South Devon Healthcare NHS
NHS Trust

Modernising Healthcare in South Devon

A Strategic Outline Case for the South Devon Integrated Care Network: A partnership for improving health in South Devon

Developed by South Devon Healthcare NHS Trust, in partnership with Teignbridge PCG, Torbay PCT, South Hams and West Devon PCT, Devon Social Services, Teignbridge District Council, Torbay Borough Council and South and West Devon Health Authority

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Why are we submitting this SOC?

Development of our estate is essential if further improvements in health and health services for the population of South Devon and the targets in the NHS Plan are to be achieved.

Together with partner organisations, we want to deliver greater integration of health and social care services to improve patient care. This will only be achieved by changes in working practices, supported by development of the estate. The principal elements of this SOC are:

- Re-providing health and social services facilities in Newton Abbot to provide joint beds for intermediate and GP care, together with a help and advice centre, integrated minor injuries and out of hours unit, dental centre, outpatient and diagnostic unit and reablement services
- Reconfiguration and improvement of the District General Hospital (Torbay Hospital) to provide an ambulatory care and diagnostic facility, an integrated emergency assessment department incorporating accident and emergency, the emergency room and a GP out of hours service, a women's unit and modern, high quality surgical accommodation and additional operating theatres.

To maintain the pace of change and ensure service delivery continues to be improved, it is important for the Health Community to secure investment now if the health economy is to meet the needs of the local population as it increases from 265,000 to 279,000 by 2010. 23% of the population is over 65 and this group represents 45% of admitted patients and 74% of bed use.

Building on progress already made, including development of a modern mental health service, provision of two new community hospitals (one built through the PFI programme) and considerable innovation in working practice, the SOC and supporting service strategies will deliver the objectives of the NHS Plan.

Joint work between the Trust and Commissioners will ensure this scheme delivers modernisation targets through integrated services in safe and appropriate facilities. The emphasis throughout the development process has been on whole systems thinking (particularly for the elderly and those with complex needs).

Financial modelling has taken account of all the development requirements envisaged within the NHS Plan that fall outside the content of this SOC. The model also identifies the resources available to the local health economy to achieve the targets required between now and 2005, when it is envisaged the major development will be completed. **The scheme is affordable** within the proposed capital ceiling of £64 million, levels of growth signalled in the Comprehensive Spending Review and our projections for the future.

"I have been impressed by the enthusiasm, commitment and vision that has been shown by all the people involved in this project. I am convinced that this partnership across secondary care, primary care and social services is what the new NHS plan is all about. If we are given the go ahead we can build a seamless service that puts the patient at the centre of things."

Dr Nick D'Arcy, Chair Teignbridge PCG and the South Devon Getting Patients Treated Group

Section: 1

Strategic Context

Regional Overview

The Trust has developed a very effective cancer unit in conjunction with Exeter and Plymouth cancer centres

At a strategic level, South & West Devon Health Authority works with North & East Devon Health Authority and Cornwall & Isles of Scilly Health Authority to develop services for the peninsula. The benefits of working together have been demonstrated by the development of the clinical networks that have already been put in place.

The peninsula Acute Services review identified a continuing need to maintain delivery of secondary healthcare services in each of the five centres of population in the South West. Services in South Devon have been developed on this basis.

This approach will be further strengthened with the establishment of the Peninsula Medical School.

The Peninsula Medical School will train at least 100 doctors per year. Clinical placements will take place in South Devon

The Regional Office has supported South Devon's modernisation bids because the Trust consistently meets its targets and has a record of innovation. The need for capital investment is also recognised and the South & West Regional Office has supported the Trust in developing this proposal.

The scheme complements other developments in the health community, including those being developed within the Plymouth Health Community, while seeking to maximise local service delivery. As a result of this scheme, there will be a minimal impact on other health communities as most services are already provided within South Devon.

South and West Devon Health Authority perspective

The Health Authority covers two distinct areas of population (South Devon and Plymouth) served by District General Hospitals 35 miles apart.

To secure health improvement for the populations, the Authority has sought to establish effective partnerships in each local health community.

Further improvement of services requires local primary and secondary services to be as effective and efficient as possible. To achieve these improvements capital investment, both in South Devon and Plymouth, is necessary. The service and financial model for South Devon is complementary to proposals developed in Plymouth.

This scheme will provide improved intermediate care and capacity to respond to the waiting time targets. It also has the potential to meet anticipated demands resulting from new technology.

South and West Devon Health Authority believe that the focus on integration and improvement is right. Forecasts of activity and bed numbers are in line with the 'Closer to Home' model of the National Beds Inquiry. The proposals are both deliverable and affordable in the context of the National Plan and the local Health Improvement Plan.

The Trust has a good record of delivering targets. This scheme will enable the Trust to continue doing so in a safe, high quality, patient-centred environment.

Communication

This proposal does not require closure of any hospitals, but it will involve the bringing together of health and social service facilities and significant changes in working practice.

These broad principles have been the subject of consultation during the establishment of PCTs and have been supported.

Wider public opinion has been sought through public surveys undertaken in conjunction with local authorities. Local people place a high priority on changes that would deliver integrated health and social care services through unified teams and shared facilities. During the development process to date, the Community Health Council has been supportive of this approach.

A wide range of staff have assisted in the development of this SOC and the probability of the scheme being funded through Public – Private Partnership has been raised with staff representatives.

A detailed community-wide communication strategy to engage all interested agencies and the public is being developed to support publication of the proposal.

Financial Strategy

The financial model for this development assumes the levels of growth set out in the current Comprehensive Spending Review and growth of 4-5% per annum thereafter for the health community. It allows for increases in prescribing in both primary and secondary care of 8.0% per annum (real terms), in tertiary spending and in the salary and associated support costs of additional staff outlined in the National Plan. The proposal also allows for a significant uplift in spending on information technology and for the effects of regulation. Over the period to 2010 the developments proposed are affordable. A more detailed analysis is provided later in this paper.

The Local Community - the people we serve

265,000 people live in South Devon and receive their healthcare within the traditional catchment area of Torbay District General Hospital. The OCS forecasts that the population will increase to 279,000 by 2010; further increases in the population are predicted to 2015.

Characteristics of the South Devon population are:

- 23% of the population is over 65 (compared to the national average of 16%).
- In the summer months, the population served increases by 100,000.
- Inward migration of people retiring to the area, together with seasonal workers for the tourism industry.
- Outward migration of young people entering higher education and seeking career opportunities that cannot be met within South Devon.
- Tourism and agriculture remain important employers.
- An increasing high-tech manufacturing base.
- A number of electoral wards that have very high levels of deprivation. A small number of areas are affected by rural isolation.
- South Devon sits between the two main population centres in Devon: Exeter is 22 miles north and Plymouth 35 miles west of Torbay.
- Over 200,000 of the catchment population lives within 10 miles of Torbay Hospital.

Population of South Devon ('000s)

Year	Total (000's)	Over 65(000s)	Over 75(000s)
2000	265	60.7	33.2
2010	279	64.8	34.3
Change	+14	+4.1	+1.1

PCT	2000	2010	Change
Torbay	135	138	+3
Teignbridge	112	122	+10
S.Hams –part	28	29	+1
Total	265	279	+14

There are 13 principle towns and associated local communities served by the Trust and services are organised around these towns. They can be sub-divided according to the PCT areas as outlined below.

Torbay: Torquay, Paignton, Brixham
Teignbridge: Newton Abbot, Teignmouth, Dawlish, Bovey Tracey, Chudleigh, Ashburton and Buckfastleigh
South Hams & West Devon: Dartmouth and Totnes
Mid Devon: Moretonhampstead.

The PCTs closely follow local authority boundaries and the Trust's good working relationships with these authorities have been strengthened through the development of PCG/Ts.

The Trust and its Services - background

Recognising the benefits of integration, South Devon Healthcare was established as a first wave whole district trust to provide easy access to a wide range of acute, community and mental health services for local people and visitors to the area.

The developments now proposed are a natural progression in service evolution, and should be seen in the context of the Trust's development over the past 10 years. Key phases of its development are summarised below.

- **Strengthening acute services:** in the early 1990s, acute specialties were expanded to provide a wide range of secondary care easily accessible to the local community. A critical mass of consultants was established in all key specialties
- **Community services:** during the mid 1990s, the Trust started development of its current model of community services. This built on the strength of local primary care and is based on each natural community, ten of which have a local community hospital
- **Mental health:** in the second half of the 1990s mental health services were restructured to provide further integration between the community and acute services, attaining Beacon Status
- **Local Leagues of Friends** have made a significant contribution to implementing service improvement programmes
- The local Health Community is **actively engaged in the modernisation agenda.** We have completed the first phase of our A&E modernisation, are midway through our second wave Booked Admissions project and starting the third, implementing Action on Cataracts and introducing Critical Care. We have achieved Beacon status for our thrombolysis programme. Following a period of innovation and piloting of intermediate care, we are ready to restructure services around the needs of older patients and those with complex needs in line with our expectations of the NSF
- This process is supported by the establishment of Torbay, Teignbridge and South Hams & West Devon PCTs. The innovative management arrangements agreed with the PCTs are helping us to drive forward intermediate care in partnership with Social Services, further improving the effectiveness of our community hospitals.
- The Trust is engaged in the South West EPR procurement at present. Therefore replacement of information systems has not been included in this SOC.

The support of the local community has been maintained throughout this process.

"Community hospitals are considered valuable and will remain 'safe' under Trust status."
~ Torbay & District CHC 1999/2000

Each community has a lead GP and a locality manager. A number of these management appointments are shared with local general practices, and one is already responsible for operational management of the Social Services team. This approach will be extended.

Strategic Service Objectives

Teignbridge PCG and Social Services District management teams have been co-located since 1999 and have a number of joint appointments in their linked management structures

Over the last three years the local health community has developed a framework for further service improvement to achieve both short-term objectives and a programme for change that will deliver the local HImP and National Plan objectives.

This process has identified that to be effective in the future the Health Community must:

- Provide a well integrated service for the local population
- Place a particular emphasis on intermediate care and rehabilitation, particularly for the most vulnerable and dependent 3000 people within the community
- Support primary care by providing rapid access to diagnostic services and specialist opinion
- Maximise the opportunity for recovery following serious illness by providing quick access for ambulatory or inpatient care, supporting this with appropriate rehabilitation opportunities
- Provide facilities that are easy for patients, staff and the local community to use.

To support this service vision, an Estate Strategy was developed. This SOC seeks to secure the investment necessary to deliver local objectives and the National Plan.

Meeting these Strategic Objectives

The Health Community has agreed to continue the pattern of general hospital and community hospital provision. These hospitals are an integral part of the health network and are dependant on each other. Service reviews have consistently demonstrated the strategic importance of local health service beds being managed together with the acute bed stock, to achieve the most effective use of resources. For this reason, this SOC seeks to secure investment for both Newton Abbot (allowing further development of Social Services partnership working and extension of intermediate care) and the DGH (Torbay Hospital). Re-design of the DGH will support the provision of patient-centred services and multi-disciplinary team working. Both developments are essential if the Health Community is to deliver the modern and consistent service that local residents and visitors should expect.

Our vision for an integrated network within South Devon

'A network that will:

- support primary and intermediate care services for local people and
- provide rapid and easy access to specialist and diagnostic treatment facilities, either as
- part of a care pathway or
- by GP direct access for the population of South Devon.

'Services and facilities will be designed to enable as much care as possible to be undertaken in the patient's local community, but where a visit to a hospital is necessary, this will be for the shortest period possible.'

To provide maximum benefit for patients, our development proposals are based on a whole systems approach involving co-ordinated local access to health and social care services. Access will be supported through widespread use of IT and will work in conjunction with NHS Direct.

The scheme will include:

- integration of intermediate care to enable diagnostic and multidisciplinary support for re-ablement to be delivered efficiently within the community. This is a logical extension of our community approach and will lead to co-location of health and social care facilities. In most locations this can be achieved in existing facilities, but in **Newton Abbot this requires a major redevelopment** (details of which are provided later in the document).
- facilities to enable an increased percentage of procedures to be undertaken in outpatients in many specialties (many as one-stop visits). This will be achieved through the creation of a treatment and diagnostic centre, which involves construction of a new building, together with redesign of existing outpatient and radiology services (including the introduction of digitalisation)
- an integrated emergency department linking the roles of A&E, emergency assessment and GP out of hours activity (for which a pilot is currently being developed)
- improvements to the day theatre zone to enable further increases in the percentage of procedures undertaken on a day case basis. Existing work on booked admissions and pre-assessment will provide the link between primary care, the diagnostic and treatment centre and inpatient care
- upgrading inpatient facilities to allow **elective care to be protected from fluctuations in emergency activity**. This will enable capacity to be developed to maintain the 2005 waiting list targets. New facilities will enable new methods of working, with care for many patients organised on the basis of dependency rather than specialty.

We believe that this scheme will redefine the balance between emergency and elective work and support our drive to deliver care within patients' communities. It will support alternatives to admission and enable us to meet the targets set out in the National Plan in a modern, safe environment, attractive to both patients and staff.

Examples of how the Trust has implemented change are given in the margins of this document. These examples demonstrate the Trust's ability, willingness and enthusiasm to embrace change and modernise working practice for the benefit of patients.

By investing in the estate the right environment will be created for staff to deliver improved care for patients and meet modernisation targets.

Home care staff will be attached to District Nursing teams and an integrated emergency response service is being established in conjunction with GP 'out of hours' services to prevent inappropriate admissions to hospital

The 'help desk' will provide a shared gateway to health, social care and associated services (e.g. supported housing) for people living in Teignbridge. NHS Direct will refer appropriate people to the service

Key assumptions supporting the approach

Our bed model builds on 6 years data and is reasonably predictive of performance. Results match those of the National Bed Inquiry

As outlined above, the population of South Devon is expected to increase to 279,000 by 2010. This represents an increase of 6%, but is equivalent to an 8% increase in workload, when age and case mix changes are considered.

- A traditional response would anticipate an increase of at least 53 beds, assuming no further change in technology or demand. A further 31 beds would be required to reduce occupancy to 85%. Average daily occupancy is currently 769 beds and this would increase to 853 using the traditional model.
- At present there are 816 acute, community and midwifery beds within the health community.
- Occupancy already exceeds 93% in the key emergency specialties of general medicine, general surgery and trauma & orthopaedics. Increases in demand will drive this figure to over 100% over the next ten years.
- In the community hospitals, occupancy has increased and is already over 85%.
- Over the last five years, the variability of bed occupancy has reduced, but we are increasingly close to the 'ceiling'. This considerably increases our risk of system failure.
- Further analysis of activity demonstrates that 1.7% of our patients (1100 patients per year) currently use 23% of the local health economy's bed stock. 200 use 7.5% of the resource.

30% of the total waiting list is for orthopaedic patients and 650 are waiting over 6 months

Changes in working practice will reduce the impact of these changes and our proposal is designed to be flexible enough to deal with variation over the next ten years.

Expected increases in activity

Most patients waiting over 6 months need orthopaedic surgery. The IACC comparative study and use of 'Checklist' indicate a well-run service performing better than average. To meet current and future need, improved facilities are required

Analysis of current activity, need and future population trends demonstrate a significant potential increase in workload for the next ten years. The population model suggests an additional:

- 6000 first outpatients (+10%)
- 4500 elective patients including day cases (+15%)
- 1950 non-elective patients (+7%)
- 19500 bed days (+8%)
- Additional nurse and therapist contacts

Using the traditional model, and staffing wards at existing levels, would require three quarters of the local nursing growth anticipated in the National Plan.

Our population model takes account of population increases, key changes in need and clinical practice including:

- An increase in **orthopaedic activity.** Currently orthopaedics represents 30% of the community waiting list. Indications suggest that the threshold for treatment is currently too high and some treatment has to be undertaken outside the district
- A significant increase in **cancer-related** work. We estimate growth of 5% pa over the next 5 years. This does not place a significant burden on beds, but will require expansion in diagnostic and treatment facilities
- Increases in **cardiac** diagnosis and assessment
- An increase in the **diabetic** population, which is expected to double over the next 10 years. As well as the demand in primary care this will generate additional work in diabetology, ophthalmology, vascular surgery and podiatry
- **gastrointestinal disease.** There have been substantial increases in this area over recent years (particularly diagnostics) and we expect this trend to continue, although we recognise some technological uncertainty

- Increases in the dental specialties. To accommodate changes in the dental service, we recognise the requirement for more primary care access and also increased specialist provision
- nurse and therapist led clinics will also increase to support the major NSF targets.

All of these factors suggest that a traditional approach is neither desirable nor sustainable.

Clinical Support

Our proposals have been generated from within the clinical community in South Devon to improve the service for the local population. The assumptions set out below, the solution, service model and outline designs are strongly supported by the local clinical community.

The inter-agency team working and joint management arrangements underpinning the locality based elements of service are not only agreed at policy level but already in place in pilot sites.

Solution

We believe that by supporting the active management of patients with significant needs, the performance of the whole system can be substantially improved.

For the majority of patients, qualitative and systematic improvements will be delivered through changes such as direct booking, booked admissions and care pathways. However for the 1100 complex need patients and similar patients in the community (3000 in total) this is insufficient. Care co-ordination will be put in place for such individuals.

The care co-ordination process will be managed in the community. An 'in-reach' team will also operate from the Emergency Department at the DGH to coordinate the safe and efficient discharge of patients, with input starting from the point of admission.

By careful design of the integrated care network and its supporting facilities and services we believe that 40 additional beds are required. This is consistent with the National Beds Inquiry 'Closer to Home' model. The table below sets out how this can be achieved with 3 differing scenarios:

Changes in bed provision

	Estimate of change		
Change	**Low**	**Medium**	**High**
Current bed number	816	816	816
Beds required for population increase	38	46	53
Increase in day surgery	0	-2	-7
Reduction in over 62 day stays	-10	-20	-29
Reduction in 31-62 day stays	-10	-21	-31
Reduction in occupancy in GM/GS/TO	13	24	31
Increase in orthopaedics	1	4	6
Increase in colorectal work	3	6	9
Total change	36	37	31
Margin for error with 40 additional beds	4	3	9
Bed requirement	851	852	846
Dental specialities	minimal impact on beds		
Cancer	minimal impact on beds		
Diabetes	minimal impact on beds		

"The Consultant Medical Staff give full support to the Strategic Outline Case for the South Devon Integrated Care Network. We have been involved with this scheme since its inception and we have all been closely consulted during the planning stages.
We are excited by the possibilities for innovative health care in emergency and elective work offered by this scheme. In particular, the development of closer working between the Trust, individual GPs, PCTs and Social Services should offer a rapid response for patients using diagnostic facilities and one-stop clinics."

Dr Robin Teague, Chairman,
Consultant Medical Staff Committee.

Notes:
Low reflects a lower than expected increase in activity and less change in day case work, the management of complex cases (expressed as a reduction in length of stay for medium and long stay patients), and small increases in orthopaedics and colorectal work.
High sets out a similar position assuming a large increase in work and a commensurately large change in effectiveness.
Medium represents a mid point.
Details of the model are available in the supporting documentation.

Section: 2

Health Service Need

Easier access for patients
Many ENT, maxillofacial, dermatology, gynaecology and urology procedures could be undertaken in Outpatients if facilities were adequate. The current alternative is inpatient or day case treatment

Access to better services

Improving access to services continues to be a principal objective of the local health community. This SOC addresses the need for facilities to cope with changing and expanding access requirements.

Waiting times

Since its inception South Devon Healthcare has always given improving access a top priority. Consequently, a full range of secondary services is now offered to the local community, with 30% of outpatient activity already undertaken in community hospitals. Outpatient access for most tertiary services is also available locally.

To provide this range of activity we have had to maximise the use of existing facilities. This has been achieved by actively investing in teams, developing our network of community hospitals and, increasingly, by working in partnership with local Social Services departments.

This strategy has been effective and delivers high quality services at 10% less than national average costs (reference costs 1989/90). **However, it is not sustainable;** we are increasingly dependant on waiting list initiatives and already over 2% of elective activity is undertaken on this basis. **Further increases in activity will be necessary to achieve NHS Plan targets.** Facilities fall short of standards necessary to secure support for the necessary further consultant expansion.

Waiting times for most specialties are better than average. However, maintenance of the current position and further improvements will only be possible with service improvement and reconfiguration. This is dependant on improved facilities being available.

Ambulatory treatment and diagnosis

The Trust's Estate Strategy identified high utilisation of existing outpatient facilities and it is now virtually impossible to re-organise or improve services further. 30% of outpatient activity is delivered in the community. Facilities in most departments do not allow an expansion of one-stop clinics, provision of a full range of outpatient intervention or proper team working. **In many cases adequate cross infection control, patient privacy and confidentiality cannot be achieved**, unless patients are brought in as day cases or inpatients. Careful consideration of future requirements has led to the development of a zoned concept enabling groups of similar specialties to share core facilities within a diagnostic and treatment centre.

Radiology services

Two years ago, the Radiology Directorate introduced 7-day working to provide improved access for emergency and urgent investigations. The health community has already invested to reduce elective waiting times but further improvement is still required. Full use is made of facilities in the community hospitals. However, adequately supporting care pathways and achieving waiting times is a continual challenge. Services will be become more patient-focused by decentralising radiographic facilities to A&E, trauma & orthopaedic clinic, gastroenterology and gynaecology areas. This will enable amalgamation of the two main x-ray departments on the DGH site further increasing flexibility. The effectiveness of the service will be improved through digitalisation.

Use of theatres

We have no theatre sessions vacant on a planned basis. We currently have (in three areas) nine theatres used principally for inpatient work, two-day theatres, a day theatre procedure room and an A&E theatre. There is a separate endoscopy suite that is also fully occupied. Over recent years, day surgery sessions have increased to include a regular Saturday morning session with additional weekend working to maintain waiting times. Three-session days are also being considered, but for inpatient theatres current bed provision and support staffing is inadequate for this to be an effective or efficient method of working.

The balance between inpatient and day case theatres is inappropriate for current needs. This is being partly addressed through our 'Action on Cataracts' initiative, but more fundamental redesign is required.

There is inadequate provision of theatre facilities to tackle current and expected future demand (particularly for orthopaedics).

Day Surgery

Experience demonstrates the importance of well integrated and designed processes. Work on care pathways in our existing day unit, the Action on Cataract Scheme and Booked Admissions will build capacity to allow for further increases in day surgery

Use of beds

For the last five years the pressure on beds has increased. We now have an acute and intermediate care bed stock of 816. Occupancy is over 93% in the main emergency specialties.

The bed model we have developed indicates that the probability of bed shortages has increased to 36 days per year in 2000/01, despite a wide range of schemes designed to stretch capacity including :

- introduction of alternatives to hospital and early discharge schemes
- use of additional capacity in the private sector
- better use of community hospitals
- improvements in re-ablement and alternatives to hospital care
- increases in day surgery rates
- improved access to diagnostics (including 7 day access to radiology).

As occupancy has increased, peaks and troughs of bed usage have reduced so, on average, there is less reserve capacity in the system to deal with peak pressures. This is leading to an increasing loss of elective activity over the winter months.

Our proposals are designed to address these weaknesses in the system and enable the community to deliver consistent, high quality services for local people.

Working with the private and voluntary sector

Investment by Leagues of Friends enables the Trust to offer a full range of ENT outpatient services at five community hospitals

A partnership with BPAS has been arranged to provide a dedicated service for women. This has increased capacity in the service to develop new day case procedures and reduce waiting times.

Improved quality of services

Feedback from staff in the lead up to the publication of the NHS Plan demonstrated the high level of enthusiasm that exists in this Trust for working flexibly across the professions

Newton Abbot hospital

Facilities at Newton Abbot are fragmented across a large, steeply-sloping site, limiting effective use, disadvantaging people with disabilities, and giving rise to high running costs. Recent changes in use, in particular the demolition of the laundry, have left an unused area in the centre of the site. Of the floor area in use, 48% is in poor condition. Newton Abbot accounts for a large proportion of the backlog maintenance

This is a whole system solution for improving the quality of service in most specialties and departments within the health community.

- Teamwork is inhibited by the existing organisation of services. Changes will allow improved multidisciplinary teamwork. To support the needs of the chronic ill; diabetic, rheumatology, elderly and pain teams will be brought together to facilitate the sharing of ideas, improvement in communication and delivery of better services. This will build on the evidence base, which clinicians in South Devon have helped to create.
- Site-specific teams have already been established for the major cancer sites. New facilities will enable them to operate more effectively.
- Facilities for patient care will be better and will enable the Trust to attract and recruit high calibre staff to deliver that care.
- The integrated gastrointestinal clinic and ward will improve care for this group of patients.
- The reorganisation of chest pain services and the emergency department will enable the NSF targets to be met and support better use of staff.
- Waiting times for orthopaedic and trauma patients will be improved, minimising disability and allowing increased independence.
- A new hospital for Newton Abbot and 'nerve centre' for services in Teignbridge.

Improved environmental quality for services

The Estate review identified that (in most cases) the estate performs well, but it will not meet future requirements and there is an increasing level of backlog maintenance.

Performance of the estate

£4.48 m	(November 2000)	existing backlog maintenance
£12.0 m		projected backlog by 2010
95%		A/B physical condition
95%		energy performance
98%		fire safety compliant
82%		functionally suitable

In terms of these key estate performance indicators, the Trust is performing well, maximising use of current assets. The income to asset value ratio of 1 to 1.1 (1998/99) was equal to the upper quartile level of performance for the benchmark group.

The most concerning element is the declining functional suitability and increasing susceptibility of the estate to failure. The Estate Strategy identified that backlog maintenance will grow substantially without a significant increase in investment. But, maintenance alone will not achieve any improvement in functional suitability. Therefore, a strategic solution is sought to drive forward modernisation and ensure the continued delivery of targets.

In a number of areas in the DGH and in Newton Abbot, achieving adequate privacy to maintain personal dignity and confidentiality is a problem.

Development of existing services and provision of new services

The SOC seeks to:

- secure continuing delivery of existing services
- meet the training criteria of the Royal Colleges and allow expansion of specialist registrars in accordance with national and regional plans
- enable further innovation and development of services as requested by commissioners
- enable the demand for services to be met
- achieve the flexibility to cope with changes in demand
- therefore enabling the health community **to achieve the National Plan targets**.

Improved strategic fit of services

Implementation of the SOC will deliver an increasingly integrated service. In particular:

- substantial improvements in access to intermediate care services and development of seamless services in the community
- a well-organised ambulatory care environment that will support patient focused multidisciplinary team working
- theatre accommodation that supports an increase in outpatient and day theatre intervention and provides effective emergency and elective accommodation
- ward accommodation that meets modern privacy and infection control standards
- an integrated emergency department able to work in conjunction with community and hospital services
- improved flexibility to deal with immediate changes in demand and longer-term development of medical care.

Meeting national, regional and local policy imperatives

In recent years, service development in South Devon has been at the leading edge of achieving national and regional policy imperatives. Our proposed scheme will meet the requirements set out in the National Plan to provide a 'springboard' for further innovation and development over the next decade. The SOC is consistent with local healthcare priorities and the findings of the National Beds Inquiry.

This scheme is vital in order to achieve the Improving Working Lives initiative for our staff. We are currently negotiating to increase our staff day nursery capacity on the DGH site, after receiving feedback from staff about the importance they place on this service.

Improved training, teaching and research needs

Current facilities need to be developed to provide accommodation for in-service training and development. We intend to provide facilities in the core of the hospital to support training:

- a skills area within the main theatres for operative procedures
- skills area close to the on-call centre
- on-going education and personal development
- the development of the Peninsula Medical School.

Flexible scheduling of orthopaedic appointments, introduction of the Springback programme (for lower back pain) and the 'New Zealand' assessment system (for hip and knee referrals) have reduced over-13-week wait patients from over 600 to almost zero in less than two years

Avoiding admission

THORT (the Torbay Hospital Outreach Respiratory Team) saved over 1,000 bed days in six months and reduced readmission rates in chest patients (suffering from COPD)

Promoting independence

The crisis assessment and rapid reablement for the elderly (CARRIE) service brings together all agencies to allow patients to maintain independence and prevent admissions to hospital. CARRIE is now being used as a national model for intermediate care

Making more effective use of resources

Medium dependency patients will be able to check in to an admissions area, walk to theatre and be able to recover in wards dedicated to this type of care. More seriously ill patients will be cared for by specialist teams with the skills and facilities to care for these higher dependency patients

- It is clear that skilled staff will be the most scarce resource for the local health community. It is therefore crucial that facilities are functionally well-designed and attractive to enable recruitment and improvements in productivity to be achieved. Outline designs deliver this objective.
- The current arrangement of facilities is causing increasing loss of elective activity. The value of this loss was estimated at between £800,000 and £1,000,000 pounds per annum in 1999/00.
- Existing arrangements for elderly care make it difficult to coordinate and deliver effective packages of care with consequences for patients, carers and social care.
- Our proposals are designed to minimise these costs and achieve reductions in unit costs at the same time as enabling improvements in quality.

Torbay Hospital has developed incrementally over the past 75 years, spreading outwards (as the photo above shows). This strategic development is needed to provide a whole-systems solution and make optimum use of the existing estate for years to come.

Consequences of this SOC not being prioritised

Possible risks are:

- **Multiple system failure**
  For the last three years our model has predicted an increasing probability of 100% bed utilisation. The unplanned, random loss of activity has a serious impact on patient perception and confidence, achievement of targets, staff morale and ultimately the viability of the organisation.
- **Loss of Royal College Accreditation** for training. This is a serious risk issue and has an impact from the perspective of clinical governance and the ongoing viability of service delivery.
- **The 'do nothing'** option shows backlog maintenance increasing from £4.28 million (as at January 2000) to £12 million over a 10-year period, if current spending patterns are maintained. Increasing investment will be required to maintain existing levels of functional suitability and provide stop-gap solutions to maintain accreditation or recover from unpredictable system failure. This would **not deliver the modern and effective health service** outlined in the NHS Plan.
- We set out the steps we are taking to prepare for this major change project in section 5. Although we are aiming for long term solutions in these preparatory moves, this is not always possible and the goodwill of staff is a crucial component - maintaining this will be very challenging without a clear way forward.
- There is a narrow window to achieve the new working practices being developed in partnership with social services and local GP practices. It is probable that the tension on the system will place these partnerships under great strain if a strategic solution is not achieved.

Possible contingency plans might include:

- Separate proposals for Newton Abbot hospital, for the Diagnostic and Treatment centre and for inpatient elements of our scheme. Some benefits would be realised, but it would not provide the infrastructure necessary to meet elective and emergency inpatient targets and is likely to increase whole life costs. As the schemes would be less attractive for Public-Private Partnership funding it is also unlikely funds could be secured.
- Developing the site incrementally as opportunities and funds permit. This would not deliver targets and would be likely to lead to significantly higher whole life costs and has the potential to make large elements of the estate redundant or difficult to develop in the future as previous 'ribbon development' would have to continue.
- Ceasing provision of the full range of acute provision in Torbay and relocating services to Plymouth or Exeter. This option contradicts the strategic view of local Commissioners, is not possible without significant capital investment on both sites and would still require reorganisation of the Torbay and Newton Abbot sites. It would lead to a significant reduction in access for the majority of the South Devon population. It is unlikely that the whole life costs would be less than the selected option and informal cost benefit analysis suggests a substantial increase in cost for local people.

Section: 3

Formulation of Options

Objectives for the Estate Strategy

Prior to the publication of the National Plan, the Trust had completed a review of the estate and its suitability to deliver service objectives. We have reviewed the Estate Strategy in the context of the National Plan and changes have been incorporated in this SOC. Of particular importance are:

- The opportunity to consider a more flexible solution for the provision of services in the Newton Abbot area
- The need to accelerate improvement in women's services to achieve National Plan objectives and improve flexibility and functional suitability on the DGH site
- The opportunity to develop a viable scheme for funding through the Public - Private Partnership
- The necessity to increase capacity to meet the requirements of the National Plan
- The need to include a digitised radiology service to support the emerging service model.

These considerations do not invalidate the approach taken in developing the Estate Strategy. They do, however, change the costs and benefits that were originally estimated for each option and the revised figures are included in this document.

The in-depth analysis of our service and current estate issues, together with consideration of the wide range of potential future service scenarios considered previously, led to the development of clear objectives for change. Only those that are relevant to this SOC are included here.

Other smaller schemes have, or are expected to be, funded through specific modernisation budgets or will be undertaken using block capital allocations. The SOC therefore deals with the key community and acute requirements of the South Devon Health Community for the next ten years.

Principles

1 Overall, the Estate must be capable of accommodating considerable service change in the future. Ideally, such change should be achieved with minimal disruption to operational services.

2 Implementation of the Estate Strategy should facilitate the continuing improvement in overall operational efficiency and effectiveness of services as well as maximising the utilisation of the estate.

3 The Estate Strategy should provide sufficient flexibility to allow the later stages of implementation to be changed in terms of their size and functional content.

4 Any new buildings proposed in the Strategy should be planned and designed to ensure that they are capable of being used, wherever practical, for a range of functions. Furthermore, the buildings should be capable of accommodating major changes in use with a minimal disruption to the remainder of the hospital and at low cost.

5 The Estate Strategy should enable decisions on functional content and size of development phases to be made as near as possible to the time of implementation. Hence, minimising the potential for buildings to be 'out of date' in terms of functional content and design before construction is complete.

6 Constraints on capital and revenue funding will necessitate the Estate Strategy incorporating proposals, wherever possible, for maximising the utilisation of the existing estate and minimising the need for expensive new buildings. Similarly, capital investment should be demonstrated to provide value for money by improving efficiency and performance of services and the estate.

Service Changes

1 The re-provision of Newton Abbot Hospital in new accommodation.

2 Reconfiguration of DGH surgical inpatient accommodation to provide improved functional suitability, separation of emergency and elective activity, and a significant increase in the number of single rooms with en-suite facilities.

3 Formation of a main 'Treatment and Diagnostic Zone' within the DGH, rationalising the existing outpatient departments at Torbay Hospital, and providing new facilities at Newton Abbot.

4 Development of a Critical Care and High Dependency Unit.

5 Expansion of the existing Accident & Emergency Department at the DGH to create an integrated emergency department involving A&E, GP out of hours and emergency assessment facilities.

6 The development of two new elective Orthopaedic theatres and a replacement Trauma theatre within the main theatre suite (releasing two old theatres for alternative use).

7 The provision of an additional day case theatre.

8 Redesign of the women's unit to provide modern and efficient services.

Effect on backlog maintenance

Completion of the schemes included in the SOC will remove £5.0 million of backlog maintenance, leaving a balance of £7.0 million. This will be eliminated by 2010, provided that existing levels of investment from the Trust's block capital allocation can be maintained.

Development of Options

A large number of options were developed and explored in terms of technical feasibility, service benefits and economic viability. These options were developed with the aim of addressing the current estate issues and performance as well as delivering changes to the estate in order that it can match the future needs of the service, as identified in Service Strategies.

Inevitably with an estate as large and complex as the Trust's, there are a considerable number of options and permutations of sub-options. However, the Estate Strategy is concerned with the broad strategic options and is intended to provide a framework within which detailed business cases for particular schemes can be developed. The principal strategic options for the Estate Strategy are summarised below.

Following publication of the National Plan and the National Beds Inquiry report a number of the Estate Strategy options can be discounted. The reasons for this are set out alongside each one.

Option 0 - Do Nothing

The Trust's Strategic Direction and Service Strategies will necessitate changes to the estate in order to be able to deliver future service requirements. These changes, combined with the need to replace engineering plant and systems and to improve functional suitability, effectively eliminate this option. However it serves as a useful 'benchmark' for examining other options. In reality, this option would necessitate expenditure on maintaining the estate in an operationally safe state as well as ensuring that full operational services could be maintained. For purposes of the option appraisal, expenditure on this option has been assumed to be only that required to ensure full compliance with fire, statutory and non-statutory standards.

Option 1 – Do Minimum

This option will enable existing backlog maintenance to be eradicated and provide for the replacement of building components, engineering plant and systems at the end of their operational life. Hence, it will ensure that the existing estate is maintained in a satisfactory physical condition, energy performance and compliance with fire, statutory and non-statutory standards over the next ten years. It does not address the issue of poor functional suitability in areas of the existing estate. It does not provide for any changes to the existing estate to meet the needs of developing and changing services, or achieving the targets established in the National Plan. It can therefore be disregarded.

Option 2 – New Treatment and Diagnostic Centre, surgical accommodation and replacement of Newton Abbot

This option takes a more radical approach to developing the estate at Torbay and Newton Abbot Hospitals through a number of major capital schemes. The option can have a number of physical planning arrangements and involves numerous sub-options and consequential departmental moves. During the development of this SOC the concept has been reviewed but essentially, involves the following:

- The development of a 'diagnostic and treatment zone' for the network at the DGH. This will include the main entrance for the hospital
- A new block between the existing Tower Block and Medical Unit to house an integrated emergency assessment unit, surgical wards and a joint medical/surgical gastrointestinal unit
- Adaptation of the vacated levels of the Tower Block to accommodate the Critical Care facility, Heart and Lung outpatients, surgical ward accommodation, histopathology and clinical staff accommodation
- Alterations to the maternity unit to provide a Women's Unit with improved facilities for obstetrics and the full range of gynaecology
- Creation of a single inpatient theatre and recovery suite that will enable easy access from all ward areas
- Incorporation of a new day theatre within the expanded Day Surgery Unit
- The re-provision of Newton Abbot Hospital in newly built accommodation.

Option 3 – New Treatment and Diagnostic Centre, extension to Tower Block Wards and replacement of Newton Abbot

This option differs from Option 2 by omitting the new ward accommodation and instead, extends the existing Tower Block to provide additional space to enable 34-bedded wards with 50% single accommodation on Levels 4 to 8. The remaining capital schemes are similar to Option 2. The feasibility of this option is questionable given the high usage of the current facility and access to the site. Functional suitability is lower and the revenue costs during the construction phase and throughout the life of the scheme are estimated to be higher.

Option 4 – New Treatment and Diagnostic Centre, re-configuration of Tower Block Wards and replacement of Newton Abbot

This option takes a different approach to the provision of inpatient accommodation by reconfiguring and refurbishing the Tower Block Wards (Level 4 to 8) to provide 50% single room accommodation with en-suite facilities but without extending the building to provide additional floor space.

Hence, the scheme results in a reduction in the number of beds per floor to 18-20 beds. The overall reduction of approximately 50 beds would mean that there would need to be further significant reductions in lengths of stay, increases in day case rates and even earlier discharges to community hospitals/nursing homes. Flexibility, disruption during construction and effective use of staff are all serious risks with this option and it does not allow for the population increases projected. It is therefore considered inadequate to deliver the modern and dependable service set out in the National Plan.

Option appraisal

Options were considered by a diverse group of clinicians, managers and commissioners. The non-financial evaluation criteria are set out below together with the optimistic, consensus and pessimistic scores allocated to each option. The capital costs were calculated and the relative cost-benefit of each scheme ascertained.

Option 2 emerged as the preferred option achieving the greatest functional suitability and lowest relative cost.

As outlined above, for a complex estate several options exist. Further work has been undertaken on the preferred option to review the components of the scheme to ensure functional suitability and minimise whole life costs. The changes considered during the review of the Estate Strategy set out above, make allowance for Capital Cost Index changes (MIPS 330) and inclusion of digitalised radiology.

The effect on the option appraisal has been reviewed and it is clear that option 2 remains the preferred solution.

Table 1: Non-financial evaluation criteria and importance weighting

Criterion	'Importance weighting'
Clinical effectiveness	100
Quality of physical environment	70
Effectiveness and efficiency of services	70
Accessibility	50
Flexibility for change	75
Acceptability to patients, staff & public	60

Table 2: Non-financial option appraisal for the scheme

Weighted Benefit Score				
Option	**Optimistic**	**Consensus**	**Pessimistic**	**Revised score**
0	425	286	152	286
1	472	333	152	333
2	871	804	635	945
3	739	667	496	745
4	772	661	533	630

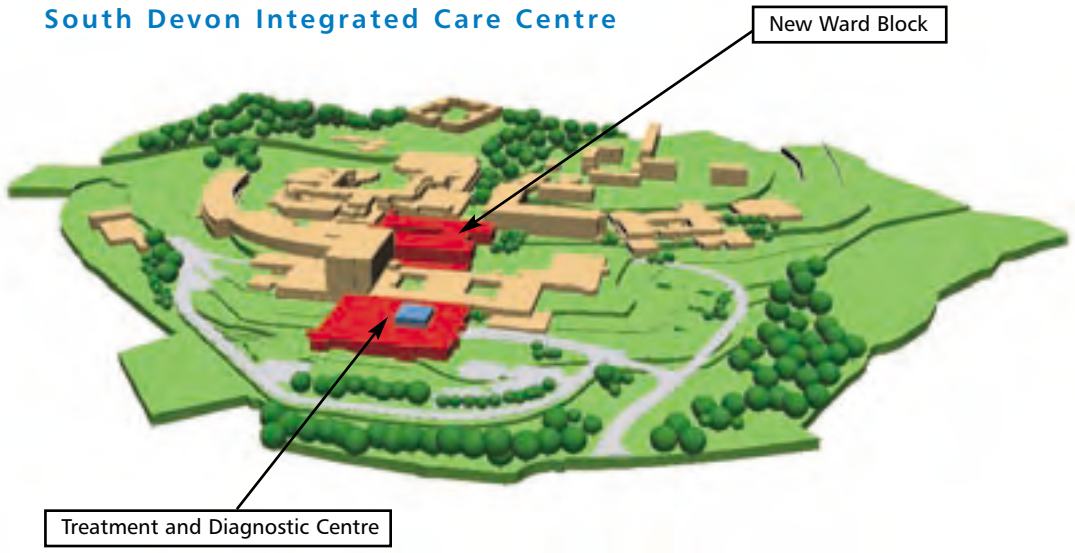
Table 3: Estimated capital costs for the options

Option	Estate Strategy Capital Cost £M	SOC Revised Capital Cost £M
0	0.9	1.0
1	12	13
2	53	64
3	52	63
4	47	58

Table 4: Ratio of non-financial benefits to capital costs of the scheme

Option	Estate Strategy Ratio of Benefits to Capital Cost	SOC Revised Ratio of Benefits to Capital Cost
0	NA	NA
1	NA	NA
2	15.2	14.8
3	12.8	11.8
4	14.1	10.9

It can be seen from the tables above that when the options were scored in the knowledge of the National Plan that Option 2 is the preferred option for further development and has consequently been used when considering the affordability ceiling. The costs of the scheme have been reviewed following outline design, review by users and costing by quantity surveyors. They are considered robust and deliverable.



The major new build (indicated in red in the plan above) provides a link between key departments and makes future strategic development possible. Services around this new 'hub' will be reconfigured to better meet the needs of patients.

One possible design option for the new look Newton Abbot hospital, which will incorporate Social Services facilities.

The current Newton Abbot Hospital dates from the nineteenth century and services are scattered across the site.

Section: 4

Affordability

South and West Devon Health Authority overview

It is vital that the cost of this scheme and the proposed Plymouth scheme sit within that which is viewed as affordable by the Health Community.

Each Trust has approached the affordability issue in a slightly different way. However, financial statements within the supporting documents have been reconciled to a financial planning framework issued by the Health Authority.

In order to fully address the current financial pressure, 2001/02 is seen as being a year of financial consolidation rather than providing significant revenue towards supporting the cost of the capital schemes. This approach does not impact on the timing of revenue requirement within the schemes.

Trust financial analysis

South Devon Healthcare Trust can demonstrate that the development is affordable.

We have looked closely at the opportunities and risks regarding our future potential income. Assumptions have been discussed in detail with our commissioners and agreement reached about likely levels of income, income growth and expenditure. These assumptions have been translated into the Trust's income and expenditure account. The assumptions are set out in detail in a comprehensive financial model supporting this SOC. Extracts from this model are set out in the tables in this section. Table 2 summarises the forecast Income and Expenditure account over a 9 year period to 2008/9.

The Trust has also examined carefully the future of its own expenditure patterns and as far as practicable has included all anticipated financial risks. All income and expenditure assumptions have been based at 2000/2001 pay and price levels except where it is expected that growth in expenditure will exceed inflation (for example, pay awards 1% greater than inflation) in accordance with the NHS Capital Investment Manual. Capital expenditure estimates have been based upon the Median Index of Public Sector Tenders level 330 for the first quarter of 2001.

The affordability calculations in this SOC look at the effect upon the entire Trust. We have looked not only at the incremental costs of the project but, more importantly, at how those incremental costs fit into the projected income and expenditure account. (Table 2).

Income

South Devon Healthcare Trust's income for patient care is currently £125 million. Income growth (in excess of inflation) has been assumed as:

Table 1

Years	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09
Percentage	5.6%	5.9%	5.7%	5.0%	5.0%	4.0%	4.0%	4.0%

Table 2 shows how these percentages have been adjusted to take into account the health economy's first calls on growth to fund such things as anticipated growth in primary care prescribing, individual patient placements and other central demands upon funds.

Expenditure

The Trust has examined its recent patterns of expenditure, its current list of cost pressures and the likely effect on costs of future developments to meet the requirements of the NHS Plan. The results of this analysis are set out in Table 5. The costs will include, in addition to anticipated service developments, such things as 1% excess inflation on pay awards, notified increases in superannuation contributions and growth in drugs costs at 8.5% above inflation. Assumptions have also been made about the net effect of: building and engineering maintenance; fuel, light, power and water; cleaning and rates for the new developments. These costs are included but with detailed workings in separate models. The net additional annual cost to the Trust of the proposed development includes the PFI unitary payment together with the net change in revenue expenses of such things as utilities, cleaning, building and engineering maintenance. This amounts to some £8 million.

Capital and PFI

We have agreed a capital affordability ceiling of £64 million and the associated revenue expenses. The affordability model assumes that the unitary payment for a PFI (Private Finance Initiative) deal will be at 11% of the capital cost of the buildings and engineering works, assuming a 30-year life of the project. The unitary payment does not include a sum for facilities management as that is left as an option to be explored in more detail in an outline business case. Table 5, showing development and other revenue cost assumptions, includes a generous allowance for support services, maintenance, utilities etc. This allowance is anticipated to be sufficient to provide resource for an increase in the unitary payment to take account of facilities management. Table 4 shows the amount of the unitary payment from 2007/08 onwards of £7.0 million per annum. This is based solely upon the capital element of the development but together with the net effect of direct revenue consequences would be some £8.0 million. The workings in Table 4 assume a continuation of expenditure of sums of money equivalent to the Trust's current capital block allocation. This is necessary to re-establish a capital base of medical equipment especially, and to catch up with backlog capital requirements.

Table 2 Income and Expenditure data

Financial years:	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Change
Anticipated growth available		4.8%	5.0%	4.7%	3.9%	3.7%	2.6%	2.5%	2.4%	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income Table 2	125.6	131.7	138.2	144.7	150.4	155.9	160.0	164.0	168.0	42.3
Base Expenditure	113.7	113.7	113.7	113.7	113.7	113.7	113.7	113.7	113.7	0.0
Capital Charges/PFI Table 3	11.9	11.8	12.2	14.6	17.3	18.0	18.1	18.1	18.1	6.2
Other revenue costs Table 4	0.0	6.1	12.3	16.3	19.4	24.2	28.2	32.2	36.2	36.2
Total Expenditure	125.6	131.7	138.3	144.7	150.4	155.9	160.0	164.0	168.0	42.3
Surplus, -Deficit	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

Table 3 Income assumptions

Financial years:	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09
Anticipated growth *Note 1*		5.6%	5.9%	5.7%	5.0%	5.0%	4.0%	4.0%	4.0%
Less, Primary Care *Note 2*		0.8%	0.9%	1.0%	1.1%	1.3%	1.4%	1.5%	1.6%
Anticipated growth available		4.8%	5.0%	4.7%	3.9%	3.7%	2.6%	2.5%	2.4%
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Income	124,128	125,628	131,658	138,241	144,738	150,383	155,947	160,002	164,002
Growth	1,500	6,030	6,583	6,497	5,645	5,564	4,055	4,000	3,936
Income	125,628	131,658	138,241	144,738	150,383	155,947	160,002	164,002	167,938

Note 1
This is the estimated growth (excluding inflation) in income that will be available to the South & West Devon health community.

Note 2
This is the reduction in the growth available to the Trust as a result of the estimated requirements by the Community to fund increases in e.g. primary care prescribing.

Table 4 Capital and PFI assumptions

Financial years:	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Current Plans	3,332	2,776	2,642						
Vehicle replacement				80	88	97	106	117	129
Energy conservation				150	150	150	150	150	150
Backlog Maintenance				550	550	550	550	550	550
Medical equipment				1,100	1,210	1,331	1,464	1,611	1,772
Works R & R				350	350	350	350	350	350
Other block				500	500	500	500	500	500
DDA		250	250	250					
EPR & ongoing IT			500	1,500	600	720	864	1,037	1,244
Cancer Services	5	1,177	1,535	124					
Totals	3,337	4,203	4,927	4,604	3,448	3,698	3,985	4,314	4,695
Calculation of Cap Chgs & PFI									
Opening NBV	104,711	102,646	101,506	101,112	100,430	98,684	97,263	96,185	95,474
Additions	3,337	4,203	4,927	4,604	3,448	3,698	3,985	4,314	4,695
	108,048	106,849	106,433	105,716	103,878	102,382	101,247	100,499	100,169
Depreciation (Avg) 5%	5,402	5,342	5,322	5,286	5,194	5,119	5,062	5,025	5,008
Closing NBV	102,646	101,506	101,112	100,430	98,684	97,263	96,185	95,474	95,160
I&E effect									
Unitary payment *Note 1*		91	468	2,979	5,834	6,762	6,981	7,032	7,032
Interest 6%	6,483	6,411	6,386	6,343	6,233	6,143	6,075	6,030	6,010
Depreciation	5,402	5,342	5,322	5,286	5,194	5,119	5,062	5,025	5,008
Charge to I&E	11,885	11,844	12,176	14,608	17,261	18,024	18,118	18,087	18,050

Note 1 *Unitary Payment for the major scheme is based upon capital expenditure (in addition to the plans above) over each year as follows:*

Capital programme	826	3,433	22,827	25,953	8,432	1,994	461

Totalling £64 million. Increments have been assumed each year for the unitary payment as this will be the most likely impact of a staged development.

Table 5 Developments and other revenue cost assumptions

Financial years:	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Additional Consultant Medical Staff	400	1,166	1,931	2,697	3,463	4,228	5,494	6,125
Additional Nursing Staff	150	447	744	1,041	1,338	1,634	1,931	2,375
Additional Therapists (Physio, OT etc.)	75	94	188	281	375	469	563	750
Pay in excess of inflation	900	1,800	2,715	3,650	4,606	5,583	6,581	7,600
Hospital Cleaning	60	129	135	142	149	157	165	173
National Menu	22	43	45	47	50	52	55	58
Information Technology	200	1,000	1,075	1,183	1,301	1,431	1,574	1,731
Drug Therapy Growth	298	595	918	1,266	1,641	2,046	2,483	2,955
Clinical Staff training	60	120	150	158	165	174	182	191
Continuing Professional Development	250	600	630	662	695	729	766	804
Intermediate Care	500	1,500	2,200	2,500	2,500	2,500	2,500	2,500
Statutory Requirements	790	829	868	902	936	960	984	1,008
Non-pay Growth/Development	100	130	169	220	286	371	483	627
Hotel services/Domestic Services	50	65	85	110	143	186	241	314
Other Support Services and Maintenance	80	800	1,200	1,200	2,400	2,800	3,000	3,200
Other Revenue Costs Contingency	80	500	600	600	1,400	2,100	2,400	3,000
Cancer Services Development	62	411	573	573	573	573	573	573
Modernisation schemes:								
Action on Cataracts	50	150	150	150	150	150	150	150
Critical care	250	250	250	250	250	250	250	250
Chest Pain Unit	175	175	175	175	175	175	175	175
Superannuation Employer's contr. incr.	1,515	1,530	1,545	1,560	1,576	1,592	1,607	1,623
Totals	6,066	12,334	16,346	19,366	24,170	28,160	32,156	36,182

Section: 5

Timetable and deliverability

Preparing for modernisation

Clearly, redevelopment of a DGH site has the potential for major disruption to service delivery. We have started to manage this risk through a strategic approach to bidding for modernisation funds and other discretionary capital. Our intention is to minimise the risk of waiting time escalation and service failure during the construction phase. This is being achieved by:

- Continuing pre-construction reduction in waiting times and numbers using non-recurring (and unsustainable) approaches
- Development of the 'Action on Cataracts' scheme which releases an inpatient theatre for use during the construction phase
- Development of Critical Care and Chest Pain Unit services to allow continuing service provision during the construction phase
- Building further capacity for the emergency department over and above that already achieved through the A&E modernisation programme
- Introduction of booked admissions
- Expansion of re-ablement to maximise the capacity of community and intermediate care services during the transitional phase
- Ongoing Clinician-Clinician service review and development.

Careful consideration will be given to the construction schedule to further minimise risks. It must be emphasised that these interim arrangements will only be effective over the expected period of construction during which time there will be an increasing risk of service breakdown.

We have agreed with partners to establish a Service Development Plan from 2001/02 that supports the implementation of this project. Decisions will be taken that are consistent with:

- Achieving National Plan objectives
- Improving health and health services for the local population
- Delivering this project.

We expect that a number of non-recurring investments will be made and this will include work with local private sector providers as far as their limited capacity allows.

Site availability

The DGH site is owned by the Trust and outline plans have met with approval from planners.

Following discussions with Teignbridge District Council, a number of sites in Newton Abbot available for redevelopment have been identified. Provision of a new hospital fits in with wider plans for the town and our proposals are being supported. Detailed work is underway on the preferred site.

On both the DGH and Newton Abbot sites, the possibility for integrated transport solutions are being considered. In recent years a number of jointly developed and successful schemes have been initiated and it has been agreed that these will continue to be expanded if this SOC is successful.

The Trust has successfully bid in partnership with Torbay Council for funding for a CCTV hospital security scheme and also to the DETR for Rural Bus Challenge money to establish a new bus route serving Torbay Hospital

Timetable

The project outline is set out below and assumes a late 4th wave or early 5th wave start. The following key programme dates are based on SOC approval being received by February 28, 2001:

● Outline Business Case	Approval	30.11.01
● OJEC Procedures	Start	07.01.02
	Finish	22.03.02
● Full Business Case	Approval	04.07.03
● Financial Close		24.10.03
● Major Construction	Commences	12.01.04
a) Outpatient Block	Complete	07.01.05
b) Ward Block	Complete	27.05.05
c) Newton Abbot hospital	Complete	23.12.05
d) Women's Services	Complete	08.08.07
● Construction	Complete	05.09.07

The Health Community expects to continue development of the OBC (Outline Business Case) at risk during the period of assessment by CPAG. Assuming the average time periods set out in guidance to advertise and negotiate contracts, the construction phase should be substantially complete by the end of 2005/6.

Project Management

Detailed arrangements are under consideration and will include a Health Community Project Board, a Project Director with direct input to the Trust Board and a dedicated team. Advice from Trusts currently implementing schemes is being sought.

Public-Private partnership

The Trust has experience of delivering a successful Public-Private Partnership scheme and is keen to grasp the opportunities of this approach to secure improvements in healthcare for the local population as soon as possible.

The potential for public-private partnership has been informally tested with the market. Early indications suggest the scheme will be attractive and a number of proposed solutions have been suggested. Contractual risk and uncertainty can be minimised by a solution that includes a small percentage of public sector capital to properly define the interface between public and private elements of the estate, and this has been accepted in principle by the Regional Office.

Conclusions

This scheme will deliver substantial improvements in healthcare for the population of South Devon and enable the ambitious targets set out in the National Plan to be met. It is supportive of other developments within the peninsula and provides an affordable solution that local partners are able to support.

Signatories to the Scheme

South Devon Healthcare Trust
Chairman
Mr D Hudson

South Hams and West Devon Primary Care Trust
Executive Committee Chairman
Dr G Lockerbie

Teignbridge Primary Care Group
Chairman
Dr N D'Arcy

Torbay Primary Care Trust
Chairman
Mr M Wickens

Devon Social Services
Director of Social Services
Mr D Johnstone

Teignbridge District Council
Chief Executive
Mr H Davis

Torbay Council
Leader of the Council
Mr R Cuming

South and West Devon Health Authority
Chairman
Mrs J Leverton

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