a site adjacent to Halton Hospital in Runcorn - the site is owned by Warrington and Halton Hospital NHS Foundation Trust (WHHFT) - and is subject to a 60 year lease arrangement, with 55 years remaining.

The CMTC has been operating under the GC5W Project Agreement since 1st June 2006 providing a range of orthopaedic services. This commercially binding contract is between the Department of Health (as the Authority), the primary care trusts in Cheshire and Merseyside and the provider, InterHealth Care Services (UK) Ltd. The five year fixed term will end on 31 May 2011. The leasehold interest in the building and equipment is expected to transfer from the Secretary of State for Health to NHS Halton and St Helens from 1 June 2011 and, under the current lease terms, the premises must be retained as a health care facility. The asset will be included on the Primary Care Trust's (PCT's) balance sheet at Depreciated Replacement Cost.

The PCT and Runcorn GP Commissioning Consortium identified four broad options for the CMTC as of 1 June 2011:

- A: Do nothing – included only to provide a benchmark for cost comparison purposes.
- B: Divest - sell the building on the open market guided by an assessment by the District Valuer.
- C: Lease - seek through a procurement process an organisation that is willing to take on a lease for the building.
- D: Utilisation - use the asset for local health care provision, if costs including capital charges, depreciation and running costs can be recouped.

1.2 Existing lease

The existing lease between the Department of Health (DH) and WHHFT contains a restrictive covenant which prevents any leasee from sub-letting the land AND buildings thereon at more than the agreed ground rent (which is £50,000 p.a. plus 5 years indexation to be applied at 1 June 2011). This would prevent the PCT from recovering the full costs of capital charges and other buildings related costs that it will incur. This would fetter progress in regard to options B, C and D.

1.3 Option appraisal

The initial option list was expanded with the inclusion of four utilisation options which were identified following discussions with a range of stakeholders, with differing combinations of surgery and/or primary care and community services.

A benefits appraisal was undertaken and, assuming that the covenant does not apply, it was concluded that the greater benefits can be achieved with the utilisation options that have the greatest proportion of primary care, intermediate care and community based services.

It was also considered that the options which resulted in a single organisation taking over the whole facility (options B, C and D1) carried the greatest risks in terms of deliverability.

The affordability implications are as follows:

	Option A £'000	Option B £'000	Option C £'000	Option D1 £'000	Option D2 £'000	Option D3 £'000	Option D4 £'000
With restrictive covenant in force							
2011/12 part year effect							
Net additional costs	873	580	940	940	942	954	955
Projected 3rd party income	-	-	317	317	226	195	114
Potential savings	-	-	-	-	55	96	96
Net cost pressure/(surplus)	**873**	**580**	**623**	**623**	**660**	**663**	**746**
2012/13 full year effect							
Net additional costs	905	-	1,434	1,434	1,442	1,490	1,497
Projected 3rd party income	-	-	419	419	299	258	150
Potential savings	-	-	-	-	219	477	477
Net cost pressure/(surplus)	**905**	**-**	**1,015**	**1,015**	**924**	**755**	**870**
With no restrictive covenant							
2011/12 part year effect							
Net additional costs	873	581	940	940	942	954	955
Projected 3rd party income	-	-	1,542	1,542	1,028	848	385
Potential savings	-	-	-	-	55	96	96
Net cost pressure/(surplus)	**873**	**581**	**(602)**	**(602)**	**(141)**	**10**	**475**
2012/13 full year effect							
Net additional costs	905	-	1,434	1,434	1,442	1,490	1,497
Projected 3rd party income	-	-	1,884	1,884	1,256	1,036	471
Potential savings	-	-	-	-	219	477	477
Net cost pressure/(surplus)	**905**	**-**	**(450)**	**(450)**	**(33)**	**(23)**	**549**

1.4 Conclusions

The key factor in identifying the best way forward is resolution of the restrictive covenant in the existing lease. If that covenant remains and is applied, none of the options represent an affordable solution to the PCT as it will not be possible to recover costs incurred.

If the covenant is removed then a number of options are feasible. Option A "do nothing" identifies a baseline cost of over £0.9m simply to mothball the facility. Option B for the sale of the facility scored badly in the benefits appraisal and carries a risk of impairment if the achieved market value is below the DV valuation. Option C for the lease of the facility scored better in benefits terms as it would retain the facility for healthcare purposes but, along with option D1, carries a higher risk of failing to attract market interest to take on the whole facility. These two options would have the best affordability if a provider can be found.

The options with an element of primary and community services scored highest in benefit terms, are seen to reduce the risk by having a mix of providers and services, and D2 and D3 could be broadly revenue neutral. D4 scored well in benefits terms but makes the most changes to the current building and requires the most capital investment and, subject to a more detailed study of which community based services could be relocated, has an ongoing revenue cost of around £0.6m.

Taking into account the overall mix of benefits, costs and risks and assuming that the covenant does not apply, it is recommended that further work should be undertaken to develop the implementation detail for options D2 and D3 as they will:

- Provide a good balance of urgent care centre, primary care, intermediate care services and surgery, with a "community hospital" feel.
- Reduce the risk of reliance on finding a single provider for the whole facility.
- Subject to a more detailed review of the capital requirements and implementation costs, deliver an affordable long-term solution.

2 Overview

2.1 Purpose

NHS Halton and St Helens, together with Runcorn Shadow GP Commissioning Consortium, has been considering options for the future utilisation of the Cheshire and Merseyside NHS Treatment Centre (CMTC) as a multi-purpose health care resource centre.

This document sets out those options and presents a business case to assist the PCT Board in considering the proposed future use of the facilities to provide local health care.

2.2 Introduction

The CMTC has been operating for five years to provide a range of orthopaedic services from forty-four inpatient beds, twelve day case beds, four theatres, a diagnostics suite and outpatient facilities. It is located on a site adjacent to Halton Hospital in Runcorn - the site is owned by Warrington and Halton Hospital NHS Foundation Trust (WHHFT) and is subject to a lease arrangement with 55 years remaining of the original 60 year lease.

The buildings on the site have been constructed and operated since 2006 by InterHealth Care Services, who have had a Department of Health procured ISTC Wave One contract to provide a range of elective orthopaedic services to patients from a wide area covering Chester, Crewe, Ellesmere Port, Knowsley, Macclesfield, Liverpool, Runcorn, Sefton, Southport, St. Helens, Warrington and Wirral.

The five-year, fixed term contract concludes on 31 May 2011. A final payment of around £33m will be made by the DH (under the legally binding terms of the contract) to recognise the residual value of the building. The leasehold interest in the building and equipment is likely to transfer from the Secretary of State for Health to NHS Halton and St Helens from 1 June 2011 and, under the current lease terms, the premises must be retained as a health care facility. The asset will be included on the PCT's balance sheet at Depreciated Replacement Cost.

NHS Halton and St Helens identified three broad options for the CMTC as of 1 June 2011:

- Divest - sell the building on the open market guided by an assessment by the District Valuer.
- Lease - seek through a procurement process an organisation that is willing to take on a lease for the building.
- Utilisation - use the asset for local health care provision, if costs including capital charges, depreciation and running costs can be recouped.

This business case was commissioned in order to:

- Evaluate the potential mix of service activities to test the viability of initial utilisation proposals.
- Test the financial viability of the service proposals, to determine what mix and level of activity is required to ensure that the costs of operating the facility are recovered.
- Set out the risks and benefits of the utilisation options.
- Compare the utilisation option with the two alternative options.

2.3 Document structure

This document has been prepared using the agreed standards and format for business cases, as set out in the Office of Government Commerce (OGC) Five Case Model and as per the HM Treasury Green Book guidance. The next sections of the document are:

- Section 3 Strategic Case: Provides an overview of the business need for change and its alignment with national and local strategies.
- Section 4 Economic Case: Develops a long list of service scoping options. A set of agreed criteria is used to appraise these options to determine the preferred option.
- Section 5 Commercial Case: Outlines the potential commercial arrangements for the preferred option.
- Section 6 Financial Case: Presents the financial viability and affordability implications for the preferred option.
- Section 7 Management Case: Demonstrates the achievability of the preferred option and the management approach.
- Section 8 Appendices: Supporting documentation.

2.4 Approach

The business case has been built up by:

- Engaging with a wide range of stakeholders during the preparation of this document to understand the key issues and opportunities from a range of perspectives – stakeholder details are included in Appendix 1.
- Applying the outcomes from that engagement to establish a schedule of potential services that could be based in the CMTC in terms of:
  - Current service provision including activity levels, costs, accommodation and funding.

  - Drivers for future provision including demographics, commissioning intentions and priorities, emerging best practice service models and care pathways.
  - Projected activity, costing, accommodation requirements and funding for services that could be located in the CMTC.
  - Accessibility implications.
  - Impact assessment on the wider health care system.
  - Benefits and risks of service provision at the CMTC.
- A high level review - by an architect experienced in healthcare facilities and design - of the suitability of the building for the emerging service options.
- Undertaking an option appraisal process with a group of stakeholders (membership details in Appendix 6).
- Completing a high level financial and commercial appraisal of the various options including a baseline “do nothing” option.

3 Strategic Case

Business cases are typically driven by the need to identify a solution to address specific business and service needs faced by an organisation or health economy. This business case is different: the availability of the CMTC facility, which is still relatively new and has been purpose built for the delivery of health care services, presents an opportunity to explore service options that would optimise use of the CMTC and of other local health accommodation in a way that would not otherwise be possible. Therefore, although the initial review is estates driven, it opens up the potential to reconsider the reconfiguration of local service and facilities in order to improve integration, streamline and redesign care pathways and increase productivity.

PART A: STRATEGIC CONTEXT

3.1 Organisational overview

3.1.1 NHS Halton and St Helens

NHS Halton and St Helens was established as a Primary Care Trust on 1 October 2006, replacing the former Halton PCT and St Helens PCT. The PCT has a total annual budget of £605million. The boundaries match those of Halton Borough Council and St Helens Metropolitan Borough Council, incorporating three main towns (St Helens, Runcorn and Widnes) and a total resident population of around 300,000.

3.1.2 Demographics

The area is significantly challenged in terms of employment opportunities, due to the decline of traditional coal mining and chemical manufacturing industries. Halton and St Helens has a high number of people on state benefits (around 38,000) and over half are on incapacity benefit (around 21,000), largely for preventable or manageable conditions. High unemployment has resulted in the area becoming one of the country's most deprived (worst 10% in the country), and this has a significant impact on the health of local populations.

3.1.3 Health profile

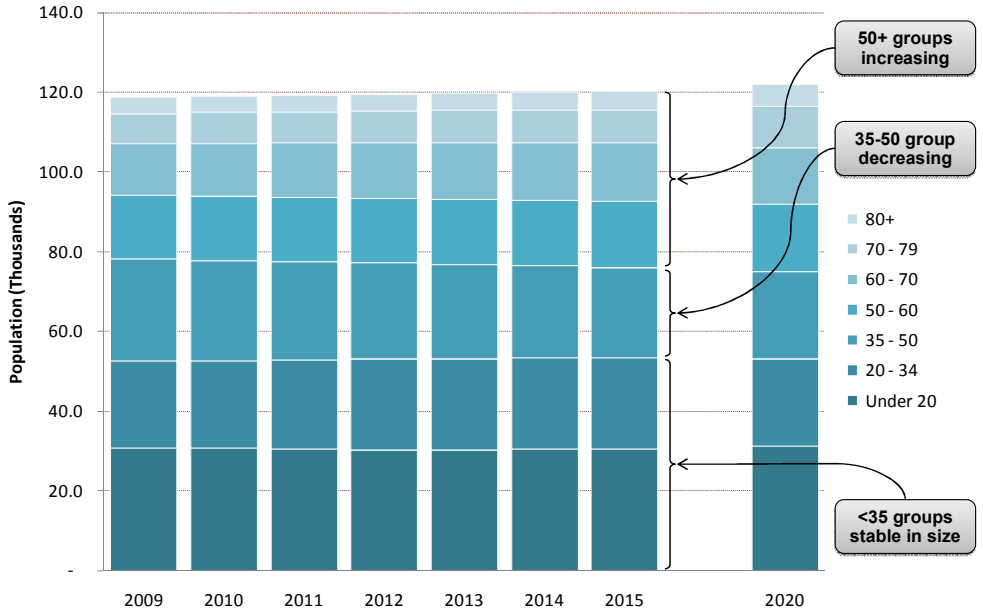
Significant health issues are experienced within the PCT boundary, including high incidences of cancer, heart disease and vascular disease; and high rates of smoking, obesity and alcohol and drug misuse:

- The mortality rate for Halton and St Helens is 19% worse than the national average, equivalent to 560 extra deaths per year. Much of this is lifestyle dependent, arising from heavy drinking, smoking and a poor diet.

- The emergency (non-elective) admission rate is 37% higher than the national average with significant resources focused reactively on treating sickness.
- Smoking prevalence is 12% higher than national average, and mortality rate attributable to smoking is 28% higher, accounting for over 129 deaths per year. There are over 1,176 annual admissions to hospital attributable to smoking, accounting for 8,500 bed days being consumed (equal to 1 full ward a year).
- Alcohol binge drinking is 27% higher than national average, with over 6,000 annual admissions to hospital relating to alcohol, and a 33% higher than national average alcohol-related mortality rate accounting for 42 more deaths per year.
- Obesity amongst adults is 10% higher, and for children is 25% higher than national average.
- There are over 3,400 annual admissions to hospital for cancer, accounting for 18,000 bed days being consumed (equal to 2 full wards a year), and the local mortality rate attributable to cancer is 20% higher than national average.

Life expectancy within Halton and St Helens is around 2 years below the national average, with local populations living in high deprivation wards living up to 6 years less than the national average. Although local life expectancy has been increasing over the last decade, this is at a slower rate than the national average, so the gap in health inequalities in the local areas compared to the national average has widened.

It is predicted that the total population will increase by 1.6% over the next 5 years. However, the 50+ age groups are becoming a larger percentage of the local population, with forecast increases in the over 65s population of 13%. Since the elderly population places the largest demand on health services, this will significantly impact on local service demand. Population forecasts for Halton UA are as follows:



3.1.4 Organisational transformation

By April 2013 all PCTs will be abolished and their commissioning role taken over by the new GP consortia. At present, there are four shadow GP Commissioning Consortia within the Halton and St Helens boundary: United League, Runcorn, STHealth and Widnes. These will form the basis of permanent GP commissioning consortia, with the new PCT Clusters leading the transition process. Details of the clusters in Merseyside and Cheshire have recently been agreed and Halton & St Helens will be part of the Merseyside cluster.

3.1.5 Runcorn Shadow GP Commissioning Consortium

Runcorn Shadow GP Commissioning Consortium consists of seven practices, covering:

- Brookvale Practice
- Weaver Vale Medical Centre
- Castlefields Health Centre
- Grove House Practice
- Heath Road Medical Centre
- Murdishaw Health Centre
- Tower House Practice

In the first three quarters of 2010/11 the Runcorn practices spent £23.4m on hospital activity against a planned budget of £25.9m.

3.1.6 Future Arrangements for Asset Ownership and Management

In light of forthcoming PCT disbandment, processes will need to be in place for acquisition/ disposal of PCT property. David Flory's letter of 16 February 2011, to all SHA and PCT Chief Executives, set clear directions concerning all transactions involving PCT property post 2011. Under this guidance, the PCT requires explicit agreement from the SHA to any property transaction (acquisition or disposal) with a value of up to £35m. For transactions over £35m DH approval is also required.

There is no guidance as yet on the process that would need to be followed for the PCT to dispose of an interest in a PFI (or LIFT) building. Recent guidance has focussed on the transfer of owned or conventionally leased buildings to Aspirant Community Foundation Trusts.

3.2 Business strategies

3.2.1 Overall planning context

The context for this development is contained within the following documents, which provide key policy drivers for determining local commissioning priorities:

- **Equity and Excellence: Liberating the NHS:** relevant policy developments within the July 2010 White Paper include the shift of commissioning from PCTs to GP Consortia; and an emphasis on patient choice of provider.
- **Spending Review 2010:** although 'protected' in the Spending Review, the NHS faces its tightest financial settlement in recent years, meaning that economic constraints will necessarily influence planning and asset management decisions.
- **Quality, Innovation, Productivity and Prevention:** the NHS needs to achieve up to £20 billion of efficiency savings by 2015, via QIPP, reinvesting any savings in patient care.
- **Transforming Community Services:** TCS supports the care closer to home agenda, aiming to improve and diversify community services so that care can be moved out of the acute setting.
- **NHS Operating Framework 2010/11:** in preparing for transition to GP commissioning, key points within the framework include: formation of PCT clusters to manage the transition; alterations in tariff and non-tariff prices for providers; publication of an outcomes framework.
- **Commissioner Investment & Asset Management Strategy (CIAMS):** a structured estate management approach, and rationalisation programme will help NHS organisations to achieve cost efficiencies, generate capital receipts, and maximise income through commercially-minded use of hospital sites.
- **Procurement guide for commissioners of NHS-funded services:** all services will need to be subject to procurement which complies with this guidance and an appropriate contract award made. Dependent on the expected delivery this will be through either an Any Willing (Qualified) Provider accreditation process of a Single tender action process.

3.2.2 Local commissioning context

The primary strategic document setting the context for this work is NHS Halton and St Helens' Commissioning Strategic Plan 2009, which outlines the PCT's strategic approach to improving the health of local populations, through a commitment to:

- Helping people to stay healthy and take greater responsibility for their own health and care.
- Increasing the range and scale of local programmes to detect illness earlier.
- Improving the quality and safety of local health care services.

The CSP has committed the PCT to improve the quality, safety and efficiency of services it commissions. This commitment is being realised through the delivery of the CSP Planned Care Workstream that has the following outcomes:

- Reduction of 10% in overall first outpatient attendances across all specialties.
- Reduction in outpatient follow up appointments (65,000 by 2013).
- Reduced wait time to 12 weeks.

These will be achieved through the following schemes:

- Planned Care Standards.
- Direct access to diagnostics.
- Integrated models of care across all commissioned services.
- Increasing day case surgery rates.
- Reducing length of stay.
- Reducing healthcare-associated infections.

These strategic objectives are supported via the detailed Commissioning Intentions (November 2010), wherein NHS Halton and St Helens and local Practice Based Commissioning Consortia formally set out their commissioning priorities. Initiatives that are relevant to this business case include:

- A shift of a significant proportion of outpatient attendances from secondary care to non-acute (community based) settings. There is also an expectation that this will achieve significant cost reductions with costs at around 70% of tariff.
- In support of this, there is an intention to develop Community Assessment and Treatment Services (CATS) for a range of outpatient specialties.
- For orthopaedics: revised thresholds for hip and knee surgical interventions, and a need to review protocols for joint replacement follow ups and discharge.
- For Urgent Care: provision of an Urgent Care Centre at the Halton Hospital site, plus a Single Point of Access solution for Urgent Care (applying learning from the SPA pilot).
- For Substance Misuse: development of a new, integrated (both alcohol and drugs) substance misuse treatment system in Halton, to commence on 1 September 2011.

3.2.3 Local Provider Landscape

The provider landscape is made up of acute, community, mental health, independent, social care, and primary care providers, offering a range of NHS clinical services to the local population of Halton and St Helens.

Approximately 70% of the PCT's commissioning budget is spent on hospital-based services, whilst the greatest number of contacts by patients with health professionals takes place in primary and community settings (over 80%). The majority of diagnostic tests and most access to urgent care services are currently undertaken in secondary care, although the initiative set out in the CSP, and changes in commissioning practices are expected to lead to a significant shift of services from acute to primary care settings.

As outlined in the 2009 CSP, the provider landscape can be summarised as follows:

- **Primary Care:** 2 walk-in centres (Widnes, St Helens); 1 community hospital (Widnes); 51 GP practices (184 GPs); 43 dentists; 29 opticians; 69 pharmacies.

- **Secondary Care:** 2 main district general hospitals, with A&E (Warrington & Halton Hospitals, and St Helens & Knowsley Hospitals NHS Trust); numerous tertiary providers.
- **Mental Health:** 1 main provider (5 Boroughs Partnership).
- **Child and Family:** wide range of providers – acute, hospitals, community services and voluntary sector.
- **Independent:** Cheshire & Merseyside NHS Treatment Centre located on Halton Hospital Site, Spire Healthcare, Fairfield Independent Hospital.
- **Voluntary Sector:** wide range of provision – adult, children's and accommodation services.
- **Community Health Services:** Halton and St Helens community services will be delivered from 1 April 2011 by a new NHS Trust organisation which will provide services across Halton and St Helens, Warrington, Trafford, Ashton, Leigh and Wigan. Work will progress over the next two years on the development of service specifications that will transform community services.

The PCT's overall commissioning portfolio for 2010/11 is as follows:

Item	Budget £'000
Services commissioned from NHS Bodies	332,115
ISTC	4,106
Services commissioned from non-NHS bodies	49,601
Primary Care Services	138,108
Provider Services	41,248
Corporate & Support Services	28,392
Reserves	8,424
CSP Investment	2,972
PBC	2,684
Unidentified CRES	(2,768)
Total NHS H &StH:	604,882

3.2.4 NHS Halton and St Helens Estates Overview

The NHS Halton and St Helens Estates Strategy 2009-14 shows that the PCT has a freehold or leasehold interest in 45 properties and an additional 50 properties owned by GPs from which it commissions services.

Total areas for PCT properties across Halton and St Helens are as follows:

- 27,154m² freehold and leasehold properties
- 68,751m² GP practices

It is intended that ownership of PCT facilities used for the provision of services will be transferred to the new community services trust.

B: CASE FOR CHANGE

3.3 Investment objectives

The availability of the CMTC building provides an opportunity for the PCT and Runcorn PBC to address commissioning priorities in terms of:

- **Quality:** improving patient care, patient safety, and patient / staff experience, by improving access to primary, community and acute services, and ensuring delivery from fit-for-purpose premises.
- **Productivity:** rationalising use of existing accommodation to improve productivity from available assets.
- **Efficiency:** reviewing clinical fit of services to existing buildings, to remove waste or dissipation of resources from the system and improve efficiency.
- **Deliverability:** achieving an expedient solution to cover ISTC building capital charges and building-related costs, that can be executed quickly, with minimal investment in infrastructure.

3.4 Current arrangements for the CMTC

3.4.1 Facilities

The CMTC building was designed to then Health Building Note (HBN) and Health Technical Memoranda (HTM) standards, and covers an area equating to approximately 5,890m² gross internal area over three main floors plus plant and services on the roof area. It has been operating for five years to provide a range of orthopaedic services from accommodation including:

- 44 inpatient beds (including 4 single rooms of which 2 are isolation rooms) and 12 day case beds.
- 4 theatres (2 ultra-clean).
- 12 outpatient consulting rooms.
- Diagnostics suite with 2 plain film X-ray rooms, 1 CT suite (16 slice), 1 MRI suite (1.0 TESLA), 1 ultrasound room.

The facility has been regarded as performing well, with achievements including the facility being free of MRSA and C Diff. National NHS Patient Experience Survey results indicate that 100% of patients would “recommend the facility to a friend”.

However, there are some reported issues with the existing building:

- The configuration of day case beds within the CMTC means they can only be used for same sex operating lists. This has restricted the flexibility of list scheduling.
- Two of the four theatres are not laminar flow and, depending on the planned future use, could require upgrading.
- Existing sinks and taps do not comply with current regulations and would need replacing if/when alterations are made to the building.
- There is no dedicated anaesthetic preparation area (the current provider's care pathways did not require such an area).

The current provider contracted out the Facilities and support staff to OCS.

3.4.2 Service contract arrangements

The buildings on the site have been constructed and operated since 2006 by InterHealth Care Services, who have had a 5 year, fixed term contract to provide elective orthopaedic services to patients from a wide area covering Chester, Crewe, Ellesmere Port, Knowsley, Macclesfield, Liverpool, Runcorn, Sefton, Southport, St. Helens, Warrington and Wirral.

3.4.3 Lease arrangements

The CMTC is located on a site adjacent to Halton Hospital in Runcorn - the site is owned by Warrington and Halton Hospital NHS Foundation Trust (WHHFT) - and is subject to a 60 year lease arrangement, with 55 years remaining. The ground rent started at £50,000 per annum and is index-linked.

InterHealth's five-year contract ends on 31 May 2011. The GC5W project agreement states that the leasehold interest in the building and equipment will transfer from the Secretary of State for Health to an NHS body – assumed at this stage to be NHS Halton and St Helens - from 1 June 2011 and the premises must be retained as a health care facility.

The existing lease between the DH and WHHFT contains a restrictive covenant which prevents any leasee from sub-letting the land AND buildings thereon at more than the agreed ground rent (which is £50,000 p.a. plus 5 years indexation to be applied at 1 June 2011). This would prevent the PCT from recovering the full costs of capital charges and other buildings related costs that it will incur.

3.5 Arrangements from 1 June 2011

At this stage it is assumed that the leasehold interest in the CMTC asset, valued by the District Valuation Service (DVS) on a Depreciated Replacement Cost (DRC) basis at £18.1m, will transfer to NHS Halton and St Helens with effect from 1 June 2011.

Assuming this transfer proceeds as anticipated, ongoing maintenance costs will be incurred by the PCT immediately from that date. It is anticipated that there will be a gap of several months between the end of service provision and commencement of services under any new arrangements due to the procurement and registration by the Care Quality Commission timetables. This will mean that it is likely that no new services will be provided from the CMTC until autumn 2011 at the earliest.

3.6 Business needs

The business needs that this business case responds to include:

- **Financial:** to cover the ongoing costs of the CMTC that will be incurred by the PCT with effect from 1 June 2011.
- **Care pathways and service redesign:** to assess opportunities to redesign and rationalise care pathways across a range of services.
- **Capacity:** to provide additional capacity within the local healthcare system, particularly for the resident population of Runcorn and immediate surrounding areas.
- **Facilities:** to reduce the overall costs of the estate within the local health and social care economy through shared use of facilities.
- **Service development opportunities:** to consider opportunities for the development of new local services through relocation or expansion to serve the local community.
- **Deliverability:** to identify a solution that can be implemented quickly, and with minimal additional investment in infrastructure.

This rationalisation prospect offers the potential to deliver against key service requirements, including:

- The opportunity to optimise the use of an existing building, and ensure strong fit between services and their accommodation.
- The opportunity to increase capacity within the local health economy, to help manage demand for clinically appropriate interventions.
- The opportunity to reduce transaction costs of care.

3.7 Main benefits criteria

Based on the investment objectives and business needs set out above, the benefits required from the future use of the CMTC have been defined as a set of criteria:

- Optimise the use of existing CMTC facilities.
- Rationalise use of other existing accommodation.
- Provide opportunities for integration of services (primary, community, acute, mental health, social care).
- Improve overall quality of service provision.

- Help to meet demand for clinically appropriate interventions.
- Maintain / improve access to services: primary / community / acute / mental health / social care.
- Maintain / improve productivity of service provision.
- Maintain / improve efficiency of service provision.
- Is deliverable within: an acceptable timescale, competition rules, available procurement routes.

3.8 Main risks

The main risks to this endeavour are outlined as follows:

- **Competition and procurement issues.** Depending on the option, the PCT may enter into either a business transaction or a service procurement. As a business transaction, the PCT could acquire the assets and then sell or lease on the assets to another owner / tenant. If the PCT retains the assets and procures services to be provided through the use of those assets, the PCT will have to comply with UK and EU procurement law and go through market testing.
- **TUPE.** If services are provided from the CMTC within a period of 3 months a new provider would have to take account of any commitments resulting from TUPE regulations.
- **Below tariff payments.** Verification is sought around the assumption that non-hospital outpatients can be charged at a lower cost than in a hospital setting (i.e. below tariff). The 2011/2012 PbR guidance will preclude pricing below tariff unless it can be demonstrated that there is a clear difference in the service specification.
- **Planning approval.** It is understood that the definition under "Permitted Use" within the lease is as a healthcare facility, but the planning approval is for an orthopaedic hospital. Clearly there is a risk that a new planning application will be needed for a change of use, potentially representing an associated delay and additional cost.
- **Lease.** As set out in section 3.4.4 above, legal interpretation of the lease is required, to clarify Schedule 5, clauses 6.2 (a) and 6.3 (c), which state that the tenant (NHS Halton and St Helens) cannot charge any sub-tenants in excess of the lease cost of £50,000 per annum (plus indexation). If these clauses stand, they represent a significant issue for the PCT, as it will not be able to pass on the cost of capital charges and other running costs through sub-lets.
- **PCT Cluster:** it is understood that the CMTC will be covered by the Merseyside PCT Cluster, whose newly appointed Chief Executive is Derek Campbell. If the cluster view is different to NHS Halton St Helen's view regarding use of the CMTC, this could represent a significant barrier to progress.

3.9 Constraints / dependencies

This asset transfer takes place within a context of constraints, including:

- **Time:** there is a need to cover costs quickly, meaning that 'do nothing' becomes a costly and impracticable option.
- **Political expediency:** given current pressures on the NHS to rationalise estates, 'mothballing' the CMTC building is not a politically acceptable solution.
- **Lease:** as above, the lease contains a restrictive covenant for the PCT, regarding charges to sub-tenants. This requires resolution through discussions between the DH, SHA and the landlord (WHHFT).
- **Transfer:** the building must be handed over to the NHS on 1st June 2011 as a fully working hospital, not as a decommissioned facility.

4 Economic Case

This section of the business case considers a range of options that have been developed in response to the project objectives and service scope identified in the strategic case.

4.1 Critical success factors

The following critical success factors have been identified:

- The preferred solution must cover the additional capital charges and other building related costs associated with the CMTC that would otherwise represent an increase in PCT expenditure.
- The preferred solution must be deliverable within an acceptable timeframe.
- The preferred solution must be compliant with the appropriate rules and guidance on procurement and competition.

4.2 Key assumptions

The appraisal process, identification of options and scoring has been undertaken on the basis of a number of key assumptions:

- That the leasehold interest in the CMTC is transferred by the Secretary of State to the PCT on 1st June 2011 and will be on the PCT's books with effect from that date.
- That the restrictive covenant in the existing lease with WHHFT is negotiated out (by DH and SHA). If this covenant remains then none of the options considered constitute value for money for the PCT and would create an unacceptably high recurrent cost pressure.
- That there is sufficient space in option D3 for the whole of the existing services based at Hallwood Health Centre (including primary care, community services and pharmacy) to relocate to the CMTC.
- That the CMTC could be available for non-health care use under option B (divest) but not under option C (lease) as the PCT would only sub-lease for health care provision.
- Service provision does not commence until at least autumn 2011, due to the requirement to undertake a formal procurement process for the services to be delivered within the CMTC.

The first two issues underpin the process – it is important to stress that if either assumption proves to be invalid, this business case is also invalid.

4.3 Service options long list

As outlined in section 2.2, NHS Halton and St Helens initially identified three broad option categories for the CMTC as of 1 June 2011:

- Divest: sell the building on the open market guided by an assessment by the District Valuer.
- Lease: seek through a procurement process an organisation that is willing to take on a lease for the building.
- Utilisation: use the asset for local health care provision, if costs including capital charges, depreciation and running costs can be recouped.

In addition, there is the need to consider a 'Do Nothing' option, to provide a baseline for development opportunities. Following further consideration the utilisation option has been developed into four service configurations giving a long list of options as follows:

- **Option A:** Do nothing.
- **Option B:** Divest.
- **Option C:** Lease.
- **Option D:** Utilisation.
  - Option D1: Orthopaedic centre.
  - Option D2: Surgical centre.
  - Option D3: Dedicated day surgery centre, plus Health Care Resource Centre (primary care / community services).
  - Option D4: Health Care Resource Centre only (primary care / community services) with no / very little surgery.

The options are described in detail in the next sections.

4.4 Option A: Do Nothing

This option is not considered to be a practical way forward – it is included only to provide a baseline.

Key features

- No services provided from CMTC – the building would be mothballed.
- The PCT would continue to pay ground rent to WHHFT, plus capital charges and relevant maintenance costs. There would be non recurrent costs to decommission equipment; there could be a capital receipt for MRI, CT and other equipment.

4.5 Option B: Divest

The leasehold interest would be sold on the open market.

Key features

- Services would be as delivered by the chosen provider.
- PCT would sell the lease via market testing and appropriate open procurement.
- PCT picks up ground rent, capital charges and relevant maintenance costs in short term until sale is completed. No ongoing costs to the PCT (if covenant does not apply).

4.6 Option C: Lease

The lease would be transferred to another organisation following market testing and open procurement.

Key features

- No service contract would be attached to the lease.
- Services would be as delivered by the chosen provider.
- The PCT would assign the lease to the chosen organisation for the remaining period (60 years).
- PCT picks up ground rent, capital charges and relevant maintenance costs in short term until sub-lease is completed. Assume that the ongoing costs should be covered by the income received through the sub-lease i.e. no net cost to the PCT (if covenant does not apply).

4.7 Option D: Utilisation options

4.7.1 Option D1: Orthopaedic Centre

Potential floor layouts are illustrated in Appendix 2. The exact layout would be as required / defined by the user – the illustrated floor layouts show that the number of single rooms could be increased but would reduce the overall bed capacity.

This option would provide:

Services

- Elective orthopaedic services: inpatient (i/p), day case (d/c), outpatient (o/p), physiotherapy, possibly Musculoskeletal (MSK).

Layout

- Ground floor - Imaging, outpatients, physiotherapy.
- First floor - 40 inpatient beds.
- Second floor - 12 day beds, 4 theatres.

This option would retain the current use of most of the building with some minor modifications.

Table 1 : Option D1 services

Floor	Services
Ground	Imaging department, outpatients, physiotherapy area, potential MSK area. Options to add an extension at the back of the building adjacent to current physiotherapy gym but this is not essential.
First	Ward area plus admin/office and support areas. Two existing 4-bed rooms could be converted in single rooms with ensuite giving a total of 40 beds (8 x 4-bed rooms, 8 single rooms). The single rooms (existing and proposed) exceed current HBN standard but the current 4-bed rooms (56m² and 60m²) are below the current standard of 72.5m².
Second	Four theatres and day surgery suite (12 beds) as current. The only modification proposed is the conversion into an anaesthetics preparation room. Two of the theatres may need to be converted to laminar flow in order to maximise orthopaedic throughput.

The market share of the range of elective orthopaedic activity provided from the CMTC in 2009/10 for the area covered by NHS Halton and St Helens and the neighbouring PCTs for Warrington, Western Cheshire and Central & Eastern Cheshire was:

- Warrington & Halton Hospitals 17.6%
- CMTC 16.2%
- Mid Cheshire Hospitals 14.3%
- St Helens and Knowsley 9.0%
- Countess of Chester 9%
- Spire Cheshire 5%

The indicative activity "gap" for NHS Halton & St Helens for activity that has been undertaken at the CMTC is:

CMTC provider	Indicative activity	Indicative value (£m)
Inpatients	251	1.168
Day Cases	653	1.078
First & Follow Ups	1,369 and 2,315	0.395
Total:	**4,588**	**2.641**

The PCT has agreed indicative contracts with a number of providers to cover this capacity gap through awards of standard acute contracts to accredited "Any Willing Providers". Patient choice of secondary care provider will demonstrate the revised provider landscape.

Clearly this is only a small proportion of the current CMTC activity provided through the GC5W Project Agreement and other commissioners are making their own arrangements. For this option to be financially viable to a provider, it is likely that the provider would need to relocate existing activity and services from another site into the CMTC in order to optimise use of the facilities and to cover the buildings-associated costs that it would be charged by the PCT.

The benefits to a provider could be all or some of:

- Reducing the current costs of service provision elsewhere by transferring elective orthopaedics to the CMTC facility.
- Adding overall orthopaedic capacity to increase market share and income, and therefore improve overall contribution.
- Freeing up space / accommodation elsewhere to facilitate other service developments or to rationalise estate.

The financial implications to the PCT are that the buildings-associated costs would be charged to the provider who would recover those costs through normal tariff charging.

4.7.2 Option D2: Surgery centre plus Health Care Resource Centre on ground floor

Potential floor layouts are illustrated in Appendix 3. As for D1, the exact layout would be as required / defined by the user – the illustrated floor layouts show that the number of single rooms could be increased but would reduce the overall bed capacity.

This option would provide:

Services

- Elective surgery services (i/p, d/c, o/p, physiotherapy); Urgent Care Centre (UCC) / diagnostic treatment centre.

Layout

- Ground floor - Imaging, UCC / diagnostic treatment centre.
- First floor - 40 inpatient beds, outpatients.
- Second floor - 12 day beds, 4 theatres.

Table 2 : Option D2 services

Floor	Services
Ground	Imaging department, UCC / diagnostic treatment centre. Options to add an extension (glass conservatory style) into the courtyard to add waiting space; also at the back of the building adjacent to current physiotherapy gym.
First	As Option D1. Ward area plus admin/office and support areas. Two existing 4-bed rooms converted in single rooms with ensuite giving a total of 40 beds (8 x 4-bed rooms, 8 single rooms). The single rooms (existing and proposed) exceed current HBN standard but the current 4-bed rooms (56m² and 60m²) are below the current standard of 72.5m². Could provide outpatient rooms in the existing admin area.
Second	As Option D1. Four theatres and day surgery suite (12 beds) as current. The only modification proposed is the conversion of clean utility into an anaesthetics preparation room.

This option is similar to option 1 in that the first and second floor would be used to provide a range of surgical inpatient, day case and outpatient services, with access to the imaging department on the ground floor.

The ground floor, however, would be used as a “Health Care Resource Centre”. Two service opportunities were considered initially: providing either primary care or urgent care services.

Primary care

Hallwood Health Centre is a GP owned facility housing two GP practices located adjacent to the Halton Hospital site. The PCT currently lease part of the building on a peppercorn rent until 2021 for a range of community services (including dentistry, SALT, a base for midwives). The site has benefited from some refurbishment works however the overall condition of accommodation at the site is ‘C’. Utilisation of clinical space is substantial at 53% although there is capacity for additional clinics if required.

No other practices in the locality have indicated an interest in relocating to the CMTC at this stage, mainly because it would mean moving further away from geographical area they serve.

On consideration of the currently available space and range of services provided at Hallwood Health Centre, it is clear that the space available on the ground floor would be insufficient even with the extension options. This option, therefore, would have the Urgent Care Centre plus outpatient facilities on the ground floor, not GPs.

Urgent Care Centre

Emergency admissions have continued to increase across Halton and St Helens PCT, with 1,471 Non Elective Emergency Admissions for Runcorn Shadow GPCC during 2009/10 (April/December). This affects the Acute Trust's ability to meet four-hour wait targets within local A&E departments and, on occasion, the percentage of cancelled elective admissions and ambulance response times.

Bed occupancy at both local acute trusts is over the nationally recommended level of 85%, with levels of 86% at St Helens and Knowsley Teaching Hospitals NHS Trust (StH&K) and over 90% at WHHFT. These high occupancy levels have an adverse effect on acute trusts being able to respond flexibly and responsively to peaks in unplanned care activity, and can potentially impact on elective admissions.

If the status quo is allowed to continue the residents of Halton will continue to access A&E in Warrington for the diagnosis and treatment of minor illness/minor injuries.

In response, there is a proposal to develop a new Urgent Care Centre on the Halton Hospital site, which is supported by the Runcorn Shadow GPCC. This new UCC would be a development of the current service delivered from the site's nurse-led Minor Injuries Unit, and would provide a jointly-led medical and nursing service, from 07:00 to 22:00, seven days a week. The service would be supported by diagnostic provision and access to pharmaceutical services. A business case and outline workforce plan have been developed, although further work is required to identify specific costs and ensure appropriate resource allocation. The CMTC building offers an alternative building to locate the UCC.

The Single Point of Access (SPA) pilot for Urgent Care will cease of 31 March 2011, but it is a PCT commissioning intention to build learning into a permanent SPA solution for UC. This would provide a 15 hour a day, 7 day a week service for professionals to ensure the quick and smooth referral of patients to the most appropriate service.

4.7.3 Option D3: Dedicated Day Surgery Centre plus Health Care Resource Centre

Potential floor layouts are illustrated in Appendix 4. The exact layout for the first floor ward would need further development, but at this stage a 28-bed wards has been modelled. Similarly, the second floor has been modelled to increase the potential number of day case beds to 22 in order to accommodate both male and female patients on the same day.

This option would provide:

Services

- Elective day surgery services; two GP practices; UCC; intermediate care ward; outpatients.

Layout

- Ground floor - Imaging, Urgent Care Centre, 1 GP practice.
- First floor - 28 inpatient intermediate care beds, 2nd GP practice, outpatients.
- Second floor - 22 day beds (2 wards), 4 theatres, outpatients.

Table 3 : Option D3 services

Floor	Services
Ground	Imaging department, Urgent Care Centre, 1 GP practice (6 GPs). Options to add an extension (glass conservatory style) into the courtyard to add waiting space; also at the back of the building adjacent to current physiotherapy gym.
First	Ward area with two existing 4-bed rooms converted in single rooms with ensuite and three existing 4-bed rooms converted into GP rooms giving a total of 28 beds (5 x 4-bed rooms, 8 single rooms). The single rooms (existing and proposed) exceed current HBN standard but the current 4-bed rooms (56m² and 60m²) are below the current standard of 72.5m². Admin area converted into GP / outpatient rooms.
Second	Current four theatres and day surgery suite (12 beds) plus second day surgery suite (10 beds) to provide separate male and female wards. Conversion of two areas into anaesthetics preparation rooms. Convert admin to outpatient rooms.

Day surgery

This option would provide a dedicated day surgery unit on the top floor with four theatres and the potential to have two ward areas (male and female) with around 22 beds. It could also be possible to include an endoscopy facility either by converting two theatres or through the conversion of other rooms on the top floor. The facility could also be used to provide dermatology procedures. Rooms currently used for administrative and office space could be easily converted into outpatient consulting rooms.

The ground and first floor would provide a range of primary care and community facilities including community hospital inpatient provision.

Intermediate Care

The PCT commissioned a review of intermediate care capacity planning and pathway which was completed at the end of 2010. The definition of intermediate care applied is as set out in the DH publication “Halfway Home” (2009): “a range of integrated services to promote recovery from illness, prevent unnecessary hospital admission and premature admission to long term residential care, support timely discharge from hospital and maximise independent living”.

Halton currently operates a pooled budget arrangement under a S75 partnership agreement between NHS Halton & St Helens and Halton Borough Council (BC), covering the period 2009 to 2012. Under this agreement, Halton BC is the host partner and manages the intermediate care budget (£4.716m for 2010/11). The PCT and Borough Council contribute funding to the Pooled Fund in proportions set out in a schedule to the partnership agreement, the proportions varying between services. Providers then invoice the Pooled Fund.

Access to all Intermediate Care service in Halton (bed and community) is via the Halton Intermediate Care Assessment Team (HICAT) which is operationally part of Halton Borough's Reablement & Rapid Response Service (RARS) service. This referral route is used by staff at WHH, GPs and community services and is open to self referral via an Intermediate Care Single Point of Access phone line.

Bed based provision for Halton service users requiring IC is provided at two sites:

- **Halton Intermediate Care Unit (HICU):** a jointly-commissioned sub-acute, 22 bedded facility located within a dedicated unit at Halton General Hospital. Pathways for admission to HICU include rehabilitative care post acute hospital admission; management of sub-acute exacerbation of chronic conditions from the community; diagnostics, treatment and sub-acute care from the community; treatment and care for single diagnosis conditions requiring higher level sub-acute management. Medical cover is provided under contract by GPs (Halton Health) supported by access to and planned input from consultant medical cover (one session per week provided by WHHFT).
- **Oakmeadows Residential Home:** 13 IC beds, with 5 additional beds block purchased during 2009/10 for additional capacity. RARS provides therapy and nursing support to Oakmeadows patients, with 24/7 medical cover from Appleton General Practice.

In addition, due to capacity issues and mainly in reaction to winter pressures, a number of beds are 'spot-purchased' (9 for 2009/10).

Halton provides a Homecare Reablement service, offering a 6-8 week home reablement programme, provided by a multi-disciplinary team which includes nurses, occupational therapists, physiotherapist, community psychiatric nurse, technical instructors, social workers, a pharmacist and support workers.

The Department of Health's guidance on Intermediate Care (2001 and 2009) has led to significant improvements in IC provision across Halton. All services work towards the locally agreed Gold Standard Framework for Intermediate Care Services, which operates within a specific QIPP framework.

Analysis of Halton Intermediate Care activity data for 2009/10 shows:

- 62% of referrals are from the acute sector and 38% from the community.
- 87% of referrals to RARs are appropriate.
- 86% conversion rate from assessment to commence IC services.

- Split between community service and bed provision is 73% community and 27% beds (however, if Halton's homecare Reablement service is excluded, the split is 41% beds and 59% community).
- 1,659 total assessments undertaken for 2009/10.

Analysis of Halton IC capacity and unit costs data for 2009/10 shows:

Table 4 : Intermediate care 2009/10

Bed capacity	HICU	Oakmeadow	Halton Total
2009/10 activity			
Number of beds	22	18	40
Number of admissions	208	178	386
Admissions/ bed	9.5	9.9	9.7
Average length of stay (days)	32*	39	
Average occupancy	83%	92%	
Total cost of unit (£)	£1,631,626	£666,497	
Cost per bed (£)	£74,165	£37,028	
Cost per bed per week (£)	£1,426	£712	

* The figure for HICU includes one service user whose length of stay was 235 days. This was a special case which was specifically approved by the Halton ECB. Excluding this case, the length of stay would have been 31 days.

The average length of stay for the NHS Benchmarking Network survey respondents was 27, with Halton reporting above this with average length of stay at 35 days. This has a significant impact on available capacity and unit costs.

Occupancy is already high at both Halton units, and there are waits for bed based provision resulting in the continued use of B3 at Halton Hospital for patients waiting for HICU. In addition, both Whiston and Warrington Hospitals are unable to consistently provide proactive coverage of A&E and other front end departments, suggesting unmet demand for local intermediate care services.

Potential demand for intermediate care services in Halton was modelled in the 2010 review, taking into account the increasingly elderly population profile (60+ age band increasing by 61% by 2031, a high proportion of long-term limiting illnesses (25% of Halton population compared with 19% nationally, and a high incidence of long term conditions.

Possible scenarios for developing capacity to meet demand were developed, starting with an assumption that 20% of hospital admissions of over 65s could be suitable for intermediate care. The impact of three different assumptions on the split of activity between bed and community provision has been modelled: 30%/70%; 35%/65%; and 40%/60%.

For Halton, results show that in all scenarios more beds are required to meet potential 2010/11 demand, and further capacity would be required within community services in all scenarios. Even with 30% productivity gain the 30%/70% split identifies a need for 11 additional beds.

Under this option, the beds currently in Halton Hospital would be relocated into the CMTC building, to improve the standard of accommodation and to provide additional capacity and to be co-located with an Urgent Care Centre and GP practices.

Urgent Care Centre

As for option D2 above.

Primary care

As for option D2 above except that accommodation would be split over the ground and first floors, with dedicated areas for each practice as well as shared space. A further detailed study would be needed to ensure that all facilities from Hallwood Health Centre could be accommodated but the initial assessment suggests that it should be possible over the two floors.

4.7.4 Option D4: Health Care Resource Centre only (no surgery)

Potential floor layouts are illustrated in Appendix 5. The ground and first floors are as for option D3 but here the top floor would have theatres removed and would be converted to provide a range of community based services.

This option would provide:

Services

Two GP practices; UCC; intermediate care ward; outpatients, base for range of community services.

Layout

- Ground floor - Imaging, Urgent Care Centre, 1 GP practice.
- First floor - 28 inpatient intermediate care beds, 2nd GP practice, outpatients.
- Second floor - Community services centre.

Table 5 : Option D4 services

Floor	Services
Ground	As Option D3. Imaging department, Urgent Care Centre, 1 GP practice (6 GPs). Options to add an extension (glass conservatory style) into the courtyard to add waiting space; also at the back of the building adjacent to current physiotherapy gym.
First	As Option D3. Ward area with two existing 4-bed rooms converted in single rooms with ensuite and three existing 4-bed rooms converted into GP rooms giving a total of 28 beds (5 x 4-bed rooms, 8 single rooms). The single rooms (existing and proposed) exceed current HBN standard but the current 4-bed rooms (56m² and 60m²) are below the current standard of 72.5m². Admin area converted into GP / outpatient rooms.
Second	Remove theatres and convert into community service facilities eg therapy centre, podiatry, phlebotomy etc.

Intermediate care, primary care, urgent care centre

As for option 3.

Other community services

This option provides the opportunity to relocate / develop a range of community based services on the second floor. The following section summarises some of those opportunities identified at this stage.

Community based outpatient clinics across a range of specialties

The PCT has committed to improving quality and efficiency of commissioned services, through delivery of the CSP Planned Care Workstream. This outlines two relevant objectives:

- 10% reduction in overall first outpatient attendances across all specialties.
- Reduction in outpatient follow up appointments (65,000 by 2013).

It is proposed that this will be supported via Planned Care Standards, direct access to diagnostics, and integrated models of care across all commissioned services.

The opportunity to provide outpatient services from the CMTC site provides a pertinent development option which aligns well with strategic direction. Specific outpatient service lines have been reviewed, and are outlined in more detail below.

ENT:

For 2009/10 total activity for NHS Halton & St Helens was 23,834 appointments, at a total cost of £5.461m.

The PCT has identified a potential to divert at least 70% of ENT diagnostics and treatment away from secondary care clinics to community settings at no more than 70% of current tariffs. There is a commissioning intention to develop Community Assessment and Treatment Services (CATS) in ENT.

Gastroenterology:

2009/2010 total activity for gastroenterology was 16,201 appointments at a total cost of £4.784m.

There is a commissioning intention to develop a CATS for gastroenterology, and it is anticipated that a minimum of 20% of gastroenterology referrals for assessment could be seen within this primary care service (diverted from secondary care).

Gynaecology

2009/2010) total activity for gynaecology was 29,977 appointments at a total cost of £8.501m.

Gynaecology complaints and symptoms represent a large proportion of GP consultations, and there is currently no formal community provision in place to support the delivery of standard or enhanced gynaecology services for Halton and St Helens. The PCT commission a consultant-led, community based level 2 sexual health service (CASH) which includes the provider arm and Brook. The PCT has also commissioned a locally enhanced service (LES) from GP's in relation to the delivery of enhanced Sexual Health services, although uptake has been low.

SUS data highlights a year-on-year increase in the numbers of gynaecological referrals to secondary care. There has also been a significant increase in the number of outpatient procedures undertaken within the time period. Opportunity locator suggests that approximately 2,900 first OP appointments per annum for gynaecology could be shifted to the community if the PCT were performing at the 25th percentile, and approx 3,900 first OP appointments could be shifted compared to the 10th percentile. This equates to a financial value of care that can be shifted of £420k at the 25th percentile, and £563k at the 10th percentile.

For follow up appointments, opportunity locator suggests that at the 25th percentile 7,730 could be moved to the community each year, releasing £770k. At the 10th percentile 9,340 follow up appointments could be moved to the community, releasing £930k. Therefore, if the PCT progressed plans to significantly shift secondary activity into the community and perform at the 25th percentile, it would collectively shift 10,630 appointments per annum which in turn would release £1.190m.

There is a commissioning intention to develop CATS for gynaecology via a range of potential service options: GP-led Community Gynaecology Clinics; Consultant-led Community Gynaecology Clinics, including diagnostic/ therapeutic interventions; Locally Enhanced Scheme/ AWP for GP's.

Dermatology

2009/2010) total activity for dermatology was 21,775 appointments at a cost of £2.914m.

There is a need to develop primary care capability to enable the implementation of shared care arrangements in dermatology, particularly where the presenting conditions require frequent attendance in secondary care clinics and/ or long term management and monitoring.

There is the opportunity for a shift of approximately 60% of current activity from secondary care clinics to community based provision at no more than 80% of current tariffs. A specification for community based provision was incorporated into the St Helens and Knowsley Teaching Hospitals NHS Trust in the 2010/11 contract. Progress to the achievement of this specification and the development of an integrated service needs to be reviewed and options to secure this offering agreed.

Musculoskeletal (MSK)

National trends and local demographic factors point to continued rising demand for MSK services, and latest estimates suggest that 30% of GP consultations are for MSK conditions.

In response to increases in PCT spend and secondary care activity across trauma and orthopaedics and rheumatology, NHS Halton and St Helens and the Practice Based Commissioning Consortia have undertaken a procurement process to provide an interface Clinical Assessment and Treatment Service, Direct Access Physiotherapy, and a Chronic Pain service.

The new service will enhance the management of patients within primary care, providing an alternative to hospital based treatment for the majority of patients being referred by General Practitioners for physiotherapy and MSK assessments and for the management of chronic pain. Patients would be referred to hospital only when there is a need for hospital based specialist services. The consortium provider is currently looking for a base for the new service.

Community midwifery

NHS Halton and St Helen's is the only PCT-run midwifery service in the North West (most midwifery services are run by the acute sector). The service looks after approximately 1,800 women, with around 1,600 births a year, divided 50:50 between Widnes and Runcorn. Births take place at WHH, Whiston, Chester, and Liverpool Women's.

At present, there is no permanent administrative base for Runcorn's community midwifery team. Instead, the team is required to work out of GP premises on an ad hoc basis, and out of cars. This impacts on efficiency and safety of working practices, and is not equitable with the Widnes team, which has access to permanent facilities and IT at their headquarters building.

There is an opportunity to develop a permanent Runcorn base for 16 midwives and 2 support workers (working out of 2 clinic rooms plus waiting and reception space). Parenting classes could also be provided from the site during evenings and Saturdays. This would align with the PCT's commissioning intentions to increase availability of community based antenatal and postnatal care in areas with poor access rates, and to increase the availability of midwifery led care.

4.8 Shortlisted options

It was agreed that all the options in the long list should be appraised.

4.9 Evaluation of shortlisted options – benefits appraisal

The benefits criteria set out in section 3.7 were given a weighting out of 100 by a project group of representatives from the PCT, the GP consortium, the current CMTC NHS contract manager and the Halton Local Involvement Network (LINk) lead officer (a list is included in Appendix 6), initially on an individual basis by participants then confirmed following discussion at the March appraisal meeting. The weightings used were as follows:

Table 6 : Benefits criteria weightings

Criteria		Ranking	Weighting
1	Optimises use of existing CMTC facilities	**1**	**15.8**
2	Rationalises use of other existing accommodation	**9**	**6.5**
3	Provides opportunities for integration of services: primary/community/acute/mh/social care	**3**	**13.4**
4	Improve overall quality of available services	**2**	**14.2**
5	Helps to meet demand for clinically appropriate interventions	**5**	**11.1**
6	Maintain/improve access to services: primary/community/acute/mh/social care	**4**	**12.4**
7	Maintain/improve productivity of existing services	**8**	**7.5**
8	Maintain/improve efficiency of service provision	**7**	**8.3**
9	Option is deliverable within: an acceptable timescale, competition rules, available procurement routes	**6**	**10.8**
		Total	**100**

Each option was then scored in turn out of 10 against each of the benefits criteria, using the following guide:

0 Does not meet criterion at all.

1 - 2 Barely meets criterion.

3 - 4 Meets criterion but not adequately.

5 - 6 Meets criterion quite well.

7 - 8 Meets criterion very well.

9 - 10 Meets criterion perfectly.

Finally, scores were multiplied by the weightings to generate a weighted score.

The results of the appraisal are:

Table 7 : Raw and weighted scores

Raw scores

		A Do nothing	B Divest	C Lease	D1 Utilise	D2 Utilise	D3 Utilise	D4 Utilise
			Sell to another org	Assign lease to another org	Ortho-paedic centre	Surgical centre PLUS	Day surg + Health Care Resource Centre	Health Care Resource Centre
1	Optimises use of existing CMTC facilities	0	4	6	6	7	4	3
2	Rationalises use of other existing accommodation	0	0	0	0	2	2	4
3	Provides opportunities for integration of services	0	0	1	3	3	7	8
4	Improve overall quality of available services	0	0	1	4	7	7	6
5	Helps to meet demand for clinically appropriate interventions	0	0	1	4	7	7	6.5
6	Maintain/improve access to services	0	0	6	6	7	8	8
7	Maintain/improve productivity of existing services	0	0	0	3	5	5	5
8	Maintain/improve efficiency of service provision	0	0	0	3	5	5	6
9	Option is deliverable within: an acceptable timescale, competition rules, available procurement routes	10	7	2	4	4	4	4
Total		**10**	**11**	**17**	**33**	**47**	**49**	**50.5**
Rank		**7**	**6**	**5**	**4**	**3**	**2**	**1**
% of highest score		**19.8%**	**21.8%**	**33.7%**	**65.3%**	**93.1%**	**97.0%**	**100.0%**

Weighted scores

									Weight
1	Optimises use of existing CMTC facilities	0.0	63.1	94.7	94.7	110.5	63.1	47.4	15.8
2	Rationalises use of other existing accommodation	0.0	0.0	0.0	0.0	13.1	13.1	26.2	6.5
3	Provides opportunities for integration of services	0.0	0.0	13.4	40.1	40.1	93.5	106.9	13.4
4	Improve overall quality of available services	0.0	0.0	14.2	56.9	99.5	99.5	85.3	14.2
5	Helps to meet demand for clinically appropriate interventions	0.0	0.0	11.1	44.3	77.5	77.5	72.0	11.1
6	Maintain/improve access to services	0.0	0.0	74.1	74.1	86.5	98.9	98.9	12.4
7	Maintain/improve productivity of existing services	0.0	0.0	0.0	22.5	37.4	37.4	37.4	7.5
8	Maintain/improve efficiency of service provision	0.0	0.0	0.0	25.0	41.7	41.7	50.1	8.3
9	Option is deliverable within: an acceptable timescale, competition rules, available procurement routes	108.4	75.9	21.7	43.4	43.4	43.4	43.4	10.8
Total		**108.4**	**139.0**	**229.2**	**400.9**	**549.7**	**568.1**	**567.4**	100.0
Rank		**7**	**6**	**5**	**4**	**3**	**1**	**2**	
% of highest score		**19.1%**	**24.5%**	**40.3%**	**70.6%**	**96.8%**	**100.0%**	**99.9%**	

The two highest ranked options were D3 (day surgery plus HCRC on 2 floors) and D4 (HRHC on 3 floors) with scores so close together that is would not be appropriate to differentiate between them, followed closely by D2 (surgical centre plus HRHC on 1 floor).

Option D1 (orthopaedic centre) was scored significantly lower than those three options but well ahead of options A, B and C.

The scoring rationale was:

Optimise CMTC facility. The do nothing option does not use the facilities at all. Other options make varying use, with the options that focussed mainly on surgery scoring highest. As the proportion of "HCRC" increased and "surgery" decreased, the more work would have to be done to the existing facility to accommodate different services. The day surgery option was also marked down because of the risk that there would not be sufficient activity to attract full use of the facility.

Rationalise other accommodation. Options A, B, C and D1 would have no impact on PCT / primary care accommodation (although there could be benefit to the wider health economy, depending on how the CMTC was used). The other options would facilitate some relocation of services to free up existing accommodation, but not to a significant level.

Opportunities for integration. Options A and B would not provide such opportunities, with option C only marginally better. The surgical options D1 and D2 should provide some degree of integration (dependent on the service provider – there has been little integration to date). The HCRC options would provide much more significant integration opportunities across primary, community and acute services and between ambulatory and non-acute inpatient services.

Improving quality. For options A, B and C the same logic applied as for integration therefore they were scored very low. For D1 the current service offers good quality therefore the improvement would be limited. For D2 and D3 there would be opportunities to improve quality through integration and redesign of care pathways. Option D4 was scored slightly lower as surgery is not included.

Meeting demand. This was scored the same as above for quality except that D4 was scored marginally higher as this option increases capacity for a wide range of community services.

Maintain/improve access. All the options which provide health care were given a score of 6 or more, with the increasing HRHC element giving a slight increase to D3 and D4.

Maintain/improve productivity. Options A, B and C would have no impact on productivity. The main benefits of improved productivity in D1 would be with the provider, but the commissioners would benefit more as more elements of the HRHC are introduced.

Maintain/improve efficiency. Scored as for productivity except that D4 was given one additional point for the benefits in running a full "community hospital" configuration.

Deliverability. Option A was given the maximum score as, by definition, it is entirely deliverable. Option B was also scored highly as it could be delivered in a relatively short timescale. The other options all require market testing, selection of one or more provider organisations, CQC accreditation etc and would therefore take longer. Option C was scored lowest as it was considered to be the most difficult to deliver in a short timescale.

Conclusion

The conclusion of the benefits appraisal was that options D2, D3 and D4 were joint preferred options as the difference in weighted scores was not significant.

4.10 Economic appraisal

An economic appraisal has been undertaken for all of the shortlisted options against both of the potential scenarios for the covenant that restricts the rent that the PCT can charge another user for the building i.e. firstly with the restrictive covenant still in force, secondly with no restriction on sub-leasing.

4.10.1 Financial assumptions

The economic (and affordability) appraisal has been made with the following approach and assumptions:

- Two variants of the appraisal have been completed. One considers the effect of the restrictive covenant in the lease for the land being retained, preventing the PCT from charging more than the ground rent for any user of the building. The other assumes that a solution is found that enables the PCT to charge the full market rent.
- The Open Market Value (OMV) for the building - defined as "the estimated amount for which a property should exchange between a willing buyer and a willing seller in an arms-length transaction after proper marketing wherein the parties had each acted knowledgably, prudently and without compulsion - has been estimated by the District Valuer at £22.5m. This valuation does not reflect the impact of the restrictive covenant which, if still in force, could significantly reduce the actual value received by the PCT. In that circumstance, the PCT could be faced with a significant impairment charge to Income & Expenditure Account (I&E) in the year of sale. This appraisal has **not** attempted to quantify the value of any impairment but it is an important additional factor to be aware of.
- Capital investment costs have been estimated - at a ***very high level*** without the benefit of a full survey – using a benchmark cost per m² for the conversion of accommodation, uplifted to reflect fees (16%), equipment (15%) and VAT (20%). Only capital costs that would be incurred by the PCT have been included in the analysis – those that would be made by a third party provider are outside the scope of this work (although these may affect the negotiated rent payable or the value of any subsequent service contract).
- The PCT capital costs associated with each option are summarised in the table below.

Table 8 : High level capital costs to be met by the PCT

Estimated capital costs includng fees, equipment and VAT	Option A £'000	Option B £'000	Option C £'000	Option D1 £'000	Option D2 £'000	Option D3 £'000	Option D4 £'000
Urgent care centre and outpatients					100		
Convert theatre space for community services							500
Convert ground floor - Imaging, UCC, GP practice						600	200
Second GP practice						150	150
Total	**-**	**-**	**-**	**-**	**100**	**750**	**850**

- Capital charges (including depreciation) on the existing building have been derived from the DV's Depreciated Replacement Cost valuation of the asset at £18.1million and its estimated useful life. During periods when the building is not in use it is treated as an asset under construction, which is not depreciated but upon which the capital absorption duty is payable.
- Ground rent payable to WHH as landlord is included at the level to which it is predicted to rise in 2011/12. Although it is possible that the freehold may be transferred to the DH before 1st June 2011, this remains uncertain and therefore, at this stage, the ground rent is still included in the appraisal. If this transfer were to take place it would have an impact on the overall valuation of the land and building, which is not yet known. A key assumption is that the PCT would not incur the capital costs of acquiring freehold as these would be borne by the Secretary of State and therefore no additional acquisition costs are included. This requires formal confirmation.
- Capital charges on any refurbishment or adaptation work have been assessed on an assumption of a 25 year useful economic life for these works.
- The latest estimates for cleaning, hard facilities management (FM) and security costs have been obtained from OCS. It has been assumed that:
  - Cleaning costs will not be incurred while capital work is in progress or if the building is not in active use.
  - Hard FM costs will be incurred for all options for which the site is retained, but at a lower level when the site is mothballed.
  - Security costs will be incurred at their stated level for all options.
- For the variant where it is assumed that the covenant does not apply, the value of rent recoverable for the building has been based on the DV's assessment of the market rent. Where only part of the building is to be let the rental income receivable has been scaled back accordingly.
- Decommissioning costs have been assumed for Option A, but will not be incurred for any of the other options.
- In all options a delay is anticipated between acquisition of the asset and its bringing back into operation. This is a reflection of the requirement for a procurement process – whether for an operator of clinical services or a construction supply chain. In each case this pushes the date that the option will be operational to 1 January 2012.

- An estimate of lifecycle costs has been included for options where the building is retained.
- Where current PCT commitments to premises costs are known (e.g. Hallwood Health Centre) any savings have been offset against the revenue costs for the option.
- For the Urgent Care Centre, net savings are assumed at 20% of the value of current activity diverted from A&E, based on work on that project completed earlier in the year. (No savings from the current MIU premises costs have been included.)
- For the intermediate care service, the net saving from diverting acute admissions has been offset against the costs of provision.
- For the variant with the covenant still applying it has assumed that FM costs could be recovered from providers - this would be subject to legal confirmation.

4.10.2 Net present costs

The net present costs of the options have been calculated using discounted cash flows over a 55 year period with a 3.5% discount rate. The results of the two appraisals are show in the tables below.

Table 9 : Economic appraisal

Discounted cash flow Summary - with covenant	**Option A** £'000	**Option B** £'000	**Option C** £'000	**Option D1** £'000	**Option D2** £'000	**Option D3** £'000	**Option D4** £'000
Net present cost							
- Capital / lifecycle costs	21,882	761	38,716	38,716	38,800	39,326	39,425
- Revenue costs	6,811	31	10,395	10,395	10,395	10,395	10,395
- Income /savings	0	0	-10,395	-10,395	-12,738	-17,955	-15,283
- Total	28,693	792	38,716	38,716	36,457	31,767	34,537
Appraisal period (years)	55	2	55	55	55	55	55
Equivalent annual cost	4,886	1,170	6,593	6,593	6,209	5,410	5,882
Note:							
Benefits appraisal scores	*108.4*	*139.0*	*229.2*	*400.9*	*549.7*	*568.1*	*567.4*
Benefits per £m EAC	*22.2*	*118.8*	*34.8*	*60.8*	*88.5*	*105.0*	*96.5*
Rank	*7*	*1*	*6*	*5*	*4*	*2*	*3*

Discounted cash flow Summary - no covenant	**Option A** £'000	**Option B** £'000	**Option C** £'000	**Option D1** £'000	**Option D2** £'000	**Option D3** £'000	**Option D4** £'000
Net present cost							
- Capital / lifecycle costs	21,882	761	38,716	38,716	38,800	39,326	39,425
- Revenue costs	6,811	0	10,395	10,395	10,395	10,395	10,395
- Income /savings	0	0	-46,851	-46,851	-36,546	-37,336	-23,280
- Total	28,693	761	2,261	2,261	12,649	12,386	26,540
Appraisal period (years)	55	2	55	55	55	55	55
Equivalent annual cost	4,886	1,124	385	385	2,154	2,109	4,520
Note:							
Benefits appraisal scores	*108.4*	*139.0*	*229.2*	*400.9*	*549.7*	*568.1*	*567.4*
Benefits per £m EAC	*22.2*	*123.6*	*595.3*	*1,041.3*	*255.2*	*269.3*	*125.5*
Rank	*7*	*6*	*2*	*1*	*4*	*3*	*5*

Given the broad assumptions behind these figures they should only be considered as indicative, at this stage. In particular, they are based on the assumption that:

- Full market rental is achieved as follows: in options C and D1 for 100% of available space, in D2 for 67% of available space, in option D3 for 55% of available space and in D4 for 25% of available space. Thus options D1 and D2 carry the greatest risk of not achieving the assumed income streams.

The results for the two variants clearly demonstrate the impact of the covenant issue on the overall financial position. If the covenant remains, the best value for money is delivered by Option D3, with D4 close behind. If the restriction described in the covenant can be removed, Options C and D1 are economically the best options, although with the greatest risk.

The affordability implication for each option under the two variants – which is the key test for the PCT in determining the right course of action - is set out in section 6.

4.11 Risks

The most significant risk to the project is associated with the resolution of the covenant issue described in the lease of land. This single issue has a huge impact on the potential income for the PCT – restricting the annual rent from a market rent of £1.5 million to c. £60,000.

The service planning associated with some of the clinical activities that may move into the facility is still at a relatively high level, and the interrelationships between these and other community and acute services within the health and social care community need to be examined in greater detail to establish with certainty the net effect on the commissioner.

There is also the scope for the capital costs of any adaptation work to be different from the estimates reflected in this report. The current costs have been derived at a very high level, without the benefit of a full survey, and further financial implications could be identified when this work is undertaken with greater accurately.

5 Commercial Case

This section of the business case outlines the NHS Halton and St Helens commercial and procurement strategy for the Cheshire and Merseyside Treatment Centre building it is due to acquire on 1 June 2011. The areas covered include:

- Competition and procurement
- TUPE
- Planning approval
- Underlying lease
- Capital funding
- PCT cluster

5.1 Competition and procurement

Depending on the preferred option, the PCT may enter into either a business transaction or as a service procurement. As a business transaction, the PCT could acquire the assets and then sell or lease on the assets to another owner / tenant. If the PCT retains the assets and procures services to be provided through the use of those assets, the PCT will have to comply with United Kingdom (UK) and European Union (EU) procurement law and go through market testing. Under the latter scenario, the procurement route would need to be a full market test, depending on the nature of the services to be included.

Under either eventuality, the PCT will have sufficient time - for the reasons stated in section 5.2 below - to prepare a robust set of service specification documents and to alert the market to maximise the number of potential bidders.

5.2 TUPE

If services are provided from the CMTC within a period estimated to be three months from the end date of the InterHealth contract, a new provider would have to take account of any commitments resulting from TUPE regulations.

Whilst the PCT will take on the obligations of the CMTC asset with effect from 1 June 2011, together with the associated financial commitments, it is highly unlikely it will be able to procure services within three months. There is a programme of works which will need to be undertaken to ensure the building is compliant with current building regulations before it can be let to potential tenants. Any potential tenant would also have to comply with current registration requirements from the Care Quality Commission. This means that the risk of TUPE requirements applying is minimal.

5.3 Planning approval

The definition under "Permitted Use" within the lease (and the land use permission) is as a healthcare facility, but it is understood that the original planning approval for the building referred specifically to an “orthopaedic hospital”. Clearly there is a risk that a new planning application could be needed for a change of use, representing an associated delay and additional cost. This risk potentially would only affect the PCT under Option D. It is unlikely to apply to Option D1 but may arise under all other Option D variants. The PCT is engaging with the planning authorities on a regular basis and does not anticipate this becoming a material issue.

5.4 Underlying lease

There is a significant issue contained within the drafting of the lease in favour of the landlord, Warrington and Halton Hospitals NHS Foundation Trust. Schedule 5, clauses 6.2 (a) and 6.3 (c) state that the tenant (which, in this case, would be the PCT) cannot charge any sub-tenants in excess of the ground rent of £50k per annum (plus indexation). Any potential bidder’s due diligence would reveal these clauses. This creates a significant impediment to the PCT mitigating its financial risks in accepting ownership of the asset. The consequence of this clause means that the PCT would be unable to recover the capital charges or any other costs associated with running the CMTC building.

This issue can only be resolved by the DH, SHA and WHHFT. Pending any further progress, it is recommended that PCT takes separate legal advice in respect of this point. It is assumed that any remedial costs would be borne by the Secretary of State.

5.5 Capital costs and funding

Table 8 in section 4.10 shows the capital investment requirements for each of the shortlisted options, with indicative capital costs to be funded by the PCT of up to £850k. This level of funding requirement may warrant exploring the options for accessing funding.

The PCT’s assumption is that the initial investment requirement would be funded by the SHA, with the PCT bearing the ongoing capital charge liability. Should this not prove to be the case the PCT could consider, in addition to use of its own Capital Resource Limit (CRL) / External Financing Limit (EFL):

- Establishing a property joint venture, such as a Local Asset Backed Vehicle (LABV), which could also embrace other projects. The benefit of this approach would be to provide access to third party finance whereby investors would match the value of the asset put in by the PCT through a cash injection. Investors would be attracted by the security of a fully indexed revenue stream which is government backed. The LABV would also be sufficiently flexible to operate beyond April 2013 by enabling participation by other public sector bodies. Potentially, this could also be structured to be “off balance sheet”, thus minimising the capital charge liability.

- Alternatively, the PCT could explore options for putting the CMTC into the local NHS LIFT. However, there is considerable uncertainty about the future of NHS LIFT projects, given the impending abolition of PCTs.

5.6 PCT Cluster

It is understood that the CMTC will be covered by the Merseyside PCT Cluster. Derek Campbell has recently been appointed as Chief Executive of the Merseyside Cluster. If the cluster view is materially different to that of NHS Halton and St Helens regarding use of the CMTC, this could represent a significant barrier to progress, complicating both logistics and the strategy going forward. This risk will be mitigated by NHS Halton and St Helen's engaging with the cluster at the earliest opportunity to maximise the likelihood of a strong alignment of objectives.

6 Financial Case

The affordability consequences to the PCT of each of the shortlisted options have been appraised. This comprised consideration of the elements of income and expenditure (as set out in section in 4.10 above) that will apply in 2011/12 (part year effect) and 2012/13 (which is essentially full year i.e. steady state).

The analysis has focussed on the premises elements of cost, since these allow the greatest comparability between options. The total financial flows for the PCT will also reflect the other direct and indirect costs of the services provided.

The results of this analysis are summarised in the table below.

Table 10 : Affordability Summary

	Option A £'000	Option B £'000	Option C £'000	Option D1 £'000	Option D2 £'000	Option D3 £'000	Option D4 £'000
With restrictive covenant in force							
2011/12 part year effect							
Net additional costs	873	580	940	940	942	954	955
Projected 3rd party income	-	-	317	317	226	195	114
Potential savings	-	-	-	-	55	96	96
Net cost pressure/(surplus)	**873**	**580**	**623**	**623**	**660**	**663**	**746**
2012/13 full year effect							
Net additional costs	905	-	1,434	1,434	1,442	1,490	1,497
Projected 3rd party income	-	-	419	419	299	258	150
Potential savings	-	-	-	-	219	477	477
Net cost pressure/(surplus)	**905**	**-**	**1,015**	**1,015**	**924**	**755**	**870**
With no restrictive covenant							
2011/12 part year effect							
Net additional costs	873	581	940	940	942	954	955
Projected 3rd party income	-	-	1,542	1,542	1,028	848	385
Potential savings	-	-	-	-	55	96	96
Net cost pressure/(surplus)	**873**	**581**	**(602)**	**(602)**	**(141)**	**10**	**475**
2012/13 full year effect							
Net additional costs	905	-	1,434	1,434	1,442	1,490	1,497
Projected 3rd party income	-	-	1,884	1,884	1,256	1,036	471
Potential savings	-	-	-	-	219	477	477
Net cost pressure/(surplus)	**905**	**-**	**(450)**	**(450)**	**(33)**	**(23)**	**549**

Note: These figures EXCLUDE any impairment cost in option B if there is a loss on sale. They also exclude any impairment that may result from a revised valuation as a result of change of use of the building.

As this table demonstrates, options C and D1 appear to present the PCT with the most affordable solution if the covenant is removed. If this is not the case, all of the options except B carry a significant recurrent unrecoverable cost, and B may carry a significant one-off impairment cost.

Without this restriction, the rent recoverable for the CMTC (at DV valuation) exceeds the costs incurred in retaining it. However, these options are also the ones that carry the greatest risk in terms of the ability of the PCT to find a partner that is willing to match the DV's assessment of the market rent for the whole building.

This risk diminishes gradually with each variant of Option D, and is lowest in Option D4. The affordability for options D2 and D3 show potentially a broadly break even position. Further work would need to done on the D2, D3 and D4 options to carry out a more detailed assessment of service relocation opportunities.

Option D4 has a net cost of around £550k. However, this is in part because the option envisages the accommodation on site of a series of services that have not yet developed sufficiently for the costs to have been identified or where a net investment is required to remedy a current service deficiency (e.g. the absence of a Runcorn base for midwives).

Least affordable is Option A, which has only been retained as a comparator. The costs of retaining the building, even when kept as low as is feasible, are significant and bring with them no corresponding benefit.

7 Management Case

Assuming that the leasehold interest in the CMTC is transferred to the PCT and that the restrictive covenant is removed, the PCT will need to identify a resource to manage a number of workstreams:

- The ongoing maintenance of the building and equipment. For all options there will be an ongoing maintenance requirement for several months in 2011/12, either in readiness for sale or lease or during the period of procuring future service providers. The PCT will need to secure the services of an FM provider at least to cover the short term requirement.
- Procurement of a third party to take over the building or of one or more organisation to secure service provision from the CMTC.
- Depending on the preferred option, estates advice may be required to undertake a more detailed study of the building alterations required.

It is recommended that a Project Team is established to oversee the next steps, with representation from Commissioning, IM&T, Procurement, Communications, Estates, Facilities Management and external advisors (for example architects) and user groups.

The scheme should be established as a PRINCE2 project with clear governance and reporting arrangements including both the PCT and the GP Commissioning Consortium.

8 Conclusions

This business case has evaluated the benefits, risks and costs of a number of options for the future use of the CMTC facility.

The key factor in identifying the best way forward is resolution of the restrictive covenant in the existing lease. If that covenant remains and is applied, none of the options represent an affordable solution to the PCT as it will not be possible to recover costs incurred.

If the covenant is removed then a number of options are feasible. Option A "do nothing" identifies a baseline cost of over £0.9m simply to mothball the facility. Option B for the sale of the facility scored badly in the benefits appraisal and carries a risk of impairment if the achieved market value is below the DV valuation. Option C for the lease of the facility scored better in benefits terms as it would retain the facility for healthcare purposes but, along with option D1, carries a higher risk of failing to attract market interest to take on the whole facility. These two options would have the best affordability if a provider can be found.

The options with an element of primary and community services scored highest in benefit terms, are seen to reduce the risk by having a mix of providers and services, and D2 and D3 could be broadly revenue neutral. D4 scored well in benefits terms but makes the most changes to the current building and requires the most capital investment and, subject to a more detailed study of which community based services could be relocated, has an ongoing revenue cost of around £0.6m.

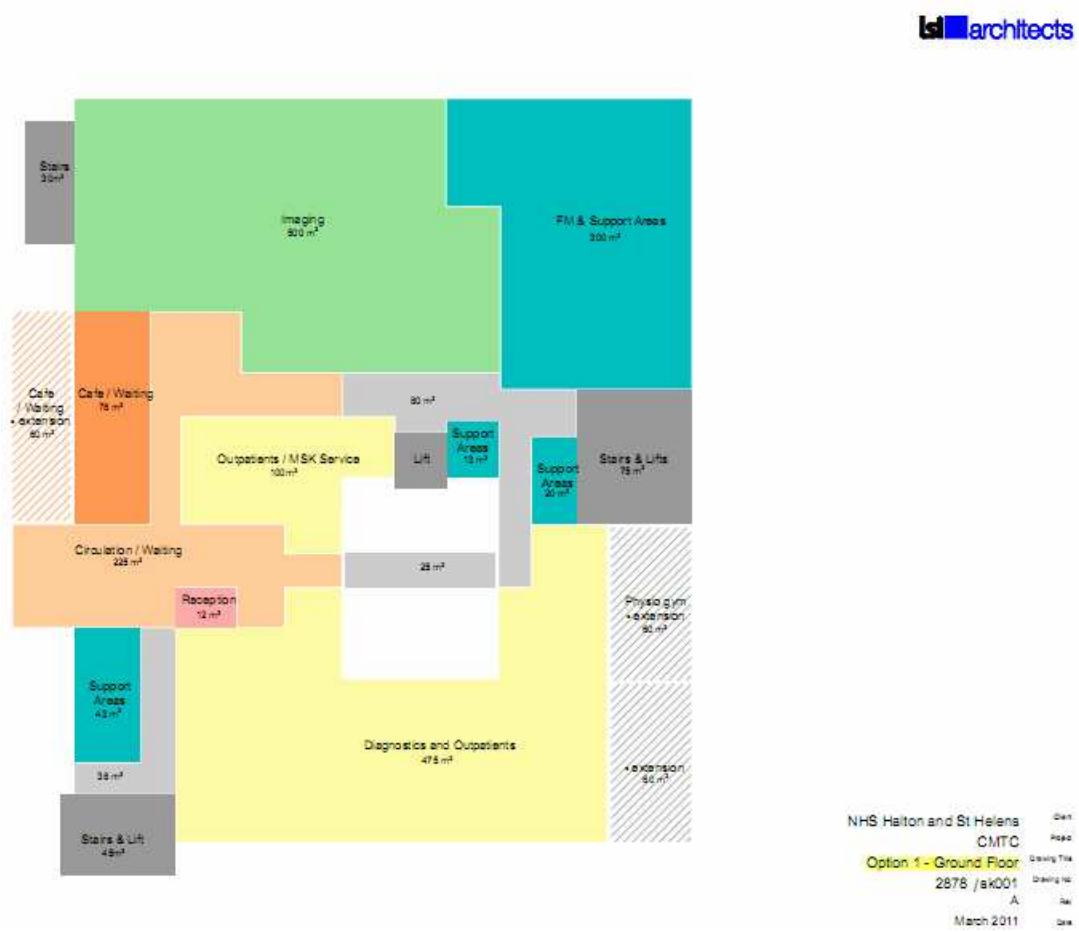
Taking into account the overall mix of benefits, costs and risks and assuming that the covenant does not apply, it is recommended that further work should be undertaken to develop the implementation detail for options D2 and D3 as they will:

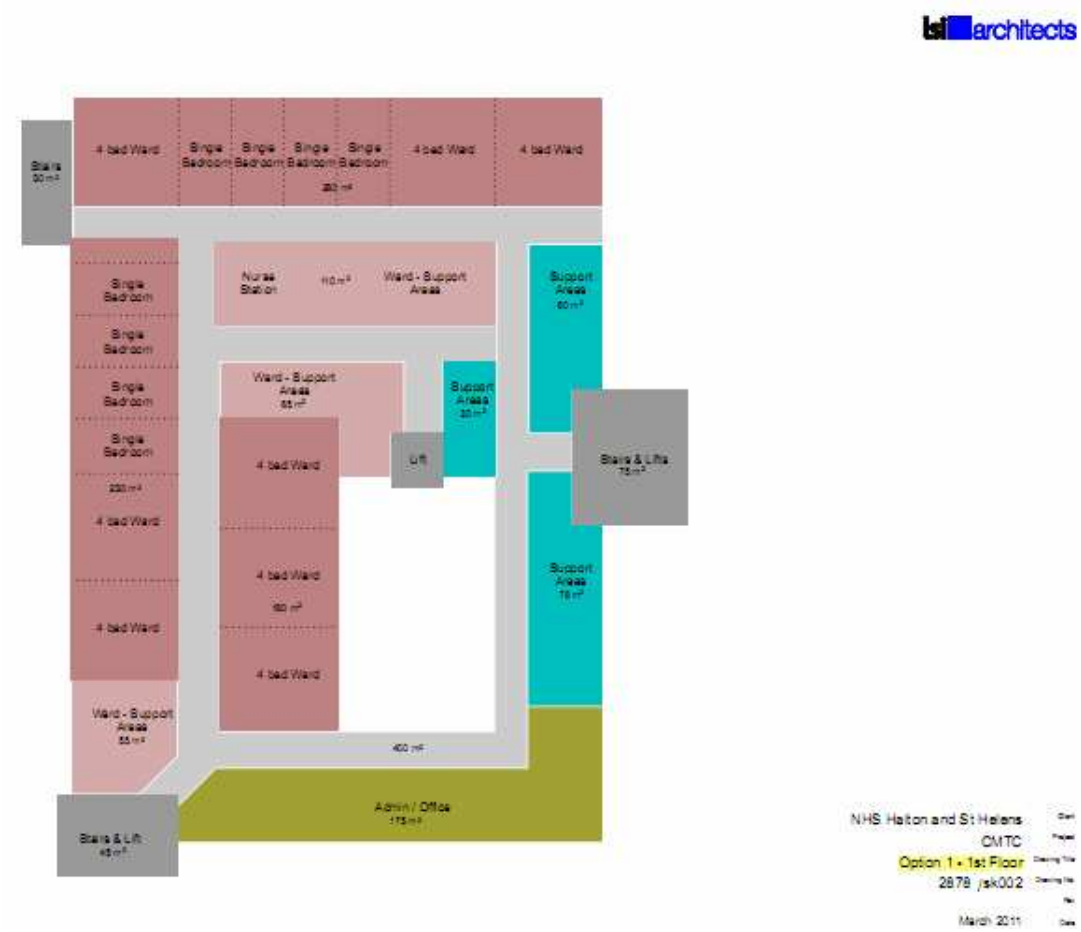
- Provide a good balance of urgent care centre, primary care, intermediate care services and surgery, with a "community hospital" feel.
- Reduce the risk of reliance on finding a single provider for the whole facility.
- Subject to a more detailed review of the capital requirements and implementation costs, deliver an affordable long-term solution.

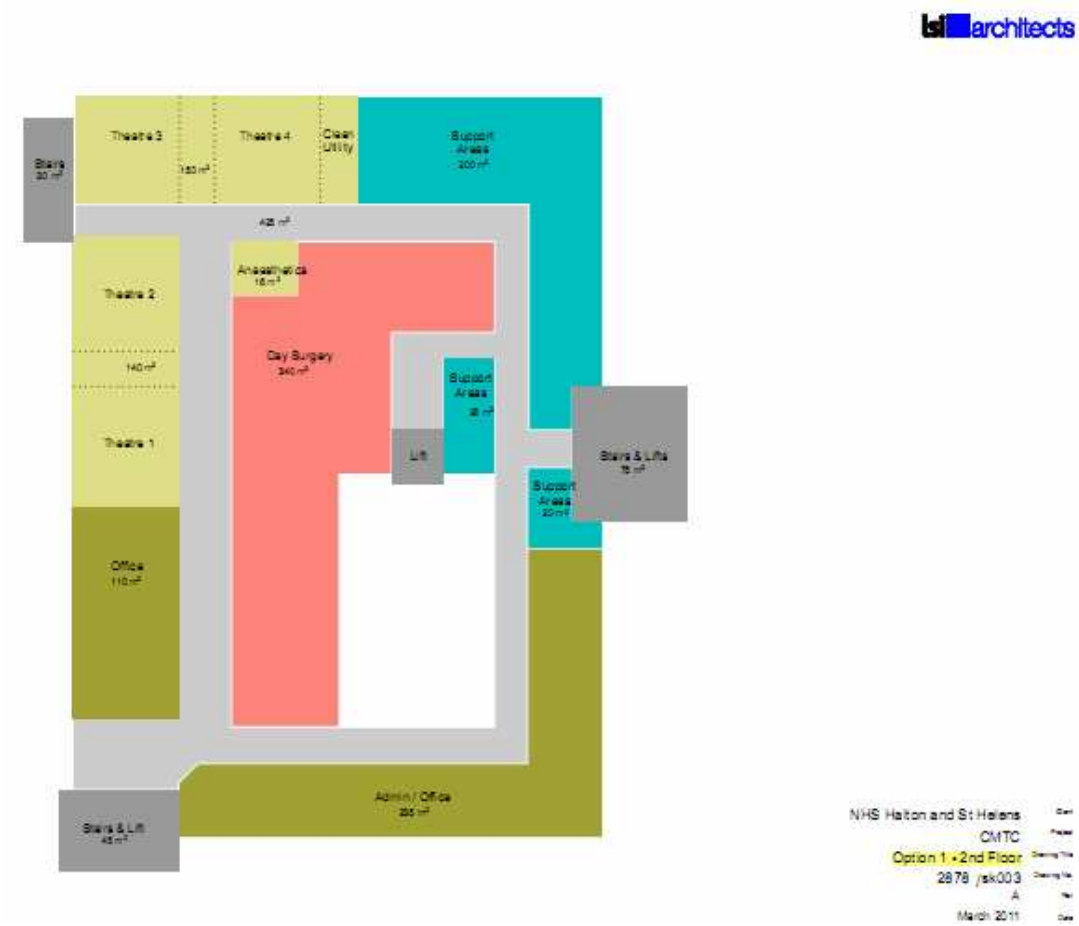
Appendix 1 Stakeholders

Name	Title and organisation
Simon Banks	Operational Director of Planned Care and Market Development, NHS Halton & St Helens
Dr Cliff Richards	Chair, Runcorn Shadow GP Commissioning Consortium
Dr Claire Forde	Vice Chair, Runcorn Shadow GP Commissioning Consortium
Chris Webb	Business Manager, Runcorn Shadow GP Commissioning Consortium
Lyn Williams	LINk Lead Officer
Pam Broadhead	Head of Independent Sector Contracts, NHS Western Cheshire
Sue Wallace-Bonner	Operational Director, Adults & Community, Halton Borough Council
Mark Holt	Halton & St Helens Community Services
Ian Ball	Assistant Director of Estates & Facilities, NHS Halton & St Helens
Ken Jones	Senior Financial Accountant, NHS Halton & St Helens
Simon Griffiths	Head of Primary Care, NHS Halton & St Helens
Mervyn Kennedy	Head of Practice Based Commissioning, NHS Halton & St Helens
Rob Foster	Director of Performance, NHS Halton & St Helens
Dave Tanner	Head of Community Commissioning, NHS Halton & St Helens
Dwayne Johnson	Head of Adults & Community, Halton Borough Council
Anne Garrett	Councillor, Halton Borough Council
Chris Turner	Urgent Care, NHS Halton & St Helens
Carina Casey-Hardman	Head of Midwifery, NHS Halton & St Helens
Jane Lunt	Operational Director, Child & Family Health, NHS Halton & St Helens
Dave Sweeney	Operational Director of Partnerships, NHS Halton & St Helens
Martin McDowell	Deputy Director of Finance, NHS Halton & St Helens
Paul Butler	Operational Director Funded Care, NHS Halton & St Helens
Barry Fereday	Head of Contracting, NHS Halton & St Helens
Jonathan Stephens	Director of Finance, Warrington & Halton Hospitals
Simon Wright	Chief Operating Officer, Warrington & Halton Hospitals
Janet Dunn	Intermediate Care, NHS Halton & St Helens
Graham Rose	Head of Commercial and Contracts, NHS North West

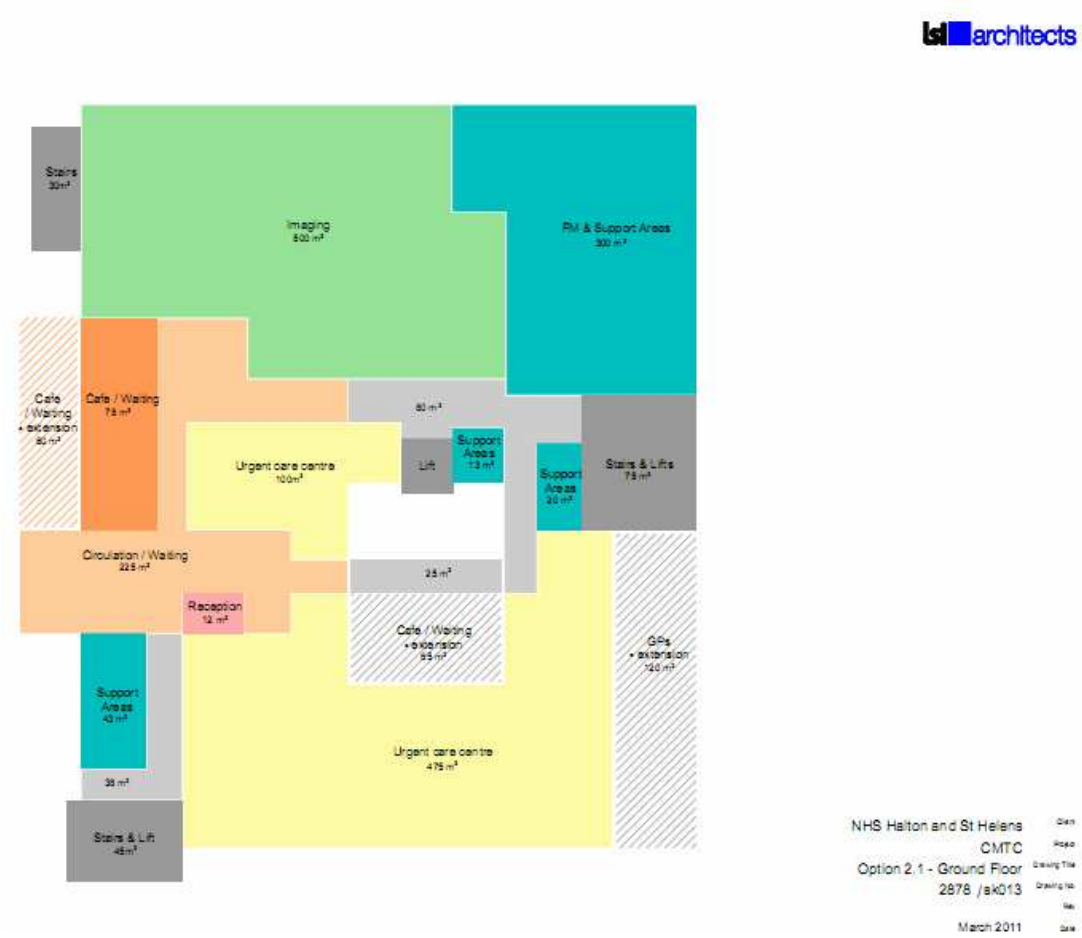
Appendix 2 Potential floor layouts – Option D1 Orthopaedic Centre

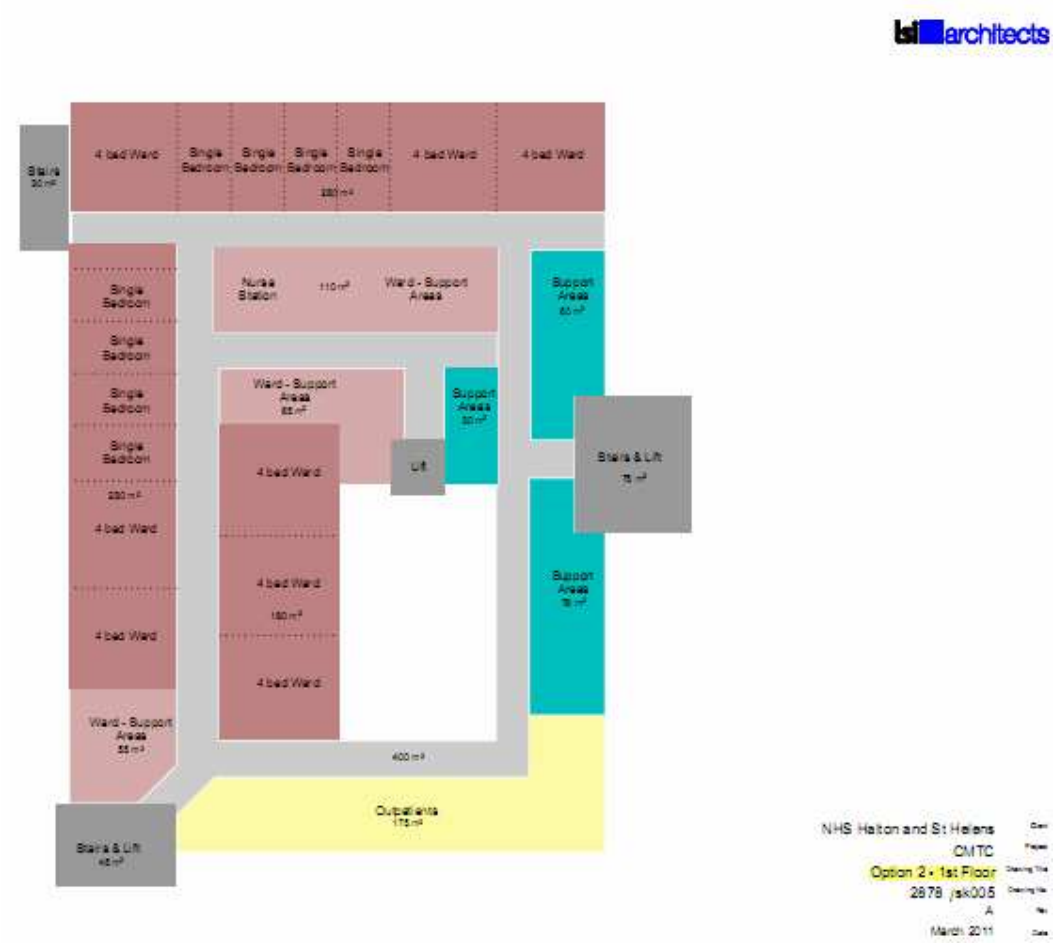


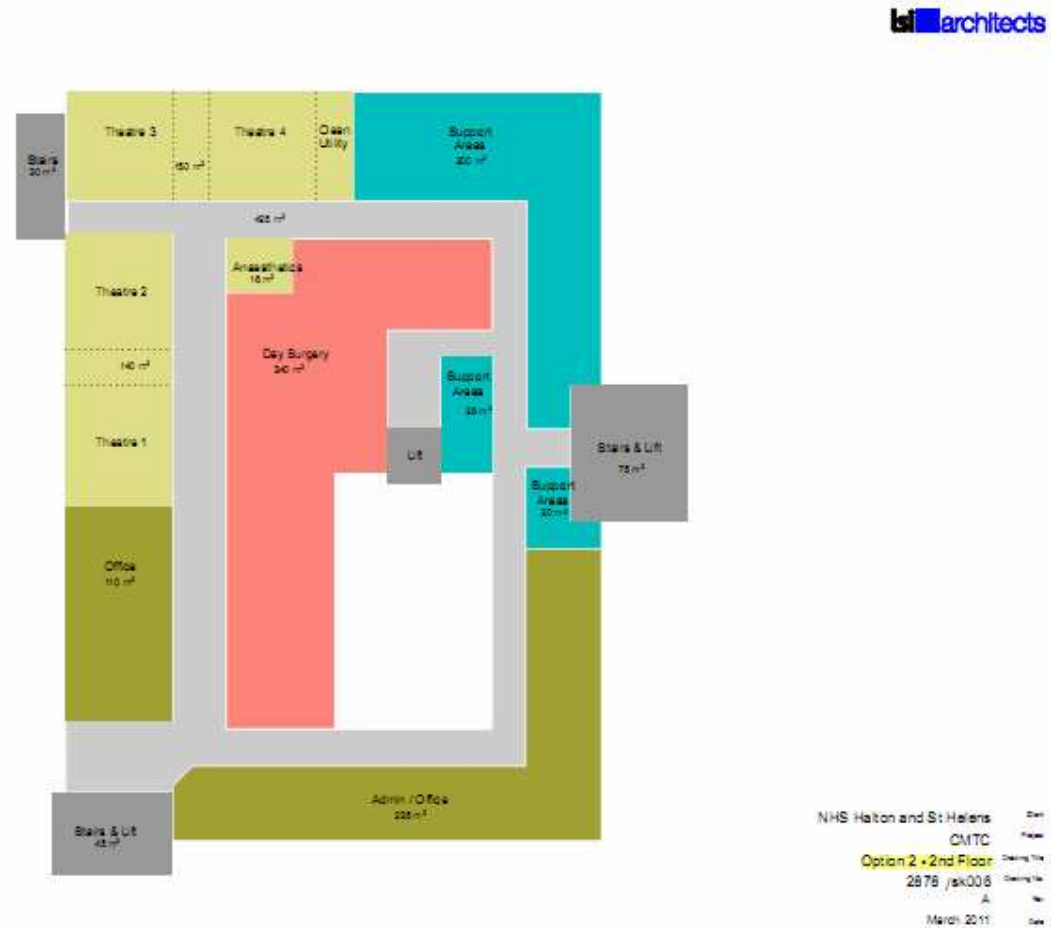

architects
4 bed Ward
Single Bedroom
Stairs
Nurse Station
Ward - Support Areas
Support Areas
Lift
Stairs & Lifts
Admin / Office
NHS Halton and St Helens
OMTC
Option 1 - 1st Floor
2879 /sk002
March 2011


architects
Theatre 3
Theatre 4
Clean Utility
Support Areas
Stairs
Theatre 2
Anaesthetics
Day Surgery
Support Areas
Lift
Stairs & Lifts
Theatre 1
Support Areas
Office
Admin / Office
Stairs & Lift
NHS Halton and St Helens
CMTC
Option 1 - 2nd Floor
2878 /sk003
A
March 2011

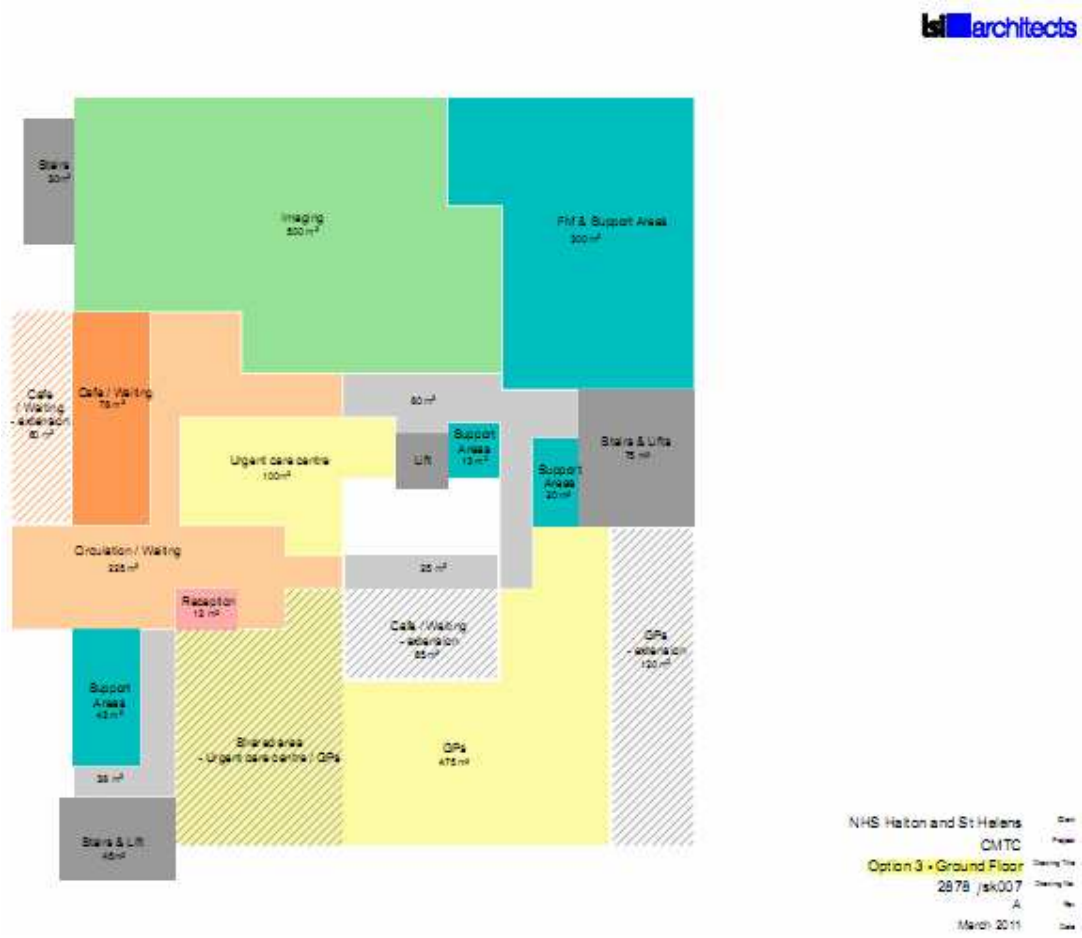
Appendix 3 Potential floor layouts – Option D2 Surgery Centre plus HCRC on one floor



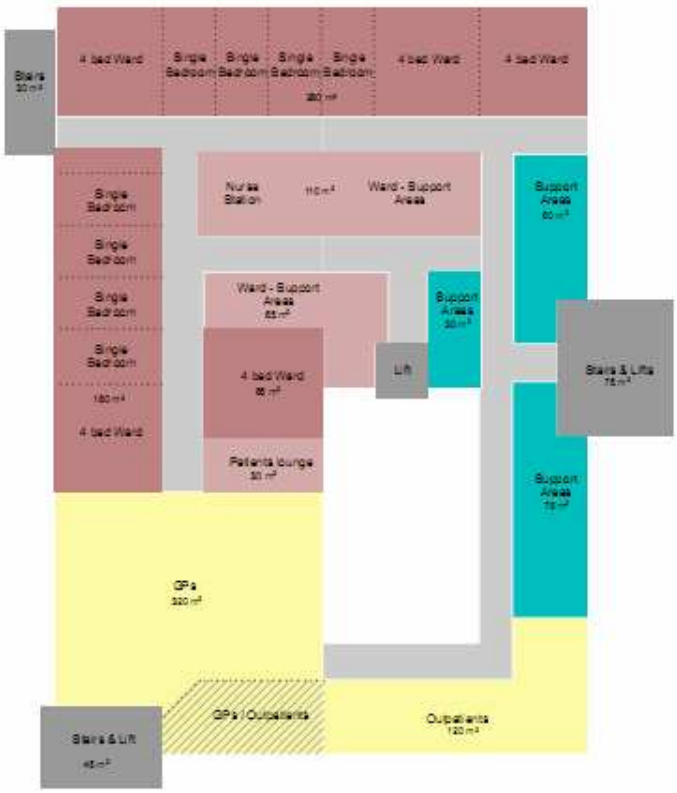

architects
Stairs
4 bed Ward
Single Bedroom
Single Bedroom
Single Bedroom
Single Bedroom
4 bed Ward
4 bed Ward
Single Bedroom
Single Bedroom
Single Bedroom
Single Bedroom
4 bed Ward
4 bed Ward
4 bed Ward
Ward - Support Areas
Nurse Station
Ward - Support Areas
Support Areas
Ward - Support Areas
Support Areas
Lift
4 bed Ward
Stairs & Lift
Support Areas
4 bed Ward
4 bed Ward
Outpatients
Stairs & Lift
NHS Halton and St Helens
CMTC
Option 2 - 1st Floor
2878 /sk005
A
March 2011


architects
Theatre 3
Theatre 4
Clean Utility
Support Areas
Stairs
Theatre 2
Anaesthetics
Day Surgery
Support Areas
Lift
Stairs & Lift
Theatre 1
Support Areas
Office
Admin / Office
Stairs & Lift
NHS Halton and St Helens
CMTC
Option 2 - 2nd Floor
2878 /sk006
A
March 2011

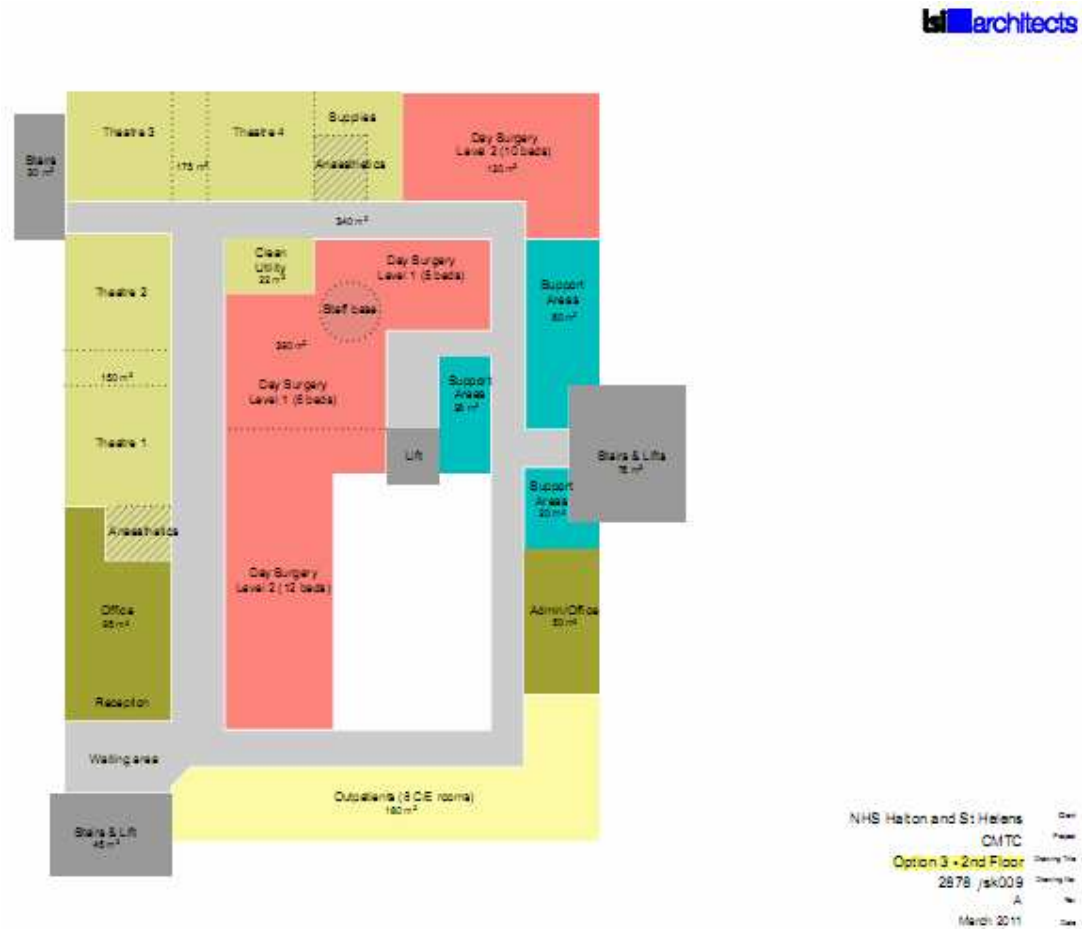
Appendix 4 Potential floor layouts – Option D3 Day Surgery Centre plus HCRC on two floors



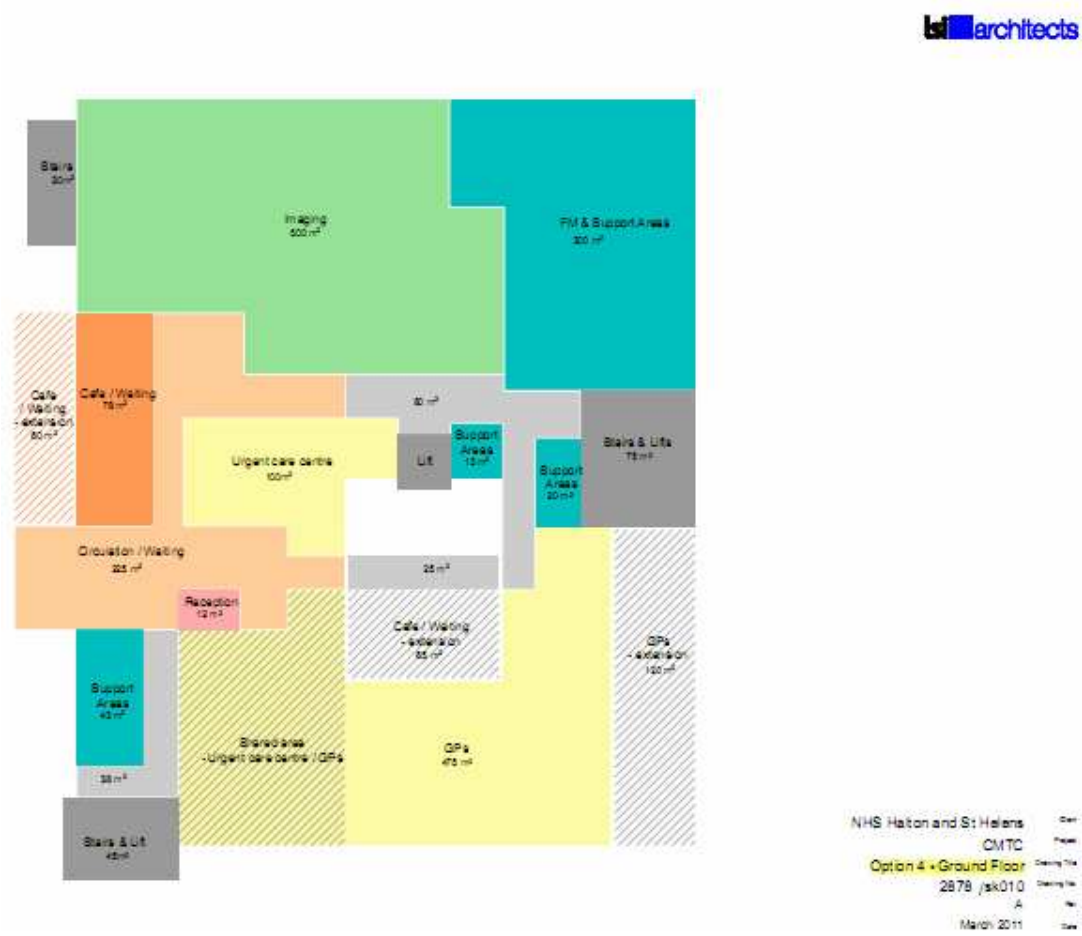
bsl architects

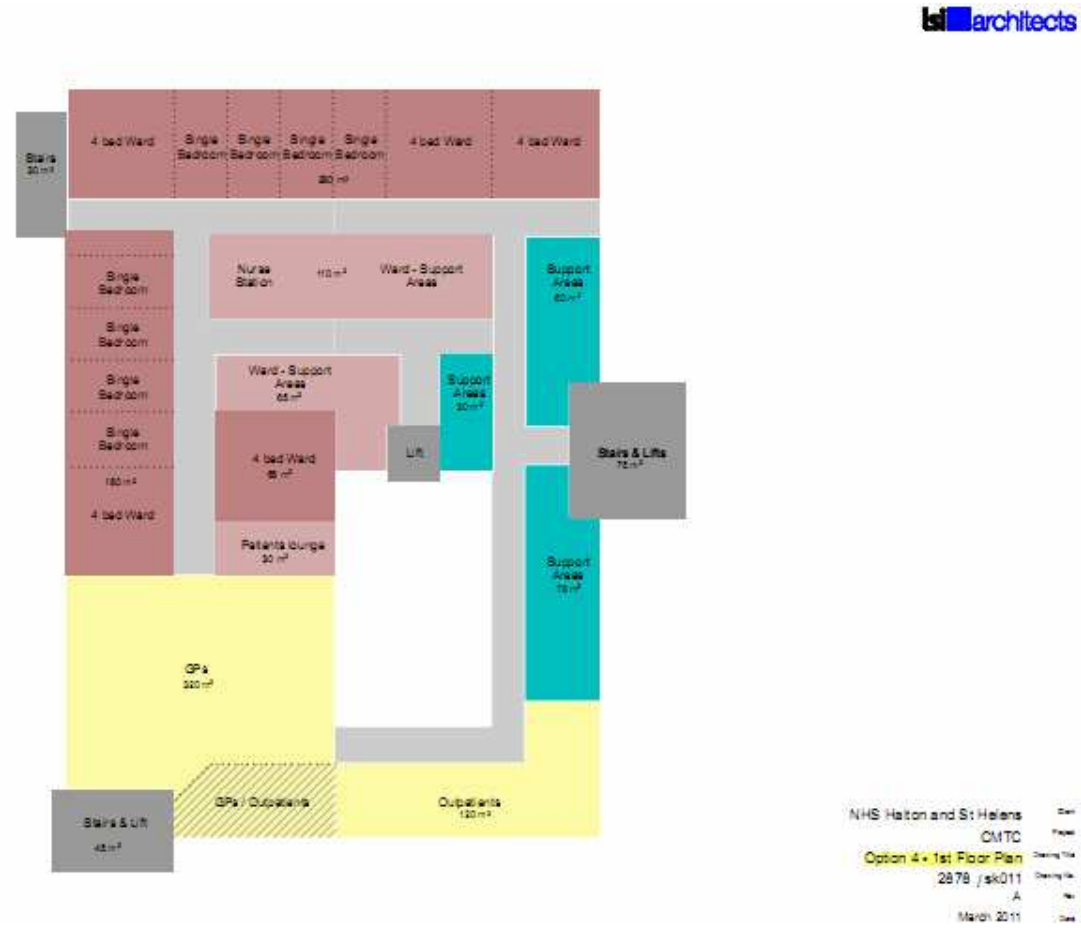


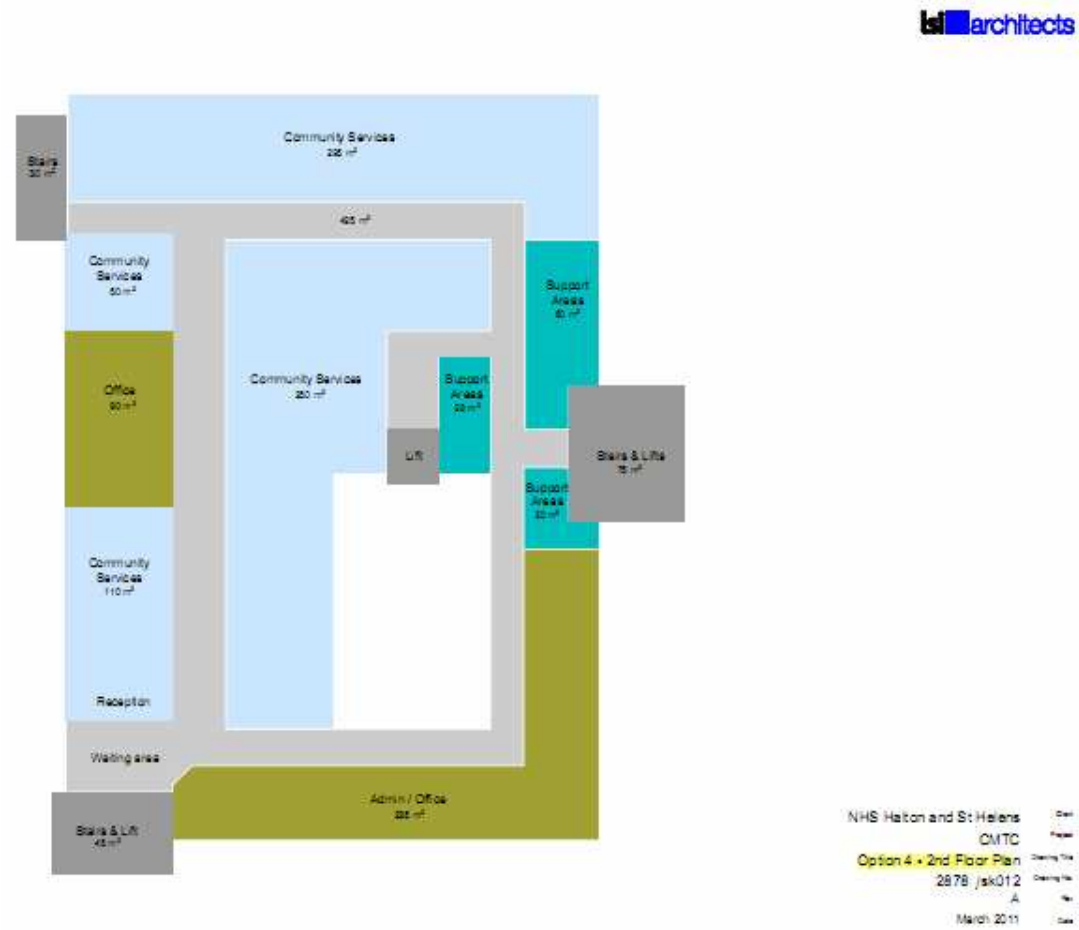
NHS Halton and St Helens
OMTC
Option 3 - 1st Floor
2878 /sk008
A
March 2011


architects
Theatre 3
Theatre 4
Supplies
Anaesthetics
Day Surgery
Level 2 (10 beds)
Stairs
Theatre 2
Clean Utility
Day Surgery
Level 1 (6 beds)
Staff base
Support Areas
Theatre 1
Lift
Stairs & Lifts
Anaesthetics
Office
Reception
Day Surgery
Level 2 (12 beds)
Admin/Office
Waiting area
Outpatients (4 CE rooms)
Stairs & Lift
NHS Halton and St Helens
CMTC
Option 3 - 2nd Floor
2878 /sk009
A
March 2011

Appendix 5 Potential floor layouts – Option D4 HCRC on three floors




lsi architects
4 bed Ward
Single Bedroom
Single Bedroom
Single Bedroom
Single Bedroom
4 bed Ward
4 bed Ward
Stairs
Single Bedroom
Single Bedroom
Single Bedroom
Single Bedroom
4 bed Ward
Nurse Station
Ward - Support Areas
Support Areas
Ward - Support Areas
Support Areas
4 bed Ward
Lift
Stairs & Lifts
Patients lounge
Support Areas
GPs
GPs / Outpatients
Outpatients
Stairs & Lift
NHS Halton and St Helens
CMTC
Option 4 - 1st Floor Plan
2879 / sk011
A
March 2011


architects
Community Services
Stairs
Community Services
Office
Community Services
Support Areas
Lift
Stairs & Lifts
Support Areas
Community Services
Reception
Waiting area
Admin / Office
Stairs & Lift
NHS Halton and St Helens
CMTC
Option 4 - 2nd Floor Plan
2878 /sk012
A
March 2011

Appendix 6 Option appraisal group

Name	Title and organisation
Simon Banks	Operational Director of Planned Care and Market Development, NHS Halton & St Helens
Dr Cliff Richards	Chair, Runcorn Shadow GP Commissioning Consortium
Dr David Lyon	GP, Runcorn Shadow GP Commissioning Consortium
Chris Webb	Business Manager, Runcorn Shadow GP Commissioning Consortium
Lyn Williams	LINk Lead Officer
Pam Broadhead	Head of Independent Sector Contracts, NHS Western Cheshire
Sue Wallace-Bonner	Adults & Community, Halton Borough Council
Ian Ball	Assistant Director of Estates & Facilities, NHS Halton & St Helens
Ken Jones	Senior Financial Accountant, NHS Halton & St Helens

Appendix 7 Affordability tables

WITH COVENANT STILL IN PLACE	Option A		Option B		Option C		Option D1		Option D2		Option D3	
	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Additional costs incurred												
Headlease	46	60	31	-	46	60	46	60	46	60	46	60
Capital charges on land and buildings	526	631	368	-	623	1,015	623	1,015	623	1,015	623	1,015
Capital charges on refurbishment	-	-	-	-	-	-	-	-	2	7	14	56
Facilities management payments	178	214	181	-	271	359	271	359	271	359	271	359
Decommissioning costs	123	-	-	-	-	-	-	-	-	-	-	-
Sub-total	**873**	**905**	**580**	**-**	**940**	**1,434**	**940**	**1,434**	**942**	**1,442**	**954**	**1,490**
Less: Income recovered												
For lease of premises	-	-	-	-	46	60	46	60	46	60	46	60
Contribution towards FM costs	-	-	-	-	271	359	271	359	181	239	149	198
Sub-total	**-**	**-**	**-**	**-**	**317**	**419**	**317**	**419**	**226**	**299**	**195**	**258**
Less: Potential savings/available funding												
Urgent care centre premises budget	-	-	-	-	-	-	-	-	55	219	55	219
Hallwood premises reimbursement	-	-	-	-	-	-	-	-	-	-	-	95
Intermediate care: saving vs acute admission	-	-	-	-	-	-	-	-	-	-	41	163
Community outpatients	-	-	-	-	-	-	-	-	-	-	-	-
MSK CATS premises budget	-	-	-	-	-	-	-	-	-	-	-	-
Community midwifery base	-	-	-	-	-	-	-	-	-	-	-	-
Sub-total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**55**	**219**	**96**	**477**
Net cost/(saving)	**873**	**905**	**580**	**-**	**623**	**1,015**	**623**	**1,015**	**660**	**924**	**663**	**755**
Acute/intermediate care provider share of total floorspace					100%	100%	100%	100%	67%	67%	55%	55%
Capital costs												
Urgent care centre and outpatients									100			
Convert theatre space for community services												
Convert ground floor - Imaging, UCC, GP practice											600	
Second GP practice											150	
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**100**	**-**	**750**	**-**
Expected useful life	25	25	25	25	25	25	25	25	25	25	25	25
Depreciation	-	-	-	-	-	-	-	-	4	-	30	-
CAD	-	-	-	-	-	-	-	-	3	-	26	-
Capital charge - part/full year	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**2**	**7**	**14**	**56**
Note: Net capital cost for economic appraisal	-	-	-	-	-	-	-	-	83	-	625	-

ASSUMING COVENANT NOT APPLIED	Option A		Option B		Option C		Option D1		Option D2		Option D3	
	2011/12 £'000	2012/13 £'000	2011/12 £'000	2012/13 £'000	2011/12 £'000	2012/13 £'000	2011/12 £'000	2012/13 £'000	2011/12 £'000	2012/13 £'000	2011/12 £'000	2012/13 £'000
Additional costs incurred												
Headlease	46	60	32	-	46	60	46	60	46	60	46	60
Capital charges on land and buildings	526	631	368	-	623	1,015	623	1,015	623	1,015	623	1,015
Capital charges on refurbishment	-	-	-	-	-	-	-	-	2	7	14	56
Facilities management payments	178	214	181	-	271	359	271	359	271	359	271	359
Decommissioning costs	123	-	-	-	-	-	-	-	-	-	-	-
Sub-total	**873**	**905**	**581**	**-**	**940**	**1,434**	**940**	**1,434**	**942**	**1,442**	**954**	**1,490**
Less: Income recovered												
For lease of premises	-	-	-	-	1,271	1,525	1,271	1,525	847	1,017	699	839
Contribution towards FM costs	-	-	-	-	271	359	271	359	181	239	149	198
Sub-total	**-**	**-**	**-**	**-**	**1,542**	**1,884**	**1,542**	**1,884**	**1,028**	**1,256**	**848**	**1,036**
Less: Potential savings/available funding												
Urgent care centre premises budget	-	-	-	-	-	-	-	-	55	219	55	219
Hallwood premises reimbursement	-	-	-	-	-	-	-	-	-	-	-	95
Intermediate care: saving vs acute admission	-	-	-	-	-	-	-	-	-	-	41	163
Community outpatients	-	-	-	-	-	-	-	-	-	-	-	-
MSK CATS premises budget	-	-	-	-	-	-	-	-	-	-	-	-
Community midwifery base	-	-	-	-	-	-	-	-	-	-	-	-
Sub-total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**55**	**219**	**96**	**477**
Net cost/(saving)	**873**	**905**	**581**	**-**	**(602)**	**(450)**	**(602)**	**(450)**	**(141)**	**(33)**	**10**	**(23)**
Acute/intermediate care provider share of total floorspace					100%	100%	100%	100%	67%	67%	55%	55%
Capital costs												
Urgent care centre and outpatients									100			
Convert theatre space for community services												
Convert ground floor - Imaging, UCC, GP practice											600	
Second GP practice											150	
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**100**	**-**	**750**	**-**
Expected useful life	25	25	25	25	25	25	25	25	25	25	25	25
Depreciation	-	-	-	-	-	-	-	-	4	-	30	-
CAD	-	-	-	-	-	-	-	-	3	-	26	-
Capital charge - part/full year	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**2**	**7**	**14**	**56**
Note: Net capital cost for economic appraisal	-	-	-	-	-	-	-	-	83	-	625	-