



South Eastern Hampshire  
Clinical Commissioning Group

# **REDEVELOPMENT OF CHASE COMMUNITY HOSPITAL**

## **OUTLINE BUSINESS CASE – MARCH 2013**

**30301- CCH OBC March 2013 - FINAL**

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## EXECUTIVE SUMMARY

1. The future of Chase Community Hospital has been the subject of discussion and engagement for many years. There are a number of factors which have led to these discussions and these are set out in section 1.28.

### 1.1 What Have Local People Told Us?

- 1.2 A Stakeholder Group, made up of local councillors, community representatives, patient groups, the League of Friends, NHS staff and local GPs has been in place for several years and has actively worked with the NHS to develop viable options for the hospital. A six week public engagement period ran in 2011 to seek the views of local residents about how to develop the right services on the hospital site and make sure that people have access to the highest quality care.

- 1.3 Three workshops with a wide range of stakeholders were then held in late 2011 and early 2012 and a number of options considered. The general consensus from stakeholders at these workshops and from wider stakeholder engagement and on-going discussion within the Steering Group is summarised below:

- Option A - do nothing and leave the hospital and its services in their current configuration should be discounted as it is known that the hospital is already underutilised. It would mean that the hospital would not be sustainable in the long term and could ultimately mean the local population having to access outpatient and inpatient care outside of Whitehill and Bordon.
- Option B - close the hospital should be discounted as it does not meet the healthcare needs of the local population and would mean they would have to access outpatient and inpatient care outside of Whitehill and Bordon.
- Option C - redesign services at the hospital to fully utilise the facility and ensure it is a sustainable healthcare facility serving the local population. This was agreed as the preferred option as it would:
  - ensure a long-term future for the hospital site by delivering clinical and cost effective services through full utilisation of the accommodation;
  - offer services which are appropriate for the population and wanted by the population; and
  - provide health services without destabilising other community hospitals in the surrounding areas.

- 1.4 A further option to develop a nursing home on the hospital site was also considered. However, the amount of space needed for this type of development in order to meet current standards and to be financially viable for a potential developer, would mean moving other services such as outpatients away from the hospital and therefore away from the Whitehill and Bordon area. This was therefore ruled out.

- 1.5 These proposals were tested with local communities in a period of engagement in October and November 2012. The feedback from this engagement suggests local people wholeheartedly support:

- expanding outpatient, day and diagnostic services;
- integrating the mental health teams with the community services;
- growing the community nursing and therapy teams;
- 55% of the 127 people (of a local population of 14,000) who answered our

survey supported the new model of bed based care.

But there remain concerns about:

- the future of the beds and possible closure of the ward;
- whether a nursing home will ever be built in the town; and
- the responsiveness of community based end of life care.

1.6 This is reflected by a petition with 2973 signatures (including 239 that were out of area) requesting that the beds are not closed at the hospital.

1.7 As a result of the work with key stakeholders, and concerns expressed by local people regarding bed based care, and feedback from the Hampshire Overview and Scrutiny Committee, three new options have been developed for consideration. The options are designed to optimise the use of the hospital and ensure local people still have access to nursed bed-based care. These options are:

- Option 1 – Re-design the hospital and provide a new model of bed based care. This option fully utilises the hospital by centralisation of outpatients, clinical community services, community care teams, primary care (up to 2 GP Practices) and mental health services on the site. It enables the provision of a minor injuries service and a new model of bed based care with nursing care being provided from the patient's home or a local nursing home. The proposal also allows for the rationalisation of local premises, including the closure and disposal of the Elizabeth Dibben Centre (owned by Southern Health NHS Foundation Trust) and replacement of two nearby GP Practice Surgeries (freehold held by the local practices). The NHS estimates that 23,422 patients would benefit from this option; 18,000 as outpatients, 5,286 as patients at the GP Surgery and 136 patients receiving care and support either at home or in the nursing home
- Option 2 - Expand the number of beds at Chase Community Hospital to 24 step up and step down beds to cover a wider catchment area, and co-locate mental health and community care teams on site. This option does not enable expansion of outpatient services, a GP Surgery on site or provision of a minor injuries service at the hospital, or the co-location of mental health services from the Elizabeth Dibben Centre.
  - In order for 24 beds to be fully occupied on the same basis as last year, 460 patients would need to be admitted to the hospital each year. An analysis of patients from the Whitehill and Bordon area for the year December 2011 to November 2012 has shown that only 107 patients would qualify for admission. This would mean that 76% of the beds would be unused unless further patients could be admitted from outside the Whitehill and Bordon area. This would involve patients and their relatives/carers travelling to Chase Community Hospital when it could be up to 27 miles from their home and there may be an alternative option for care closer to home (Alton Community Hospital, Petersfield Community Hospital, local nursing home, local hospice or care at home).
- Option 3 – Expand the number of beds at Chase Community Hospital to 12 step up and step down beds and 12 end of life care beds to cover a wider catchment area, and co-locate mental health and community care teams on site. This option does not enable expansion of outpatient services, a GP Surgery on site or provision of a minor injuries service at the hospital, or co-location of mental health services from the Elizabeth Dibben Centre. In addition it will require office

accommodation to be rented elsewhere for community teams who will need to move away from the hospital.

- An audit has shown that 20 end of life patients from the Whitehill and Bordon area could be cared for in the end of life beds but an additional 210 end of life patients would need to be admitted from outside Whitehill and Bordon to ensure the beds were fully utilised. In order to draw end of life patients from a wider area patients and relatives from outside Whitehill and Bordon would need to choose Chase Community Hospital as their preferred place to die and this would need to be supported by their GP.

1.8 Having canvassed GPs in South Eastern Hampshire only those currently referring to Chase Community Hospital have indicated that they would consider referring their patients into the hospital for end of life care.

### **1.9 What are we proposing?**

1.10 Following qualitative and financial appraisal of all three options (see section 1.33) the preferred option is Option 1. This involves re-designing the hospital to significantly expand outpatient and primary care services on site and provide a new model of bed based care in patients' own homes and at a nursing home in Liss. The details of the proposal are below.

#### **1.11 Increasing outpatient services**

This option fully utilises the hospital by introducing more outpatient clinics on site and expanding existing clinics, in line with feedback from the engagement with local people.

1.12 The objectives for new Out Patient Services at Chase Community Hospital site are to:

- Significantly expand the range of outpatient services able to be provided locally from 8,900 outpatients to 18,000
- Improve patient choice for outpatient services
- Extend contraception, sexual health and substance misuse services
- Expand current services by introducing new services at the hospital in line with suggestions from local people to include:
  - a) Dermatology
  - b) Nephrology (renal)
  - c) Mental Health
  - d) Older People's Mental Health clinics including memory clinics
  - e) GP services on site
  - f) Minor Injuries Service
  - g) Community Clinics including IV antibiotics
  - h) Oxygen assessment
  - i) Voluntary services
  - j) Healthy lifestyle initiatives
  - k) Diabetes education service
  - l) Phlebotomy
  - m) Local screening

1.13 This option will also involve moving clinical community services, community care teams, up to two GP practices and mental health services onto the Chase site. This

will enable the provision of a minor injuries service from the Chase Hospital, which was considered to be a priority during engagement with local people.

1.14 Bed based care

In addition to expanding outpatient clinics at Chase Community Hospital the preferred option proposes a new clinical model for bed based care. The model is based on a team of health and social care professionals working together to support patients in their own homes and prevent admissions to acute hospitals.

1.15 Called an 'Integrated Care Team' it is grouped around a population of approximately 30,000 people and made up of:

- primary care - GPs and practice nurses;
- community care - community nursing teams led by community matrons with input from therapists, specialist nurses and mental health nurses;
- secondary care - support from consultant geriatricians and in reach nurses; and
- social care - social workers, domiciliary care, community independence team and access to reablement beds.

1.16 The team will:

- use the latest clinical software and their knowledge of patients to identify those most in need of support;
- anticipate the care needs of those patients;
- ensure that there are earlier interventions promoted by the multidisciplinary team;
- visit a patients' home between the hours of 0700 and 2330, as required by their clinical need;
- provide night nursing between the hours of 2200 and 0700 if required;
- provide direct access and referral to the GP out of hours service if the patient should deteriorate and require direct admission to an acute hospital; and
- facilitate an earlier discharge for any patient admitted to an acute hospital under the supervision of the community matron to ensure that there is an opportunity to regain and maximise independence.

1.17 In the new model each patient has:

- a designated care co-ordinator who is responsible for synchronising every aspect of the individual patient's care and acting as a single point of contact for the patient and their carer and/or loved ones;
- a formulated care plan developed in conjunction with colleagues in the integrated care team and the patient; and
- a care plan that is shared with the out of hours GP service and the ambulance service.

1.18 Access to nursing home beds

Retaining access to bed based care for patients from Whitehill and Bordon has been an on-going concern of the Stakeholder Group and local people. In response to these concerns the NHS has committed to purchasing up to four nursing home beds to ensure that local people, who need to be cared for in a nursed bed, would still have access to this type of care. Patients could also be admitted to Petersfield Hospital.

- 1.19 There is currently no nursing home in Whitehill and Bordon, and the lack of local provision of nursing home beds has been consistently raised as a concern by local people should the beds at Chase Community Hospital close.
- 1.20 In response the CCG has worked with local GPs to identify two nursing homes that would be able to provide the new model of care; step up, step down and end of life care. There is already a well-established relationship between local clinicians, commissioners and these nursing home providers and the NHS already has a contract with one to provide continuing health care beds. Therefore the new model of care could be put in place as soon as required.
- 1.21 Both nursing homes are in Liss which is a journey of 6.3 miles from Whitehill and Bordon. Acknowledging that transport to Liss is an issue for local people, the CCG has committed to arrange for transport to be provided for patients and their relatives should this option go ahead. Local people have also said they would like to be able to stay with their relatives whilst receiving end of life care and therefore accommodation would also be made available at the preferred nursing home for relatives.
- 1.22 Development of a nursing home in Whitehill and Bordon  
Given the lack of a nursing home in the town initial investigations were undertaken as to the commercial viability of a new nursing home within a five mile radius of Bordon. These have indicated that there is potentially some demand.
- 1.23 Positive discussions have been held with a number of nursing home providers and several possible sites have been identified in Whitehill and Bordon.
- 1.24 One of these sites, Quebec Barracks, has recently been sold by East Hampshire District Council to The Homes and Communities Agency (HCA). The HCA expect to submit a planning application by the end of 2013, which includes potential for a nursing home, with works starting in 2014 and completing by 2015. However, the CCG cannot guarantee at this stage that a nursing home will be built.
- 1.25 In addition recent engagement with a local nursing home provider has identified the potential for a nursing home in Whitehill and Bordon on a smaller scale than a national provider would be seeking. If the redevelopment of Chase Community Hospital is approved further discussions about this opportunity will be taken forward.
- 1.26 Whilst plans for a new nursing home are being developed there would be no gap in service provision for bed based care, as beds would be provided in Liss.
- 1.27 The preferred option also allows for the rationalisation of local premises, including the closure and disposal of the Elizabeth Dibben Centre (owned by Southern Health NHS Foundation Trust) and replacement of two nearby GP practice surgeries (freehold held by the local practices).
- 1.28 Why Are We Proposing the Redevelopment of Chase Community Hospital?**
- 1.29 Health need  
Whitehill and Bordon has a population of around 14,000, with an Eco-Town planned which will include some 4,000 new homes, 35% of which will be 'affordable housing'. The population is projected to increase from 14,000 to 23,823 by 2031.

While the population of eastern Hampshire is generally healthier than the national average, the wards of Hangers & Forest, Whitehill Chase and Whitehill Deadwater are among areas with the highest health needs in east Hampshire.

The local area also has higher proportions of under16s and older people than the average in England.

### 1.30 Utilisation

Over recent years, inpatient admissions to Chase Community Hospital have decreased. Changes in patients' needs and the ways in which healthcare staff can support these needs in patients' own homes means the demand and use of inpatient beds at Chase Community Hospital has declined. There were originally 24 beds open at Chase Community Hospital. Eight of these beds provided 'step up' and 'step down' care supported by GPs. The remainder of the beds were used for different cohorts of patients over the years but this has declined due to changes in clinical practice and development of new models of care, which focus on treating patients in their own homes. These changes mean that there are 12 beds currently commissioned, with only eight open. On average, only 7.5 beds a day (136 admissions) from July 2011 until June 2012 have been used. This is inefficient, creates potential quality challenges and is unsustainable.

### 1.31 Sustainability

In order to operate a 24/7 service 17.08 whole time equivalent (wte) nurses are required at Chase Community Hospital to ensure a minimum of two nurses on duty at any one time. This is the absolute minimum level of staff to provide a safe service, regardless of the number of patients on the ward.

For some time now in order to sustain the beds at Chase Community Hospital, nurses from Petersfield Community Hospital have had to transfer to cover any shortfalls in staff. However, it has become increasingly difficult for the service provider to attract staff with the right skills given the future uncertainty of the beds. This situation is not sustainable and reflects the position of other similar sized inpatient wards in the country.

### 1.32 Equity

The NHS Benchmarking Network's report (2011) into community hospitals revealed that the average number of community hospital beds per 100,000 local population was 29. In Whitehill and Bordon the figure is 53 per head of population.

Only patients registered with one of the six local GP practices who have admitting rights to Chase Community Hospital can be referred into the hospital for inpatient care. This limits the number of patients who are able to use the inpatient beds.

More patients can be admitted into the beds at other community hospitals such as Petersfield and Alton as any patient who meets the referral criteria may be accepted irrespective of which GP practice the patient is registered with.

The small number of beds and the requisite levels of staffing required mean that the inpatient beds at Chase Community Hospital are the most expensive community beds in Hampshire, tying up resources which could benefit a greater number of patients if deployed differently.

## 1.33 **How were the Options appraised?**

1.34 Local councillors, community representatives, local clinicians, NHS providers and commissioners attended an Option Appraisal Workshop held on the 1<sup>st</sup> February

2013 to assess each of these options and identify a preferred solution. The criteria used to evaluate the options had been previously developed by key stakeholders in October 2011. Each of the options was described in detail at the workshop. Nineteen of the attendees completed the options appraisal forms, 12 of whom are members of the Steering Group. These were completed confidentially but we can advise the following completed the forms:

- 3 local GPs (one of whom is a member of the Steering Group)
- 2 from the Macmillan Service (one of whom is a member of the Steering Group)
- 4 front line members of nursing staff from Southern Health NHS Foundation Trust (two of whom are members of the Project Board/Steering Group – Area Manager for South Eastern Hampshire and Area Matron)
- 2 patient representatives (one of whom is a member of the Steering Group)
- 1 LINK representative (also a member of the Steering Group)
- 3 local Councillors (all of whom are members of the Steering Group)
- 1 Town Partnership representative (also a member of the Steering Group)
- 1 representative from the local voluntary sector
- 2 representatives from Hampshire County Council Social Services (one of whom is a member of the Steering Group).

The outcome of this appraisal, which compares the options purely in benefit terms with no regard to cost, concluded that the preferred option was Option 1.

1.35 A summary of the scores allocated to each of the options can be seen in Table 1. This demonstrates that Option 1 scores most highly with a weighted score of 30.47. Weighting was calculated on the basis of the ranking that key stakeholders attributed to the previously agreed criteria.

**Table 1**

|                       | Option 1<br>Redesign the hospital and provide a new model for inpatient care |             |                 | Option 2<br>Expand the number of beds at Chase Community Hospital to 24 step up and step down beds to cover a wider catchment area and co-locate mental health services and community services on site |             |                 | Option 3<br>Expand the number of beds at Chase Community Hospital to 12 step up and step down beds and 12 end of life care beds to cover a wider catchment area |             |                 |
|-----------------------|--|-------------|-----------------|--|-------------|-----------------|---|-------------|-----------------|
|                       | No Fit   | Partial Fit | Good Fit        | No Fit   | Partial Fit | Good Fit        | No Fit  | Partial Fit | Good Fit        |
| <b>Total Votes</b>    | 11   | 65          | 99              | 55   | 87          | 34              | 56  | 91          | 29              |
| <b>Raw Score</b>      | -11  | 65          | 297             | -55  | 87          | 102             | -56   | 91          | 87              |
| <b>Weighted Score</b> | -1.22  | 6.49        | 30.47           | -5.39  | 8.92        | 10.55           | -5.45   | 9.54        | 8.87            |
| <b>Rank</b>           |  |             | 1 <sup>st</sup> |  |             | 2 <sup>nd</sup> |   |             | 3 <sup>rd</sup> |

## Financial and Economic Appraisal of the Options

1.36 The three options have also been subject to a financial and economic appraisal using a model compliant with the Capital Investment Manual. Optimum bias and risk have been quantified in each option. The options were evaluated over a 25 year period and Net Present Values and Costs (NPV & NPC) calculated.

1.37 Table 2 below brings together the results of the non-financial and economic appraisals including a cost per benefit point calculation for each option. It shows the costs over 25 years discounted by 3.5% per annum to show the effect of the time value of money or the Net Present Value. This 'whole life cost' is then divided by the benefit points given by the stakeholders for each option, giving us a cost per benefit point:

**Table 2**

| Chase Hospital Option Appraisal   |                          |                             |                                |                        |                   |                |                        |      |
|---|--------------------------|-----------------------------|--------------------------------|------------------------|-------------------|----------------|------------------------|------|
| Summary Option Appraisal  |                          |                             |                                |                        |                   |                |                        |      |
| Options   | Revenue Costs Impact FYE | Non Recurring Revenue costs | One off costs Capital Excl VAT | Net Cash Flow 25 years | Net Present Value | Benefits Score | Cost per Benefit point | Rank |
|   | £'000                    | £'000                       | £'000                          | £'000                  | £'000             | No *10         | £'000                  |      |
| Option 1 - Redesign hospital and provide new model of inpatients care               | 353,950                  | 325,000                     | 2,322,543                      | 11,850,237             | 8,778,625         | 36             | 245,625                | 1    |
| Option 2 - 24 step up/ step down beds, co-locate MH services and community services | 1,063,042                | -                           | 322,715                        | 27,961,807             | 18,906,299        | 14             | 1,342,777              | 2    |
| Option 3 - 12 Step up/step down beds plus 12 end of life beds                       | 1,245,512                | -                           | 1,379,501                      | 33,762,813             | 23,118,562        | 13             | 1,783,840              | 3    |

1.38 This analysis demonstrates that:

- Option 1 is the most financially advantageous as a result of the level of achievable savings. Although it has the highest capital cost these are offset by the level of net savings generated by the new model of bed based care.
- Option 2 is substantially more expensive (£700,000) per annum than Option 1.
- In the current challenging financial climate Options 2 and 3 do not represent value for money, are not affordable to the local health system and could not be delivered.
- Option 1 provides the best level of benefits of all the options at an affordable cost. It is therefore concluded that Option 1 is the preferred option.

### Financial Implications of Option 1 on Existing Budgets

1.39 Table 3 below sets out the revenue consequences of Option 1:

- a net NHS systems revenue saving of £198,000 per annum from 2015/16 onwards;

- a requirement for non-recurring revenue expenditure of £325,000 in 2014/15 which includes the additional training required for community nursing staff;
- the bed modelling impact includes the cost of the nursing home beds and their community support;
- the estates impact includes capital charges and depreciation and savings from closure of Elizabeth Dibben Centre;
- it is assumed that the cost for outpatient services will be cost neutral as it is a simple change of location.

**Table 3**

| Revenue:                                       | 2014/15       | 2015/16 onward | 2014/15 Split NHS |            |          |             |
|--|---------------|----------------|-------------------|------------|----------|-------------|
|  | Health System |                | CCG               | NHSCB      | Property | Southern    |
|  | £000's        | £000's         | £000's            | £000's     | £000's   | £000's      |
| Increase in building charges                   | 120           | 120            | 0                 | 0          | 120      | 0           |
| Increased recovery from occupants              | (86)          | (86)           | 0                 | 0          | (117)    | 31          |
| Savings from other vacated buildings           | (71)          | (71)           | 0                 | 0          | 0        | (71)        |
| <b>Subtotal - Estates Impact</b>               | <b>(37)</b>   | <b>(37)</b>    | <b>0</b>          | <b>0</b>   | <b>3</b> | <b>(41)</b> |
| Bed modelling impact                           | (161)         | (161)          | (111)             | 0          | 0        | (50)        |
| <b>Subtotal Recurring costs impact</b>         | <b>(198)</b>  | <b>(198)</b>   | <b>(111)</b>      | <b>0</b>   | <b>3</b> | <b>(91)</b> |
| Non-recurrent training costs                   | 125           | 0              | 125               | 0          | 0        | 0           |
| Non-recurrent other payments                   | 200           | 0              | 0                 | 200        | 0        | 0           |
|  |               |                |                   |            |          |             |
| <b>Total increased cost / (decreased cost)</b> | <b>127</b>    | <b>(198)</b>   | <b>14</b>         | <b>200</b> | <b>3</b> | <b>(91)</b> |

1.40 South Eastern Hampshire CCG will reinvest the revenue saving of £198,000 in:

- Strengthening the outpatient department with nursing staff, IMT and diagnostics;
- Increasing access to psychological therapies in the area north of Butser;
- Supporting end of life care packages.

1.41 Having had extensive discussions with partner organisations about the implementation of the proposed model of bed based care, it was recognized that there is significant benefit in the creation of a resource available to primary, community and social care partners, to use flexibly to support the needs of individual patients. This resource (£100,000) recognizes that there can be pressures on families and partner organisations in supporting people in their home and can be used to mitigate those pressures.

### Capital Costs for the Preferred Option

1.42 The out-turn capital costs for the re-development are estimated at £2.9 million and these costs have been quantified by Cyril Sweett, the PCT's cost advisors. Ownership of Chase Community Hospital will transfer to NHS Property Services from 1<sup>st</sup> April 2013. The redevelopment has been identified as a legacy scheme and the capital funding identified in this outline business case has been included in the forecast capital programme for 13/14 and 14/15 submitted to the DoH. Expenditure estimated at £76,000 is required for fees to enable completion of the design and production of a full business case.

- 1.43 Following approval of the outline business case, the full business case will be developed to confirm the detailed design and capital costs and submitted for approval in July/August 2013. Approval for allocation of the capital monies will need to be obtained from NHS Property Services. Costs for the capital works have been included in the 13/14 and 14/15 forecast capital spending plans for NHS Property Services.
- 1.44 It is envisaged that works will start on site in September/October 2013 and will take 18 months to complete. It is proposed to submit and achieve planning approval for the additional car parking spaces and new entrance to the GP Surgeries prior to the submission of the full business case.
- 1.45 Construction works will not commence until the new model of bed based care is implemented and the beds at Chase Community Hospital have closed. In order to ensure works commence on site in September/October 2013, in conjunction with the development of the full business case, we will commence staff consultation, commission the nursing home beds and finalise the new model of bed based care. Following approval of the full business case the beds at Chase Community Hospital will close and the new model of bed based care will be implemented and works can then commence at Chase Community Hospital.

### **Approval Required**

- 1.46 Subject to the views of the Hampshire Health Overview and Scrutiny Committee the South Eastern Hampshire Clinical Commissioning Group is requested to approve this Outline Business Case on the following basis:
- To produce a full business case for the major re-development of accommodation at the Chase Community Hospital at a capital cost estimated at £2.9 million to be funded from NHS capital sources
  - To enhance and expand acute outpatient and community services
  - To implement the proposed new model for bed based care and close the current beds at Chase Community Hospital
  - To commission a GP led minor injuries service
  - To relocate primary care services and adult and older people's mental health services into Chase Community Hospital
  - To approve expenditure estimated at £76,000 for fees to enable completion of a detailed design and a full business case
  - To approve delegated authority for the Director of Finance to approve agreement to proceed to tender for the capital works once the design has been fully developed

# Outline Business Case for Chase Community Hospital

## BACKGROUND

2. Chase Community Hospital is situated in Whitehill and Bordon and consists of a single building which was purpose built in 1991. Over the years there has been a gradual decline in the use of inpatient and outpatient services at the hospital. Some elements of the accommodation reflect models of inpatient and day care which are outdated. Changes of use of parts of the building have taken place over the years, but it has been clear for some time that the building is under utilised.
- 2.1 South Eastern Hampshire Clinical Commissioning Group (SEHCCG) represents a registered population of 14,000 in Whitehill and Bordon. Development of services to be delivered from Chase Community Hospital is a key element of SEHCCG commissioning intentions. However, the range of healthcare services that a population of this size could sustain is limited.
- 2.2 The following services are currently provided from Chase Community Hospital:
  - Inpatient care: (12 beds funded, 8 beds open) providing step up, step down and end of life care.
  - A range of acute and community outpatient clinics including:
    - Abdominal Aortic Aneurysm Screening
    - Basingstoke Counsellors
    - CAMHS
    - Domestic Abuse Advisor
    - Diabetic Clinic
    - Diabetic Nurse Practitioner
    - Diabetic Dietician
    - Drug & Alcohol
    - ENT
    - Eye Clinic
    - Family Planning and GU Clinic
    - Gynae
    - Musculoskeletal Service
    - Memory Clinic
    - Oral Surgery
    - Paediatrics
    - Paediatric Audiology
    - Podiatry
    - Retinal Screening
    - Rheumatology
    - Sight Loss Advisor
    - Orthoptics
    - Speech & Language
    - Catheter & Wound Clinic
    - Oxygen Assessment
  - Diagnostics: radiology
  - Community Team bases
  - Out of Hours primary care base
  - Age Concern Day Centre

- 2.3 Acute specialty and community services are provided by a range of different providers including Hampshire Hospitals NHS Foundation Trust, Southern Health NHS Foundation Trust and Solent Healthcare NHS Trust. Current activity is detailed in Appendix 1.

## **WHY CHANGE?**

### **Population Health Need**

3. A detailed Health Needs Analysis has been undertaken to ensure that any plans developed will meet the future health needs of local people. A summary of this follows and the full report is available in Appendix 2.
- 3.1 Whitehill and Bordon form a single conurbation following housing development in the 1970s and 1980s. A major development of an Eco-Town is planned within the boundaries of the settlements of Whitehill and Bordon, on land to be vacated by the MoD.
- 3.2 Whitehill and Bordon already form the second largest town in east Hampshire. The current population is around 14,000. However, the planned Eco-Town will include some 4,000 new homes, 35% of which will be “affordable housing.” The population is projected to increase from 14,000 to 23,823 by 2031.
- 3.3 Currently the local population includes a high proportion of military families, with a growing population of young people and families.
- 3.4 In east Hampshire health is generally better than the average for England. However, there are a significant number, 2230, of children living in poverty. Some 17% of Year 6 children are classified as obese. Priority areas for health improvement in east Hampshire include chronic disease management, cancer and healthy ageing.
- 3.5 People living in rural areas are more deprived than town residents in accessing NHS services. An ageing population will have a much greater impact on health services than relative deprivation.
- 3.6 The local area has higher proportions of under 16s and older people than the average in England. The wards of Hangers & Forest, Whitehill Chase and Whitehill Deadwater are among areas with the highest health needs in east Hampshire. However, up to the 2020s the impact of the Whitehill and Bordon Eco-Town Development on the need for healthcare is likely to be limited, meaning that there will be time to develop services as may be needed.
- 3.7 Analysis also shows that the impact of an ageing population on healthcare is greater than potential population increase.

### **Lifestyle and Health Needs**

- 3.8 Local health indicators show that inequalities in mortality rates are relatively low with the birth rate being similar to the national average. Tooth decay is significantly lower than the national average in 5 year olds. Whilst the teenage pregnancy rate has increased slightly it is still lower than the national average. Hospital admissions for alcohol specific conditions for the under 18s is significantly lower than nationally.
- 3.9 Key lifestyle indicators show that smoking rates are significantly lower than Hampshire or England rates, and there is a significantly lower percentage of higher

risk drinking than the English average. The percentage of obese adults in Whitehill and Bordon is lower than the national average, and there is a lower rate of drugs misuse than the English average.

### **Healthcare Needs that could be addressed in a Community Setting**

- 3.10 The Health Needs Assessment concluded that healthcare needs that might be met by locally provided services include:
- Services to reduce teenage conception rates and improve sexual health
  - Vascular diseases – services to reduce admission rates for atrial fibrillation and stroke potentially through virtual wards
  - Cancer – services to reduce admissions to acute hospitals
  - Older people – early diagnosis and treatment of dementia and depression

### **Utilisation**

- 3.11 Alongside an analysis of health need, NHS commissioners have been working with local providers to better understand the use of Chase Community Hospital. There is space for 24 beds at the hospital. Eight of these beds have always provided 'step up' and 'step down' care supported by GPs.
- 3.12 The remainder of the beds have been used for different cohorts of patients over the years but this has declined due to changes in clinical practice, the development of new models of care and the introduction of new service strategies (see section 5), which focus on treating patients in their own homes and preventing unnecessary hospital admissions.
- 3.13 At the current time twelve beds are funded but for the last two years these beds have on average been occupied 61% of the time. As a result only eight beds are currently open with an audit undertaken at the hospital from July 2011 to June 2012 showing that on average only 7.5 beds a day (136 admissions) have been used.
- 3.14 Chase Community Hospital has the fewest number of beds of any NHS inpatient facility in Hampshire; less than half the size of any other NHS-run inpatient service in Hampshire. This makes it more expensive per occupied bed day than other community hospitals. The occupancy of the eight beds currently open at the hospital varies between 58% and 92%. Whilst the average length of stay has fallen by 30% since 2007 to 19 days it remains significantly longer than almost all other community hospitals in Hampshire. This level of usage has remained unchanged over the course of the last two years.
- 3.15 Flexibility within the current 12 beds that are funded has been available on an ad hoc basis should more than the 8 beds open be needed. However, there has not been a need and if all of the 24 beds physically were open on the ward, 76% would potentially be unoccupied.
- 3.16 Equally an audit in May 2011 revealed that outpatient clinics at the hospital were only in use between 38% and 42% of the time, with the X-ray facility available only two mornings a week.

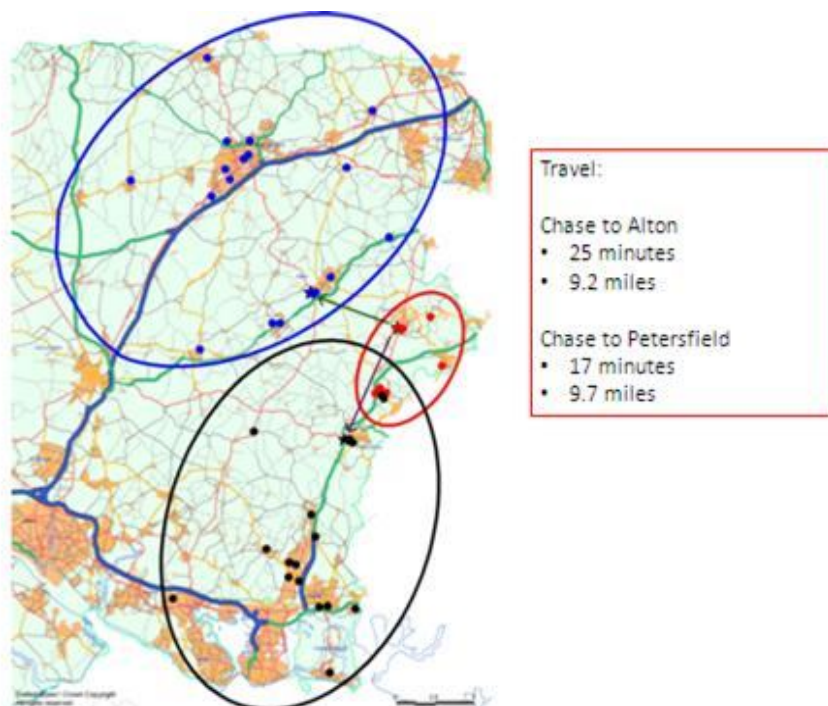
## **Sustainability**

- 3.17 The NHS has a duty to ensure that we consistently deliver safe and high quality care. Staffing levels need to be sufficient to ensure that patients are cared for by appropriately qualified and experienced staff in safe environments. This is in accordance with the NHS Constitution, the NHS Act 1999 and the Nursing and Midwifery Council. Demonstrating sufficient staffing is one of the six essential standards that all health care providers must meet to comply with the Care Quality Commission.
- 3.18 In order to operate a 24/7 service 17.08 wte nurses are required at Chase Community Hospital to ensure a minimum of two nurses on duty at any one time. This is the absolute minimum level of staff to provide a safe service, regardless of the number of patients on the ward.
- 3.19 For some time now in order to sustain the beds at Chase Community Hospital, nurses from Petersfield Community Hospital have had to transfer to cover any shortfalls in staff. However, it has become increasingly difficult for the service provider to attract staff with the right skills given the future uncertainty of the beds.
- 3.20 This situation is also compounded by the low number of beds and occupancy levels. This results in nurses dealing with insufficient patients to guarantee their clinical competency is maintained, to ensure patient safety and the quality of care provided adheres to best practice. This situation is not sustainable and reflects the position of other similar sized inpatient wards in the country. A nine bed ward for older people in Devon recently closed for the same reasons following a Care Quality Commission inspection and other community hospitals in Hampshire have been subject to a series of temporary closures over recent years for the same reasons.

## **Equity**

- 3.21 The NHS Benchmarking Network's report (2011) into community hospitals revealed that the average number of community hospital beds per 100,000 local population was 29. This is in line with recommendations in the NHS Estates Strategy that states any new community facility being built should have at least 48 beds and serve a population of at least 100,000 to 200,000.
- 3.22 The Whitehill and Bordon population of 14,000 local people currently have access to 53 community hospital beds per 100,000 of local population. If all 24 beds were open it would have the impact of increasing that number to 171 beds per 100,000 population. This is nearly six times the average number of beds and would result in significant inequality across Hampshire.
- 3.23 Referral to the beds at Chase Community Hospital is also restricted to patients registered with one of the six local GP Practices who have admitting rights and provide the medical cover during normal General Medical Service (GMS) contracted hours. For periods outside of the GMS Contracted Hours medical cover is provided by the GP Out of Hours Service. Admission is either following discharge from an acute hospital bed or directly from the patient's own home.
- 3.24 Admission into the beds at other community hospitals such as Petersfield and Alton is much higher as any patient who meets the referral criteria may be accepted irrespective of which GP Practice the patient is registered with. Medical care is then provided by a local GP Practice until the patient returns to their own home and the care of their own GP.

The diagram below illustrates the variance in geographical areas regarding the catchment area of patients that are accepted into the various community hospitals - Alton in the north (blue), Chase in the middle (red), and Petersfield in the south (black).



3.25 A full Equality Assessment is available at Appendix 3.

### Community Feedback

3.26 NHS commissioners and providers started talking to the local community in 2009 in recognition of the low use of the community beds and the fact that models of care were changing which was likely to lead to a further reduction in the beds at Chase Community Hospital. Over the intervening period since 2009, new models of care have continued to be introduced, including a virtual ward model in the Whitehill and Bordon area.

3.27 A Steering Group has been in place for several years made up of local GPs, elected members, LINK, local voluntary organisations, Hampshire County Council Adult Services, and the League of Friends. The objective of on-going discussions with this group and the wider community has been to co-produce a plan for services and a model of care that meets the health needs of the local population and to ensure that these have a sustainable and viable future.

3.28 A six week engagement period ran from May 16 until June 24, 2011. The aim of this engagement was to seek the views of local residents about how to develop the right services on the hospital site and make sure that people have access to the highest quality care. An on-line survey and a series of drop in events allowed local people to give their views on the most important aspects of bed based care and how far they would be prepared to travel. 72% of respondents said they were in favour of expanded outpatient clinics at Chase Community Hospital and provided comments and suggestions for those services. A report is available at Appendix 4.

3.29 Three workshops with a wide range of stakeholders were held in late 2011 and early 2012 and a number of options considered. The general consensus from stakeholders

at these workshops and from wider stakeholder engagement and on-going discussion within the Steering Group is summarised below:

- Option A - do nothing and leave the hospital and its services in their current configuration. This was discounted as it is known that the hospital is already under utilised. It would mean that the hospital would not be sustainable in the long term and could ultimately mean the local population having to access outpatient and inpatient care outside of Whitehill and Bordon.
- Option B - close the hospital. This was discounted as it does not meet the healthcare needs of the local population and would mean they would have to access outpatient and inpatient care outside of Whitehill and Bordon.
- Option C - redesign services at the hospital to fully utilise the facility and ensure it is a sustainable healthcare facility serving the local population. This was agreed as the preferred option as it would:
  - ensure a long-term future for the hospital site by delivering clinical and cost effective services through full utilisation of the accommodation;
  - offer services which are appropriate for the population and wanted by the population; and
  - provide health services without destabilising other community hospitals in the surrounding areas.

3.30 A further option to develop a nursing home on the hospital site was also considered. However, the amount of space needed for this type of development in order to meet current standards and to be financially viable for a potential developer, would mean moving other services such as outpatients away from the hospital and the Whitehill and Bordon area and this was therefore ruled out.

3.31 These proposals were tested with local communities in a period of engagement in October and November 2012. The feedback from this engagement suggests local people wholeheartedly support:

- expanding outpatient, day and diagnostic services;
- integrating the mental health teams with the community services;
- growing the community nursing and therapy teams;
- 55% of the 127 people (of a population of 14,000) who answered the survey supported the new model of care.

But there remain concerns about:

- the future of the beds and possible closure of the ward;
- whether a nursing home will ever be built in the town;
- the responsiveness of community based end of life care.

This is reflected by a petition which was handed to Barbara Rushton South Eastern Hampshire CCG Chair Person in October 2012 with 2973 signatures (including 239 that were out of area) requesting that the beds are not closed at the hospital.

3.32 As a result of the work with key stakeholders and concerns expressed by local people regarding bed based care and feedback from the Hampshire Overview and Scrutiny Committee, three options have been developed which are designed to optimise the use of the hospital and ensure local people still have access to nursed

bed-based care. These options are detailed in section 6, and the outcome of an appraisal to identify the preferred option is set out in section 7.

## DEVELOPING NEW MODELS OF CARE

### Step Up and Step Down Care

4. Since its creation in 1948 the NHS has consistently improved the quality of care and increased the services it provides to patients. Today, more people are treated faster and more effectively than ever before. At the same time, the number of actual hospital beds in the UK has been steadily falling, with the number of hospital beds reducing by 31% in the last 20 years from 211,617 in 1984 to 145,218 in 2004<sup>1</sup>. Providing care away from hospitals can be more expensive and challenging, but it is sometimes the right thing to do.
  - 4.1 In 2008 the Community Hospitals Association<sup>2</sup> produced a profile of community hospitals in England, using six databases (Community Hospitals Association 2008). This exercise compared provision in 1998 and 2008 and concluded that there were fewer classic community hospitals with beds and increased diversification of local community facilities, such as intermediate care units, rehabilitation units, community care homes and resource centres.
  - 4.2 There is no nationally defined or prescriptive guidance for health premises but there is a national recognition that commissioners must plan to meet local needs and circumstances, providing accessible services and economic investment in facilities. As less complex care is being provided in community health facilities close to patient's homes, in patient's own homes and through virtual wards, health facilities need to be efficient, effective and flexible in order to accommodate new models of care. A set of working definitions in order to plan for facilities in Hampshire has been agreed and an estates strategy developed. This sets out the minimum number of beds for a new facility as being 48 with 24 beds per ward to ensure a safe and financially sustainable facility and service. These will serve a population of between 100,000 – 200,000 each and will be accessible within 30 minutes.
  - 4.3 The inpatient ward at Chase Community Hospital currently provides three types of care. These are: 'step up' beds to prevent patients needing to be admitted to an acute hospital; 'step down' rehabilitation for patients who have been in an acute hospital; and end-of-life care for patients who choose to die in a community hospital setting. Although the ward physically has 24 beds, beds have closed over the years due to changes in models of care and the decline in usage.
  - 4.4 Reduction in bed occupancy at Chase Community Hospital reflects the fact that advances in treatments such as chemotherapy drugs, intravenous antibiotics or some of the new long-acting drugs for long-term conditions replace those that used to be given to patients when they were in hospital. Now a new generation of drugs, a better skilled staff and better information technology mean that this can be done at home or as an outpatient in community settings. Also rehabilitation can now be delivered in a patient's home and patients with chronic long term conditions such as COPD, asthma and diabetes are being taught to manage their own conditions with the support of specialist nurses in the community resulting in a reduced need to go into hospital.

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<sup>1</sup> NHS Confederation: Why we need fewer hospital beds.

<sup>2</sup> National Institute for Health Research:

12/177 - New research on community hospitals – activity, appropriateness and cost-effectiveness

- 4.5 In Whitehill and Bordon, Community Care Teams now have the clinical skills to treat many more older patients with complex needs at home and the evidence<sup>3</sup> suggests that this delivers better health outcomes and better experiences for the patient.
- 4.6 New models of care have been introduced elsewhere in Hampshire and across the country, with encouraging results. The Health Foundation<sup>4</sup> cited a number of examples of good practice in their 2011 review, ranging from specialist services to support people with long term conditions to stay out of hospital, to examples of 'hospital at home' from around the world. Closer to home, an initial pilot commissioned by Hampshire County Council, demonstrated that following an acute episode 60-70% of patients returned home following a period of bed-based 'reablement' in a nursing home setting rather than accessing long-term residential or nursing care at the point of hospital discharge and this model has been introduced in other areas of the county such as Hythe.
- 4.7 Data analysed from GP practices for the period December 2011 to November 2012 identified 230 patients aged over 75 (the average age of patients in the audit was 82) who had a longer than 14-day stay in an acute hospital for every speciality. Clinicians had advised that the patients most likely to need an admission are those who are over 75 who have been in an acute hospital bed for longer than 14 days for geriatric medicine, trauma and orthopaedics, intermediate care and rehabilitation specialties. Only 107 of the 230 would have been eligible for admission to Chase Community Hospital under the specialties identified by GPs.
- 4.8 An audit of 55 admissions to Chase Community Hospital has been undertaken by local clinicians including GPs, Social Services, Macmillan and staff from the ward at Chase Community Hospital. The audit concluded that 94% of these patients would have been potentially suitable for care in their own home or for those requiring 24 hour care, admission to a nursing home. Of the patients reviewed:
- 20% were end of life patients (9/10 of whom had previously expressed a preference to die at home)
  - 37% were step up (16% did not actually have a 'health care' need)
  - 43% were step down
- 4.9 The changes in patients' needs, and the ways in which healthcare staff can support their needs in their own homes, means that current inpatient services at Chase Community Hospital are under-used while other local services, such as a recently developed assessment and treatment service, are seeing an increase in demand.
- 4.10 In addition a review of 26 studies that compared the effects of community-based services with equivalent services for hospital inpatients, undertaken by the Health Foundation<sup>3</sup> in 2011, concluded that:
- There are potential gains to be made from shifting at least some inpatient and day case services from hospital into the community. Those potential gains include better health outcomes for patients, greater patient satisfaction with services and more cost-effective delivery of treatment.
  - Primary care can be an effective alternative to hospital treatment for some patient groups, in particular the elderly and those with complications arising from long-

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<sup>3</sup> The Health Foundation: Getting out of Hospital. *The evidence for shifting acute inpatient and day case services from hospitals into the community 2011*

<sup>4</sup> The Health Foundation: Getting out of Hospital. *The evidence for shifting acute inpatient and day case services from hospitals into the community 2011*

term conditions such as heart failure and chronic obstructive pulmonary disease (COPD).

- Intermediate care from community hospitals may reduce mortality and lead to similar quality of life compared with inpatient care in elderly people with acute illness.
- Patients seem more satisfied with treatment at home compared to hospital inpatient care.
- Early discharge from hospital into community-based care settings is associated with better patient satisfaction scores and equivalent quality of life scores.

4.11 The NHS End of Life Strategy<sup>5</sup> and a report by the NHS Confederation<sup>6</sup> also suggests that:

- Most people would prefer to be cared for at home at the end of their lives, as long as high quality care can be assured and as long as they do not place too great a burden on their families and carers<sup>7</sup>;

### Specialist Palliative Care

4.12 An NHS Confederation Briefing: *Improving End of Life Care*<sup>8</sup> reported that over 50 per cent of people wish to die at home but only 20 per cent do. In Hampshire there is an average of 11,300 deaths per year and 70% of these occur in people aged 75 or over. Approximately 6,500 patients per year die in acute hospitals in Hampshire despite the evidence suggesting that the majority of people would prefer to be cared for in their own home. This reflects the national picture and research undertaken by the Midhurst Macmillan Service which provides a palliative care service which covers the population of Whitehill and Bordon.

4.13 A 'Population Based Palliative Care Needs Assessment' (Appendix 5) was undertaken in 2005 for the Central South Coast Cancer Network. This concluded that there were a sufficient number of beds in the area accessible to the population of east Hampshire. Following on from this assessment, the Specialist Palliative Care Group has developed a work programme which runs through to 2014 and includes the following as key objectives:

- Patient experience
- Service Improvement and Development
- Communication
- Service Delivery
- CSCCN Guidelines Protocols and Policies
- Clinical Trials
- Audit
- Peer Review

4.14 An audit by the Macmillan team in 2011 identified that 21% of patients who were seen by The Midhurst Macmillan Team had expressed a preference for care to be provided from Chase Community Hospital. This need was met within the current bed availability and there was no evidence of a need to increase the bed numbers.

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<sup>5</sup> NHS End of Life Strategy.

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_086345.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086345.pdf)

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[http://www.goldstandardsframework.org.uk/Resources/Gold%20Standards%20Framework/PDF%20Documents/NHS\\_Confed\\_Briefing\\_on\\_end\\_of\\_life\\_care.pdf](http://www.goldstandardsframework.org.uk/Resources/Gold%20Standards%20Framework/PDF%20Documents/NHS_Confed_Briefing_on_end_of_life_care.pdf)

- 4.15 In the CCG audit 20% of patients had been admitted to Chase Community Hospital for end of life care, but nine out of ten of these patients had previously expressed a preference to die at home.
- 4.16 If bed numbers for end of life care were increased to 12 beds (as suggested in options 2 and 3 below), patients from surrounding areas would need to be admitted to these beds to ensure they were fully utilised. This would mean recruiting patients from other areas currently covered by The Rowans Hospice to the south, St Michael's and Phyllis Tuckwell to the north and even further away from Woking and Sam Beard Hospice, St Wilfrid's Hospice in Chichester and St Barnabas in Worthing. This would destabilise the viability of these hospices and could mean people in this areas having to travel a considerable distance to access bed based palliative care.

### **Developing an Integrated Care Model**

- 4.17 In response to the identified trends and evidence base, Southern Health Foundation NHS Trust, which provides many of the services and staff in the hospital and the community, local NHS commissioners (initially Hampshire PCT but more recently South Eastern Hampshire CCG) and key stakeholders have been working together to develop a new model for bed based care in the Whitehill and Bordon area.
- 4.18 A Kings Fund report<sup>9</sup> in 2012 concluded that services have struggled to keep pace with demographic pressures, the changing burden of disease, and rising patient and public expectations. It stated that too much care is still provided in hospitals and care homes, and treatment services continue to receive higher priority than prevention. It concluded that:
- The traditional dividing lines between GPs and hospital-based specialists, hospital and community-based services, and mental and physical health services mean that care is often fragmented and integrated care is the exception rather than the rule.
  - Current models of care appear to be outdated at a time when society and technologies are evolving rapidly and are changing the way patients interact with service providers.
  - Care still relies too heavily on individual expertise and expensive professional input although patients and users want to play a much more active role in their care and treatment.
- 4.19 It suggested that local leaders need to take a strategic view on implementing integrated models of care rather than focusing on short-term fixes designed to preserve existing services. South Eastern Hampshire CCG has embraced this challenge and has committed to commissioning integrated care in its Commissioning Intentions for 2013-16.
- 4.20 National Voices, the national coalition of health and social care charities in England, has worked with the Kings Fund, Nuffield Trust and NHS Future Forum to develop a defining narrative for integrated care based centred on a patient's view:

*"My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes"*

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<sup>9</sup> Kings Fund. *Transforming the delivery of health and social care: The case for fundamental change*. Chris Ham, Anna Dixon, Beatrice Brooke. 2012

- 4.21 A new Commissioning Strategy and Clinical Model for the Delivery of Integrated and Urgent Care Services for the Fareham and Gosport, Portsmouth and South Eastern Hampshire Clinical Commissioning Groups is currently being developed (Appendix 6). The overarching principles of this model are that where possible, more patients will be cared for at home with increased input from community nurses and therapists. Some patients will receive nursing care in nursing home beds commissioned by the NHS. For those patients with needs best met within a community hospital inpatient bed then admission to Petersfield Community Hospital will be possible.
- 4.22 The objectives of this new model will be to:
- involve patients and their carers in the planning and delivery of their care
  - involve the wider community in planning services and to listen and respond to user needs in the local community
  - ensure equity of access and good health outcomes
  - commission all services to enable equity of access to all
  - develop community based and integrated care services delivered by multi-disciplinary teams with a single point of access in primary care.
  - ensure that services delivered in a community based setting are of equal or improved quality compared to existing hospital provision
  - ensure that all services, regardless of where they are delivered, are cost effective and provide value for money by increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge
  - ensure that services delivered in a community based setting do not present risks that undermine the sustainability of the whole health and social care economy
  - continually review all community based services and enhance services to ensure and assure that they offer best value and performance identifying alternatives as necessary
- 4.23 In practice the integrated care model is based on a team of health and social care professionals working across primary, secondary and community care services to focus their expertise and skills around the management of patients at home, whom otherwise are at risk of admission to an acute hospital.
- 4.24 Each integrated care team will be grouped around a population of approximately 30,000 people and made up of:
- primary care (the patient's GPs and practice nurse);
  - community care (community nursing teams led by community matrons with input from therapists, specialist nurses and mental health nurses);
  - secondary care (support from consultant geriatricians and in reach nurses); and
  - social care (social workers, domiciliary care, community independence team and access to reablement beds).
- 4.25 The team use the latest clinical software and their knowledge of patients on their caseload to identify those patients most in need of support, often the frail elderly and people living with long term conditions. The team will then anticipate the care needs of those patients, in an attempt to ensure that there are earlier interventions promoted by the multidisciplinary team.
- 4.26 Each patient has a designated care co-ordinator who is responsible for synchronising every aspect of the individual patient's care and acting as a single point of contact for the patient and their carer and/or loved ones. This involves the formulation of a care plan in conjunction with colleagues in the integrated care team and the patient to

anticipate the care needs of the individual patient. This is then shared with the out of hours GP service and the ambulance service. The integrated care team looks to avoid the duplication of visits by professionals through the development of transferrable skills and fosters the idea of 'telling the story once'.

- 4.27 The model includes community nurses visiting patients' homes between the hours of 0700-2330, with additional support of night nursing if required between 2200 and 0700. The community nurses have direct access and referral to the GP out of hours cover if the patient should deteriorate and require direct admission to an acute hospital.
- 4.28 If admission to an acute hospital should occur, the Community Matron will facilitate an earlier discharge for the patient to ensure that there is an opportunity to regain and maximise independence
- 4.29 The development of Integrated Care Teams is designed to expand on the 'virtual ward' model of care that is already operating in Hampshire. A decision has recently been taken that the new Integrated Care Team will be piloted in Whitehill and Bordon.

## STRATEGIC FIT

5. A number of key strategies and documents have been considered in the development of potential solutions for Chase Community Hospital and the population of Whitehill and Bordon. These include:
- Transforming Community Services: enabling new patterns of provision. 2009<sup>10</sup>
  - Ageing Well in Hampshire: Older People's Well Being Strategy<sup>11</sup>
  - Joint Hampshire Adults' Mental Health Commissioning Strategy<sup>12</sup>
  - Joint Hampshire Commissioning Strategy for Older People's Mental Health<sup>13</sup>
  - A new Decade for Health: Portsmouth and South East Hampshire Sustainability Plan. 2010<sup>14</sup>
  - NHS Hampshire Estates Strategy 2010-2015<sup>15</sup>
  - Commissioning Strategy and Clinical Model for the Delivery of Integrated and Urgent Care Services (Appendix 6)
  - The NHS Confederation: *Why We Need Fewer Hospital Beds*
  - Royal College of Nursing – Guidance on Safe Nurse Staffing Levels in the UK
  - A Population Based Palliative Care Needs Assessment (Appendix 5)
  - NHS End of Life Care Strategy - *promoting high quality care for all adults at the end of life*
  - Kings Fund: *Avoiding hospital admissions*. Sarah Purdy 2010
  - The Health Foundation: *Getting out of Hospital. The evidence for shifting acute inpatient and day case services from hospitals into the community 2011*

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<sup>10</sup>

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093197](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197)

<sup>11</sup> <http://documents.hants.gov.uk/adultservices/older-people/AgeingWellinHampshire-OPWBStrategy.pdf>

<sup>12</sup> <http://www3.hants.gov.uk/joint-mental-health-commissioning-strategy2012.pdf>

<sup>13</sup> <http://www3.hants.gov.uk/joint-mental-health-commissioning-strategy2012.pdf>

<sup>14</sup> <http://www.portsmouth.nhs.uk/Downloads/Sustainability/100812%20SustainabilityPlanJuly.pdf>

<sup>15</sup> <http://www.hampshire.nhs.uk/index.php/about-us/key-documents/strategy-documents>

- Kings Fund. *Transforming the delivery of health and social care: The case for fundamental change.* Chris Ham, Anna Dixon, Beatrice Brooke. 2012

## OPTIONS FOR THE REDEVELOPMENT OF CHASE COMMUNITY HOSPITAL

6. As a result of on-going discussion with the Chase Community Hospital stakeholder group, local providers and Hampshire County Council Adults Services, a number of potential options for the future of Chase Community Hospital have emerged. In the summer of 2011 a six week public engagement period (Appendix 4) helped inform the emerging proposals.

6.1 This was followed by three workshops with a wide range of stakeholders in late 2011 and early 2012 in order to develop options that would:

- ensure the future of Chase Community Hospital as a sustainable healthcare facility serving the local population;
- ensure a long-term future for the hospital site by delivering clinical and cost effectiveness through full utilisation of the accommodation;
- offer services which are appropriate for the population and wanted by the population; and
- provide services that would not destabilise other community hospitals in the surrounding areas.

6.2 The key requirements identified at these workshops were as follows:

- 'Step up' and 'step down' bed based care to be provided in patients' own homes, in a nursing home setting, and at Petersfield Community Hospital, through new models of care;
- Increased range of acute and community outpatient specialties;
- Improvements in local services for sexual health and substance misuse;
- Co-location of mental health services into the hospital;
- GP practices to move into the hospital building.

6.3 The general consensus from stakeholders at these workshops and from wider stakeholder engagement is set out at section 3.29 and is summarised below:

- Option A - do nothing and leave the hospital and its services in their current configuration should be discounted as it is known that the hospital is already underutilised. .
- Option B - close the hospital should be discounted as it does not meet the healthcare needs of the local population.
- Option C - redesign services at the hospital to fully utilise the facility and ensure it is a sustainable healthcare facility serving the local population. This was agreed as the preferred option

6.4 These proposals were tested with local communities in a period of engagement in October and November 2012. The feedback from this engagement suggests local people wholeheartedly support:

- expanding outpatient, day and diagnostic services;
- integrating the mental health teams with the community services;
- growing the community nursing and therapy teams;

- 55% of the 127 people who answered our survey supported the new model of care.

But there remain concerns about:

- the future of the beds and possible closure of the ward;
- whether a nursing home will ever be built in the town;
- the responsiveness of community based end of life care.

6.5 This is reflected by a petition with 2973 signatures (including 239 that were out of area) requesting that the beds are not closed at the hospital. In response to these concerns and feedback from the Hampshire Overview and Scrutiny Committee, three options have been developed which are designed to optimise the use of the hospital and ensure local people still have access to nursed bed-based care. These three options and the impact of each are described below:

#### 6.6 **Option 1- Re-design the hospital and provide a new model of care.**

This option would involve fully utilising the hospital by centralisation of outpatients, clinical community services, community care teams, primary care (up to two GP practices) and mental health services on one site. The proposed floor plans for the hospital and site plan indicating additional car parking are attached in Appendix 10.

It enables the provision of a minor injuries service and includes a new model of bed based care with nursing care being provided from the patient's home or a local nursing home. The proposal also allows for the rationalisation of local premises, including the closure and disposal of the Elizabeth Dibben Centre (owned by Southern Health NHS Foundation Trust) and replacement of two nearby GP practice surgeries (freehold held by the local practices).

The impact of this option is:

- Provides inpatient beds at a local nursing home in Liss (6.3 miles from Chase Community Hospital)
- 23,422 patients would benefit from this option
- Fully utilises Chase Community Hospital
- Provides new model of care with a Consultant for Elderly Medicine on site at Chase Community Hospital and the nursing home once a week
- Enhances care delivered at patients' homes (when applicable) by a team of nurses, doctors and other health professionals
- May impact on carers and increase demands on Adult Social Services so additional funding has been included to support this
- Centralises outpatients, clinical community services, community team base, primary care (2 x GP surgeries) and mental health services on one site
- Significantly expands the range of outpatient services able to be provided locally from 8,900 outpatients to 18,000
- Extends contraception, sexual health and substance misuse services
- Expands current services by introducing new services to the hospital to include:
  - a) Dermatology
  - b) Nephrology (renal)
  - c) Mental Health
  - d) Older People's Mental Health clinics including memory clinics
  - e) GP services on site

- f) Minor Injuries Service
- g) Community Clinics including IV antibiotics
- h) Oxygen assessment
- i) Voluntary services
- j) Healthy lifestyle initiatives
- k) Diabetes education service
- l) Phlebotomy
- m) Local screening

- Improves patient choice for outpatient services
- Requires a capital investment in the building of £2.9 million
- Allows patients who express a wish to die at home to do so supported by community care teams
- Involves relocation of adult and older people's mental health services for improved integrated working
- Reduces travel for local population for outpatient appointments
- Means patients would need to travel to Liss for admission to most appropriate nursing home (6.3 miles)
- Provides free transport for relatives to visit patients admitted to a nursing home bed.
- Provides additional car parking spaces at Chase Community Hospital

There is currently no nursing home in Whitehill and Bordon, and the lack of local provision of nursing home beds has been consistently raised as a concern by local people should the beds at Chase Community Hospital close.

In response we have worked with local GPs to identify two nursing homes that would be able to provide the new model of care; step up, step down and end of life care. There is already a well-established relationship between local clinicians, commissioners and these nursing home providers and the NHS already has a contract with one to provide continuing health care beds. Therefore the new model of care could be put in place as soon as required.

Both nursing homes are in Liss which is a journey of 6.3 miles from Whitehill and Bordon. Acknowledging that transport to Liss is an issue for local people, the CCG has committed to support transport arrangements for patients and their relatives should this option go ahead.

**6.7 Option 2 - Expand the number of beds at Chase Community Hospital to 24 step up and step down beds to cover a wider catchment area, and co-locate mental health and community care teams on site.**

This option does not enable expansion of outpatient services, a GP surgery on site or provision of a minor injuries service at the hospital, or the co-location of mental health services from the Elizabeth Dibben Centre.

The impact of this option is:

- Maintains provision of inpatient beds in Chase Community Hospital
- 9,360 patients would benefit from this option
- Allays stakeholder concerns about bed closures
- To be fully occupied, 107 patients using the beds would come from Whitehill and Bordon and 353 from further afield
- Reduces the unit cost of each occupied bed day (as long as occupied)
- Does not result in improved patient choice for outpatient appointments

- Means that elements of redevelopment strategy not achievable:
  - a) No GP surgery on site
  - b) No provision of minor injuries service at Chase Community Hospital
  - c) No expansion of outpatient services
  - d) No co-location of mental health services i.e. re-provision of Elizabeth Dibben Centre
- Less patients would be treated at home which we know provides better outcomes and is what people would like
- Requires £391,633 additional investment each year to staff the ward
- This £391,633 investment in nursing would need to be taken from existing services.
- Unable to close Elizabeth Dibben Centre which has an opportunity cost of £72,000 p.a.
- Requires additional capital investment of circa £400,000 to upgrade aspects of the environment to meet current standards
- Patients from across south eastern Hampshire needing step down care (bed based care after a period in an acute hospital) would need to be admitted to Chase Community Hospital regardless of their home location.
- For patients from outside of Whitehill and Bordon to be cared for in the beds, local GPs need to agree to care for other practices' patients.
- GPs from outside of Whitehill and Bordon have said they would not refer into the step up beds. (Currently 5 practices refer into Chase; 21 practices refer into Petersfield; 17 practices refer into Alton)
- Opening more beds at Chase Community Hospital could destabilise Alton and Petersfield community hospitals.
- Up to 27 mile journey for relatives of patients from across South Eastern Hampshire.
- Poor public transport links to Whitehill and Bordon will impact on relatives of patients from across south eastern Hampshire being able to visit patients at Chase Community Hospital

**6.8 Option 3 – Expand the number of beds at Chase Community Hospital to 12 step up and step down beds and 12 end of life care beds to cover a wider catchment area, and co-locate mental health and community care teams on site.**

This option does not enable expansion of outpatient services, a GP surgery on site or provision of a minor injuries service at the hospital, or co-location of mental health services from the Elizabeth Dibben Centre and will require office accommodation to be rented elsewhere for community teams who will need to move away from the hospital.

The impact of this option is:

- Maintains provision of inpatient beds in Chase Community Hospital
- 9,360 patients would benefit from this option
- Allays stakeholder concerns about bed closures
- To be fully occupied 107 patients using the beds would come from Whitehill and Bordon and 353 from further afield.
- Reduces the unit cost of each occupied bed day (as long as occupied)
- Does not result in improved patient choice for outpatient appointments
- Means that elements of redevelopment strategy not achievable:

- a) No GP surgery on site
  - b) No provision of minor injuries service at Chase Community Hospital
  - c) No expansion of outpatient services
  - d) No co-location of mental health services i.e. re-provision of Elizabeth Dibben Centre
- Would require relocation of the physio department to another area of the hospital and the office accommodation for community care teams would need to be rented away from the hospital.
  - Loss of administrative support space i.e. meeting room.
  - Work to undertake conversion of the ward area to provide single bedrooms with en-suite facilities would take approximately six months and the ward would need to close whilst this was undertaken
  - Requires £480,133 additional investment each year to staff the ward including specialist palliative care nurses
  - Unable to close Elizabeth Dibben Centre which has an opportunity cost of £72,000 p.a.
  - Requires £94,000 p.a. additional investment to reprovide office accommodation off the hospital site for the community teams who would be displaced by the expansion of inpatient beds
  - The additional funding required for the specialist palliative staffing would need to be taken from existing services.
  - Additional capital investment of £1.4 million required to bring Chase Community Hospital environment to meet the standard for specialist palliative care i.e. single /en-suite rooms.
  - More patients will die in hospital than at home. The majority of patients have expressed a wish to die at home.
  - Patients from across south eastern Hampshire needing step down care (bed based care after a period in an acute hospital) would need to be admitted to Chase Community Hospital regardless of their home location.
  - For patients from outside of Whitehill and Bordon to be cared for in the beds, local GPs need to agree to care for other practices' patients.
  - GPs from outside of Whitehill and Bordon have said they would not refer into the step up beds. (Currently 5 practices refer into Chase; 21 practices refer into Petersfield; 17 practices refer into Alton)
  - Opening more beds at Chase could destabilise Alton and Petersfield community hospitals and other hospices in the area
  - Up to 27 mile journey for relatives of patients from across South Eastern Hampshire.
  - Poor public transport links to Whitehill and Bordon will impact on relatives of patients from across South Eastern Hampshire being able to visit patients at Chase Community Hospital

## **OPTION APPRAISAL**

7. Key stakeholders developed and agreed criteria for assessing options at the workshops in October 2011 and ranked the criteria according to what they felt were

most important to the local population. This criteria was developed in October 2011 prior to the stakeholder group assessing any options for the hospital. The criteria therefore reflects what stakeholders felt was important for their community. The criteria are set out in the table below:

| <b>CHASE COMMUNITY HOSPITAL –<br/>CRITERIA FOR ASSESSING OPTIONS</b> |  |   |                |
|--|--|---|----------------|
| <b>No.</b>   | <b>Criteria</b>  | <b>Statement</b>  | <b>Ranking</b> |
| 1  | Ensuring that Chase Community Hospital meets the current and future healthcare needs of the local population | Ensure that services developed/introduced meet the needs of an increase in the age group of 0-15 year olds to include sexual health<br>Ensure that the services developed meet the needs of an increase in age group of those aged 85 and over to include early identification and treatment for depression and dementia<br>Provision of step-up/step-down services to the local population<br>Provision of services to support patients with cancer who would otherwise be treated in an acute setting | 1st            |
| 2.   | Ensuring that Chase Community Hospital is fully utilised   | Increase utilisation of the hospital clinic space<br>Increase use and range of diagnostic facilities on site<br>Provide alternatives to travelling to acute settings<br>Provide services currently not available at Chase Community Hospital<br>Development of services to increase social element e.g.: looked after children, links with schools and involvement of senior citizens, drug/alcohol/mental health groups for adults and children  | 2nd            |
| 3.   | Provision of the right care in the right place at the right time for the appropriate length of time          | Reduce hospital length of stay<br>Reduce the rate of hospital readmission<br>Provide alternatives to making long term decisions from an acute hospital bed<br>Provide care closer to home   | 3rd            |
| 4.   | Helping people recover from episodes of ill health or following treatment                                    | Improving recovery from injuries or trauma<br>Improving outcomes from planned procedures<br>Helping older people to recover their independence after illness or injury  | 3rd            |
| 5.   | Enhancing quality of life for people with long terms conditions  | Supporting people to manage their condition<br>Improving functional ability<br>Reducing time spent in hospital<br>Enhancing quality of life for carers  | 3rd            |
| 6.   | Alignment with PCT and CCG mission, vision and goals   | Promotes public health and reduces health inequality<br>Drives transformation with a focus on quality, innovation, productivity and prevention<br>Delivers evidence based, quality care<br>Address equality and diversity needs to the community  | 4th            |
| 7.   | Ensuring people have a positive experience of care   | Improving responsiveness to personal needs<br>Improving experience at the end of life<br>Environment enables dignity and respect  | 4th            |

|     |   |   |     |
|-----|---|---|-----|
| 8.  | Stakeholder acceptability                       | Acceptable to patients and public<br>Travel distance and accessibility<br>Acceptable to PCT/GP commissioners<br>Acceptable to external stakeholders – local authorities, voluntary sector and providers | 4th |
| 9.  | Fit with other services                         | Part of integrated model of delivery<br>Part of a network of services   | 4th |
| 10. | Helping provide wider benefits to the community | Sensitive to economic climate<br>Enables community involvement<br>Reducing carbon footprint   | 5th |

7.1 Local councillors, community representatives, local clinicians, NHS providers and commissioners attended an Option Appraisal Workshop held on the 1<sup>st</sup> February 2013 to assess each of these options and identify a preferred solution. The criteria they had previously developed (see above) were used to evaluate the options in order to identify a preferred solution. Each of the options was described in detail at the workshop. Nineteen of the attendees completed the options appraisal forms, 12 of whom are members of the Steering Group. These were completed confidentially but we can advise the following completed the forms:

- 3 local GPs (one of whom is a member of the Steering Group)
- 2 from the Macmillan Service (one of whom is a member of the Steering Group)
- 4 front line members of nursing staff from Southern Health NHS Foundation Trust (two of whom are members of the Project Board/Steering Group – Area Manager for South Eastern Hampshire and Area Matron)
- 2 patient representatives (one of whom is a member of the Steering Group)
- 1 LINK representative (also a member of the Steering Group)
- 3 local Councillors (all of whom are members of the Steering Group)
- 1 Town Partnership representative (also a member of the Steering Group)
- 1 representative from the local voluntary sector
- 2 representatives from Hampshire County Council Social Services (one of whom is a member of the Steering Group).

. The outcome of this appraisal concluded that on a qualitative basis the preferred option was Option 1. This compares the options purely in benefit terms with no regard to cost.

7.2 A summary of the scores allocated to each of the options can be seen in Table 1 below which demonstrates that Option 1 scores most highly with a weighted score of 30.47. Weighting was calculated on the basis of the ranking that key stakeholders attributed to the criteria:

**Table 1**

|                       | Option 1<br>Redesign the hospital and provide a new model for inpatient care |             |                 | Option 2<br>Expand the number of beds at Chase Community Hospital to 24 step up and step down beds to cover a wider catchment area and co-locate mental health services and community services on site |             |                 | Option 3<br>Expand the number of beds at Chase Community Hospital to 12 step up and step down beds and 12 end of life care beds to cover a wider catchment area |             |                 |
|-----------------------|--|-------------|-----------------|--|-------------|-----------------|---|-------------|-----------------|
|                       | No Fit   | Partial Fit | Good Fit        | No Fit   | Partial Fit | Good Fit        | No Fit  | Partial Fit | Good Fit        |
| <b>Total Votes</b>    | 11   | 65          | 99              | 55   | 87          | 34              | 56  | 91          | 29              |
| <b>Raw Score</b>      | -11  | 65          | 297             | -55  | 87          | 102             | -56   | 91          | 87              |
| <b>Weighted Score</b> | -1.22  | 6.49        | 30.47           | -5.39  | 8.92        | 10.55           | -5.45   | 9.54        | 8.87            |
| <b>Rank</b>           |  |             | 1 <sup>st</sup> |  |             | 2 <sup>nd</sup> |   |             | 3 <sup>rd</sup> |

7.3 During the option appraisal workshop concern was expressed that no options had been developed that proposed the potential for 12 or 16 beds at Chase Community Hospital.

7.4 Under the NHS Estates Strategy, 48 beds with 24 bedded wards is the minimum requirement for a new facility to ensure a safe and financially sustainable service and 24 beds is the minimum number of beds in an existing facility that would meet these criteria.

## FINANCIAL APPRAISAL OF THE OPTIONS

8. The three options have been subjected to a financial and economic appraisal using a model compliant with the Capital Investment Manual (CIM).

8.1 All current guidance has been followed in constructing the economic and financial appraisal principally using the CIM. The model uses standard discounting cash flow techniques over 25 years at a rate of 3.5% to reflect the time value of money. Capital charges and depreciation are excluded from the model as per the guidance, as is VAT given its circular flow into the Treasury.

8.2 Costs included are:

- Revenue costs based on savings and costs identified in 11.3 and 11.4. This excludes capital charges and interest.
- Capital costs for each option are at the same base date and VAT has been excluded. They exclude planning contingencies and inflation but include optimum bias.
- Opportunity costs have been included such as disposal of surplus estate.

- Lifecycle and backlog maintenance costs have been excluded in all options but will be developed in the preferred option in the full business case.

### 8.3 Capital Costs of each Option

|  | Option 1     | Option 2   | Option 3     |
|--|--------------|------------|--------------|
|  | £'000        | £'000      | £'000        |
| <b>Capital costs INCLUDING VAT, Planning contingency &amp; inflation</b> | <b>2,879</b> | <b>400</b> | <b>1,650</b> |
| <b>Capital costs EXCLUDING VAT, Planning contingency &amp; inflation</b> | <b>2,323</b> | <b>323</b> | <b>1,380</b> |

### 8.4 Revenue Costs for each Option

|  | Option 1              | Option 2   | Option 3   |
|--|-----------------------|------------|------------|
|  | £'000                 | £'000      | £'000      |
| <b>Bed model savings</b>                                   | <b>(161)</b>          | <b>0</b>   | <b>0</b>   |
| <b>Pay (savings) costs</b>                                 | <b>Included above</b> | <b>392</b> | <b>480</b> |
| <b>Non pay (savings) costs</b>                             | <b>(37)</b>           | <b>71</b>  | <b>165</b> |
| <b>Total Revenue (for re-investment) / additional cost</b> | <b>(198)</b>          | <b>463</b> | <b>645</b> |
|  |                       |            |            |
| <b>One off revenue costs 2014/15</b>                       | <b>325</b>            | <b>25</b>  | <b>25</b>  |

The table above shows that only option 1 provides funds for re-investment in local services. Both alternative options require considerable additional funds to enable them.

## Conclusion of the Financial Option Appraisal

8.5 Table 2 below brings together the results of the non financial and economic appraisals including a cost per benefit point calculation for each option.

**Table 2**

| Chase Hospital Option Appraisal   |                             |                                      |                                      |                              |                      |                   |                           |         |
|---|-----------------------------|--------------------------------------|--------------------------------------|------------------------------|----------------------|-------------------|---------------------------|---------|
| Summary Option Appraisal  |                             |                                      |                                      |                              |                      |                   |                           |         |
| Options   | Revenue Costs<br>Impact FYE | Non<br>Recurring<br>Revenue<br>costs | One off costs<br>Capital Excl<br>VAT | Net Cash<br>Flow 25<br>years | Net Present<br>Value | Benefits<br>Score | Cost per<br>Benefit point | Ranking |
|   | £'000                       | £'000                                | £'000                                | £'000                        | £'000                | No *10            | £'000                     |         |
| Option 1 Redesign hospital and provide new model of inpatients care               | 353,950                     | 325,000                              | 2,322,543                            | 11,850,237                   | 8,778,625            | 36                | 245,625                   | 1       |
| Option 2 24 step up/ step down beds, co-locate MH services and community services | 1,063,042                   | -                                    | 322,715                              | 27,961,807                   | 18,906,299           | 14                | 1,342,777                 | 2       |
| Option 3 12 Step up/step down beds plus 12 end of life beds                       | 1,245,512                   | -                                    | 1,379,501                            | 33,762,813                   | 23,118,562           | 13                | 1,783,840                 | 3       |

8.6 This analysis showed that the most financially advantageous option was Option 1. Although Option 1 requires the highest capital investment, these costs are offset by the level of net savings generated as a result of the new model of care.

8.7 Option 2 is some £700,000 per annum more expensive than the preferred option. In the current challenging financial climate options 2 and 3 would be considerably more expensive to the local health system than Option 1. Option 1 provides the best level of benefits of all the options at an affordable cost. It is therefore concluded that Option 1 is the preferred option.

### Affordability

### Capital Costs

8.8 Capital cost estimates for the scheme were prepared by Hampshire PCT's cost advisors Cyril Sweett. Details of all capital cost estimates are set out in an Appendix 8, in the format of OB Cost Forms.

## Capital costs for Option 1

8.9 The key elements of capital costs for approval are set out below:

|                              | <b>Option1</b>   |
|------------------------------|------------------|
| Works and Associated costs   | 1,647,000        |
| Fees @18%                    | 273,000          |
| Equipment costs              | 90,000           |
| Contingency 7%               | 141,000          |
| VAT                          | 448,000          |
| <b>Subtotal</b>              | <b>2,527,000</b> |
| Optimum bias                 | 312,000          |
| Inflation to completion date | 67,0000          |
| VAT Recovery                 | (90,000)         |
| <b>Outturn for approval</b>  | <b>2,879,000</b> |

### Forecast Out-turn costs

- 8.10 Total forecast outturn costs for the scheme are estimated at £2.9m as set out in the table above which includes allowances for optimism bias and projected inflation. In addition some VAT is reclaimable.
- 8.11 Optimism bias reflects Treasury guidance on public sector capital projects. This advises that outturn costs estimates have a tendency to be overly optimistic. A range of factors usually dependent on the stage of development can affect the final costs. These include planning consent, robustness of survey information, and involvement of design team and contractor capabilities. Using the DH model the PCT cost advisors have calculated these at an additional 14.5%.
- 8.12 Significant mitigation of optimism bias risks can be expected as planning and design progresses. However as risks materialise they will be transferred to the known risks contingency allowance. Should the risk not materialise then it will be removed from the cost risk altogether.
- 8.13 Building costs are not fixed in this outline business case as tenders are not yet let. The costs could therefore be subject to inflation. The cost advisors use a public sector tender price index based on completion date to make an allowance for costs movement between the start and completion of works. For this scheme they have calculated the cost risk for inflation of around £67,000.
- 8.14 It is estimated that around £90,000 of VAT to be paid on works can be reclaimed.

- 8.15 The forecast out-turn costs are £2,876,757.
- 8.16 Expenditure will be required to develop the design and produce the Full Business Case and this is estimated at a total of £76,000. This fee expenditure includes the costs of an energy efficiency review of the design details.
- 8.17 NHS Property Services will own Chase Community Hospital site from April 2013 and would thus assume responsibility for capital funding

### **Return on Investment**

- 8.18 On a capital investment of £2.9m plus non recurring costs of £325,000 and a saving of £198,000 p.a. this project gives a return on investment of 6% per annum

### **Revenue Consequences**

- 8.19 The overall recurring revenue effect on the NHS system following completion of the preferred option is an estimated annual saving of £198,000, from 2015/16 onwards. This is based on two GP practices moving into the Chase. This savings figure would reduce to £108,000 if a second practice does not move into the Chase, though an estimated non-recurring expenditure of £200,000 would be avoided.
- 8.20 The effects on individual NHS organisations have been estimated and will be confirmed in the Full Business Case. Contract adjustments may be necessary and will aim to ensure an equitable approach to recovery of costs from new occupants of accommodation, whilst acknowledging savings targets levied by commissioners.
- 8.21 Having had extensive discussions with partner organisations about the implementation of the proposed model of bed based care, it was recognized that there is significant benefit in the creation of a resource available to primary, community and social care partners, to use flexibly to support the needs of individual patients. This resource (£100,000) recognizes that there can be pressures on families and partner organisations in supporting people in their home and can be used to mitigate those pressures.
- 8.22 The key recurring revenue effects from the proposed schemes are summarised below.

#### Additional recurring costs

- Additional capital and depreciation charges for Chase Hospital reflecting additional capital investment and IT infrastructure £120,000
- Additional support to Hampshire County Council Adult Services £100,000
- Additional costs for a minor injury LES scheme: commissioned from local GP practices £15,000
- Spot purchase nursing homes beds £251,000
- Transport for patients and relatives to nursing home £9,500
- Southern Health Community Nursing Staff virtual ward home care and support to nursing home placements £64,000

**TOTAL additional recurring costs £560,000**

#### Reductions in recurring costs

- Savings from closure of the Elizabeth Dibben Clinic building (£71,000)
- Net savings on premises costs from relocation of two GP surgeries into Chase Community Hospital (£87,000)
- Savings closure of inpatient beds. Chase staff costs for reinvestment (£600,000)

#### **TOTAL reduction in recurring costs £758,000**

This results in net recurring funds for reinvestment of £198,000.

8.23 In addition to the above recurring revenue effects, there will be some non-recurring revenue costs in year one as follows:

- Non recurring training costs of £125,000 for community nursing staff to ensure effective introduction of improved virtual ward home care and support to nursing home placements.

8.24 This full year effect of funds released for reinvestment will not be reached until 2014/15. The net saving at year one is £73,000, which will be reinvested by South Eastern Hampshire CCG in a number of services that have been identified as priority areas for 2013/14. These include:

- Ensuring that Chase Community Hospital has the necessary IT infrastructure to support anticipated wider range of outpatient clinics, together with the necessary administrative and nursing support and diagnostics.
- Increasing Access to Psychological therapies (IAPT): while large parts of Hampshire now have access to psychological (talking) therapies following an investment programme in 2010/11, the area north of Butser Hill has not benefitted from this investment. The CCG therefore intends to use some of the savings to commission this service for the population during 2013/14.
- End of Life packages of care: feedback during the engagement on Chase Hospital has revealed that end of life care and the ability to access the right support for patients and their families is crucial to ensuring patients can die in their place of choice with dignity. The CCG will work with local end of life care providers to commission additional support for people at the end of life.

The full year effect of £198,000 savings will continue to be invested in these schemes in 2014/15 and also in other local priorities identified in the coming years' planning round.

8.25 Potential non recurring costs of £200,000 have also been identified to offset negative equity in a local surgery to facilitate re-location into Chase Community Hospital. If the whole system savings are used to judge the payback period for this one-off investment then this will be achieved in 14 months.

At this time it is assumed that the National Commissioning Board who is responsible for primary care budgets will fund this one-off cost. Primary Care Premises Group has approved the business case and supports this investment. At this time the funding streams are not confirmed.

We are awaiting confirmation of the funding streams for primary care investment, however if the CCG is asked to fund this one-off payment then the savings for reinvestment would be delayed by one year.

8.26 Potential non recurring costs of £200,000 have also been identified to offset negative equity in a local surgery to facilitate re-location into Chase Community Hospital. Based on the estimated whole system annual recurring revenue savings the payback period for non-recurring expenditure to offset this negative equity is 14 months. Any negative equity funding is subject to approval by Primary Care.

8.27 Table 3 below provides a summary of the revenue effects on the health system and also provides an outline of the effects on individual NHS organisations.

**Table 3**

| Revenue  | Health System |             |              | CCG           | NHSCB      | NHS Property Services | Southern    |
|--|---------------|-------------|--------------|---------------|------------|-----------------------|-------------|
|  | 2013/14       | 2014/15     | 2015/16      | 2014/15 Split |            |                       |             |
|  | £000's        | £000's      | £000's       | £000's        | £000's     | £000's                | £000's      |
| Increase in building charges                   | 45            | 120         | 120          | 0             | 0          | 120                   | 30          |
| Increased recovery from occupants              | (45)          | (86)        | (86)         | 0             | 0          | (117)                 | 0           |
| Savings from other vacated buildings           | 0             | (71)        | (71)         | 0             | 0          | 0                     | (71)        |
| <b>Subtotal - Estates Impact</b>               | <b>0</b>      | <b>(37)</b> | <b>(37)</b>  | <b>0</b>      | <b>0</b>   | <b>3</b>              | <b>(41)</b> |
| Bed modelling impact                           | 0             | (161)       | (161)        | (111)         | 0          | 0                     | (50)        |
| Non-recurrent training costs                   | 0             | 125         | 0            | 125           | 0          | 0                     | 0           |
| Non-recurrent other payments                   | 0             | 200         | 0            | 0             | 200        | 0                     | 0           |
| <b>Total increased cost / (decreased cost)</b> | <b>0</b>      | <b>127</b>  | <b>(198)</b> | <b>14</b>     | <b>200</b> | <b>3</b>              | <b>(91)</b> |

8.28 Further details of both capital and revenue consequences of the scheme are set out in Appendix 7.

## **DETAILS OF THE PREFERRED OPTION (OPTION 1)**

9. Following both qualitative and financial appraisal of all three options, Option one has emerged as the preferred option in both qualitative and financial terms. Option one involves fully utilising the hospital by centralising of outpatients, clinical community services, community care teams, primary care (up to two GP practices) and mental health services on one site.

9.1 It enables the provision of a minor injuries service and includes a new model of bed based care with nursing care being provided from the patient's home or a local nursing home. The proposal also allows for the rationalisation of local premises, including the closure and disposal of the Elizabeth Dibben Centre (owned by Southern Health NHS Foundation Trust) and replacement of two nearby GP practice surgeries (freehold held by the local practices).

9.2 This option would achieve the following objectives:

- Integration of up to two GP practices into the existing building
- Provision of minor injuries service
- Integration of mental health services into the existing building, allowing the disposal of Elizabeth Dibben Centre
- Rationalisation and improvement of outpatient and therapy facilities to meet current requirements and standards
- Re-use of catering and support services accommodation to provide flexible office bases for community teams
- New model of bed based care
- Increase in on site car parking provision

A Charter will be provided setting out the range of services to be offered at the Chase Community Hospital. It will also provide a set of measurable outcomes as a result of the redevelopment.

9.3 To achieve this requires re-planning of a significant proportion of the existing accommodation. However, it should be noted that some areas of the building will remain unchanged; these include the main entrance/reception and waiting area, the x-ray department, the Age Concern Day Centre and the bookable group room/meeting area. It should also be noted that the proposed works are all within the footprint of the existing building, apart from a new entrance lobby to be formed to enable access to the GP surgeries.

9.4 The building has an overall area of 2764 m<sup>2</sup>. Works will be required in three main areas; the current ward area, the outpatient department and the current catering and support services area. Overall, works will be required in some 48% of the building area. The majority of these will take place in the current ward area which, at around 770 m<sup>2</sup> of accommodation, represents around 28% of the building area. Re-planning this ward area provides enough space for two GP practices and dedicated space for mental health.

9.5 In order to carry out the works and minimise disruption to service delivery some phasing will be necessary. The initial phase will involve works to the vacated ward area which will include forming the GP practice accommodation. When completed the GP consulting rooms and associated patient areas will initially be used to provide

decanting space for outpatient clinics, whilst works in the outpatient department are carried out. The main areas of works and key elements of new accommodation are summarised below.

## **Outpatient Services**

- 9.6 Feedback from engagement carried out during October and November 2012 with local people indicated a high level of support for the expansion of outpatient services at Chase Community Hospital. The services we are planning to provide are those that will best meet the healthcare needs of the local population and have all been identified as a requirement by commissioners and providers, clinicians, public health, service leads, key local stakeholders and the general public. These services may be an expansion of services already provided at the hospital as well as a transfer of activity being delivered from acute hospitals in the area, all of which are in line with the Transforming Community Services Strategy and providing care close to home.
- 9.7 There has already been an increase in activity in some services currently delivered from the hospital including diabetic clinics, family planning, GU Medicine, gynaecology, general paediatrics, paediatric audiology, retinal screening. Choose and Book clinics have been re-promoted to the GPs to ensure usage.
- 9.8 There is potential to expand further the range of acute and community outpatient specialties provided at Chase Community Hospital. These will complement the existing services in acute hospitals and surrounding community hospitals in Alton, Petersfield and Haslemere but will not destabilise any of these services. Release of the ward at Chase Community Hospital will provide the necessary space to achieve this.
- 9.9 Discussion with local GPs and stakeholders demonstrated a need to introduce additional sessions locally for sexual health and substance misuse services and the SEH CCG are proposing to extend current provision.
- 9.10 The following are some of the services that have either already been increased or we will be looking to introduce or expand. This list is not exhaustive. The services will reflect the changes in delivery of health care provision as it improves and changes:
- Dermatology
  - Orthopaedics
  - Nephrology (renal)
  - Pain Clinics
  - Mental health and older peoples mental health clinics
  - Community clinics including IV antibiotics
  - Expansion of sexual health services
  - Expansion of substance misuse services
  - Expansion of pain clinic
  - MacMillan outpatient clinics
- 9.11 The re-planning of the existing outpatients area will achieve a number of objectives.
- Bookable consulting room provision will be re-planned to provide three new consulting rooms which meet current space standards;
  - Two further existing consulting rooms will be retained and refurbished.
  - Consulting and treatment facilities for sexual health will be provided, which meet current standards.

- Similarly, consulting and treatment facilities for speech therapy and podiatry will be re-located to re-planned rooms which meet current standards.
- Two treatment rooms will be available to serve all outpatient clinics; these will meet current standards.
- A dedicated room for audiology will also be provided.
- The rooms used for sexual health clinics are below current standards; access to additional facilities is required to meet increased demand locally.
- Similarly, an expansion of substance misuse services is planned in response to increased local demand; this will require additional access to bookable clinic rooms.
- Podiatry, physiotherapy and occupational therapy provision is well used and will be retained on site as part of the proposed re-development.

### **Mental Health Services**

- 9.12 Currently the nearby Elizabeth Dibben Centre provides accommodation for both Adult Mental Health and Older People's Mental Health Services which are both provided by Southern Health NHS Foundation Trust. The Elizabeth Dibben Centre has clinical rooms for outpatient consultations and also some group therapy. In addition the building provides accommodation for the community teams providing care for both adults and older people's mental health.
- 9.13 The Elizabeth Dibben Centre is an older building which is not currently fully utilised. It is proposed that clinical services and staff functions transfer from the Elizabeth Dibben Centre into Chase Community Hospital. This will involve providing remodelled accommodation to meet current requirements and will also allow better integration of mental health with other local community care teams based at the hospital.
- 9.14 A dedicated mental health area utilised by adult and older people's mental health services will be formed within part of the current ward area. This will have a separate entrance off the main hospital circulation corridor. Waiting and reception facilities will be provided within the mental health area, together with three consulting rooms and a treatment room.
- 9.15 The Elizabeth Dibben Centre is owned and operated by Southern Health Foundation NHS Trust. The building will be closed and the site sold following re-provision of facilities at Chase Community Hospital.

### **GP Practices**

- 9.16 There are four GP practices with surgeries within a three mile radius of central Bordon. It is intended to re-provide the nearby Pinehill Surgery with new accommodation within the Chase Community Hospital.
- 9.17 The Pinehill Practice (Dr. McGregor-Wood and Partners), currently provide services from the Pinehill Road Surgery. The practice has four GPs together with three practice nurses and a healthcare assistant. The current surgery building is some 30 years old and the practice has outgrown the accommodation.
- 9.18 Accommodation will also be available to accommodate a second GP practice and discussions are taking place regarding the viability of this proposal.
- 9.19 The two GP practice areas will be formed in the part of the building which contains the current inpatient ward area. A separate entrance will be formed to a shared waiting and reception area. Staff facilities will also be shared. The two practices will

occupy separate and defined clinical areas. These are based on current standards and allow a total of five clinical rooms (four consulting and one treatment/exam) to replace the Pinehill Surgery and a total of four clinical rooms (three consulting and one treatment/exam) to replace a second local surgery.

- 9.20 The South East Hampshire Clinical Commissioning Group supports the rationalisation of GP premises in Whitehill and Bordon through re-location to available space at Chase Community Hospital.

### **Minor Injuries Service**

- 9.21 During discussions with stakeholders regarding future services in Whitehill and Bordon, the subject of urgent care was discussed and stakeholders were keen to see a minor injuries unit (MIU) provided at Chase Community Hospital. However, the local population is not sufficiently large enough to make a MIU at the hospital viable as approximately 20,000 patients per year would be required to ensure the feasibility of such a unit.
- 9.22 Figures show that between April 2010 to June 2011, 4,500 people from Whitehill and Bordon attended an Emergency Department at an acute hospital. Based on analysis undertaken by the College of Emergency Medicine, 25% of patients seen at an Emergency Department could be treated via a minor injuries service. It is estimated that only 30 patients per month from Whitehill and Bordon would require access to a minor injuries service and consequently a MIU would not be sustainable. Therefore it was agreed that as part of the proposals for Chase Community Hospital that a Local Enhanced Service (LES) would be offered to GP practices in the area for the provision of a minor injuries service.

### **Integrated care at home and in a nursing home**

- 9.23 The preferred option would offer local people access to an enhanced integrated care team in their own homes as detailed in section 4. However during the consultation process the local provision of nursing home beds was raised as a concern by local people should the beds at Chase Community Hospital close. There is currently no nursing home in Whitehill and Bordon. Initial investigations were undertaken as to the commercial viability of a new nursing home within a five mile radius of Bordon and these have indicated that there was potentially some demand. Positive discussions have been held with a number of nursing home providers and several possible sites have been identified in Whitehill and Bordon. Chase Community Hospital site was also considered but has been ruled out as there would be insufficient space available for this type of development that would enable current standards to be met and be financially viable for a developer. It would also mean moving other services such as outpatients away from the hospital and the Whitehill and Bordon area.
- 9.24 Potential sites identified include two within the planned Eco-Town Development area. One of these sites, Quebec Barracks, has recently been sold by East Hampshire District Council to The Homes and Communities Agency (HCA). The HCA expect to submit a planning application by the end of 2013 with works starting in 2014 and completing by 2015. However, we cannot guarantee at this stage that a nursing home will be built. Recent engagement with a local nursing home provider has identified the potential for a nursing in Whitehill and Bordon on a smaller scale than a national provider would be seeking. There may be an opportunity realised should the redevelopment of Chase Community Hospital be approved and discussions will be taken forward on this basis.

- 9.25 The South Eastern Hampshire CCG is also working closely with other public sector partners e.g. Hampshire County Council, to understand the social care needs for the population of Whitehill and Bordon. Hampshire County Council Adult Services would also like to procure beds in this area for social care on a spot purchase basis. There is also recognition that the new model of care will place additional pressure on Adult Services providing the social care elements of this model.
- 9.26 Whilst the plans for a new nursing home are being developed there would be no gap in service provision for bed based care. Two nursing homes have been identified by local GPs that would be able to provide the new model of care; step up, step down and end of life care. There is already a well-established relationship between local clinicians, commissioners and these nursing home providers and the NHS already has a contract with one to provide continuing health care beds. Both nursing homes are in Liss which is a journey of 6.3 miles from Whitehill and Bordon. Therefore the new model of care could be put in place as soon as required.
- 9.27 Local people have raised their wish to be able to stay with their relatives whilst receiving end of life care and therefore accommodation would also be made available at the preferred nursing home for relatives.
- 9.28 Discussions with local people have raised concern about their ability to visit their relatives if beds were to move away from Chase Community Hospital. Analysis has demonstrated that public transport to existing nursing homes in Liss, Liphook, Alton, Farnham and Petersfield is poor. When local people were asked about what they considered to be a reasonable distance to travel for an inpatient stay, 42% said it was reasonable to travel 7 to 10 miles, with 36% saying 0 to 7 miles and 21% saying over 10 miles. Therefore we are proposing to include 'free' transport for relatives during the period of inpatient care and the costs for this have been included in this outline business case.

### **Physiotherapy**

- 9.29 Physiotherapy will be retained in its current location. However, rationalisation of equipment and storage space will allow the formation of five individual treatment cubicles, significantly improving patient privacy.

### **Catering Area / Office Space**

- 9.30 The dining area will be retained. This is used by the Day Centre, other voluntary groups and staff. However, the existing food preparation and storage areas will become surplus as no inpatient meals will be prepared on site. The surplus areas will be converted to form office accommodation for health visitors.

### **Support Services Area / Office Space**

- 9.31 Rooms originally provided to support inpatient services include general stores, linen storage and a body store and viewing room. These areas will be converted to form offices and storage areas for Community Physiotherapy and OT Teams, Community Midwives, and the Community Care Team.

### **Car Parking**

- 9.32 The introduction of two GP practices, mental health and additional outpatient clinics on to the site will require additional car parking. Only one area of the site is able to provide additional parking. This area can be developed to form a further 23 parking spaces.

## PROGRAMME

10. Following approval of the outline business case, the full business case will be developed to confirm the detailed design and capital costs and submitted for approval in July/August 2013. Approval for allocation of the capital monies will need to be obtained from NHS Property Services. Costs for the capital works have been included in the 13/14 and 14/15 forecast capital spending plans for NHS Property Services.
- 10.1 It is envisaged that works will start on site in September/October 2013 and will take 18 months to complete. It is proposed to submit and achieve planning approval for the additional car parking spaces and new entrance to the GP Surgeries prior to the submission of the full business case.
- 10.2 Construction works will not commence until the new model of bed based care is implemented and the beds at Chase Community Hospital have closed. In order to ensure works commence on site in September/October 2013, in conjunction with the development of the full business case, we will commence staff consultation, commission the nursing home beds and finalise the new model of bed based care. Following approval of the full business case the beds at Chase Community Hospital will close and the new model of bed based care will be implemented and works can then commence at Chase Community Hospital.
- 10.3 The construction period allows for phasing of the works and an indicative plan is set out below:
  - Phase 1: Works to current ward area to create accommodation for two GP practices and mental health clinical area.
  - Phase 2: Out Patient Department functions move temporarily to GP areas whilst works undertaken in OPD area
  - Phase 3: Community staff move to GP areas whilst works undertaken in catering/support services/community offices area
  - Phase 4: GP practice areas commissioned

## Key Dates

|      |                                |                        |
|------|--------------------------------|------------------------|
| 10.4 | Outline Business Case approval | March 2013             |
|      | Full Business Case approval    | July/August 2013       |
|      | Start on site                  | September/October 2013 |
|      | Completion                     | March/April 2015       |

## RISKS

11. There is a high level risk associated with organisational change within the NHS. Whilst the proposed re-development would achieve a significant net saving to the local NHS system as a whole for reinvestment, premises rental costs for the new facilities at the Chase Community Hospital will represent an increase on current premises costs for some service providers. These will be confirmed in the full business case when design work and subsequent costing is completed. An initial indication of rental cost recovery, based on occupied areas, is shown in the Table 3 in Section 8 of this paper. An equitable approach to the revenue consequences of the re-development will be required; this may require contract variations between commissioners and some service providers. A detailed risk register is attached in Appendix 9.

## APPROVAL REQUIRED

12. Subject to the views of the Hampshire Health Overview and Scrutiny Committee the South Eastern Hampshire Clinical Commissioning Group is requested to approve this Outline Business Case on the following basis:
- To produce a full business case for the major re-development of accommodation at the Chase Community Hospital at a capital cost estimated at £2.9 million to be funded from NHS capital sources
  - To enhance and expand acute outpatient and community services
  - To implement the proposed new model for bed based care and close the current beds at Chase Community Hospital
  - To commission a GP led minor injuries service
  - To relocate primary care services and adult and older people's mental health services into Chase Community Hospital
  - To approve expenditure estimated at £76,000 for fees to enable completion of a detailed design and a full business case
  - To approve delegated authority for the Director of Finance to approve agreement to proceed to tender for the capital works once the design has been fully developed