Children's inpatients FBC Lanesborough Level 5 development Response to Queries November 2014

1 Introduction

Discussions during November 2014 at EMT, BCAG and informally with non-executives produced a number of queries relating to the full business case for the development of inpatient facilities on the fifth floor of the Lanesborough Wing.

For each query we have responded with a statement of the extent to which the query can be answered, or if there is an outstanding risk, the steps which are being taken to mitigate it. These principally relate to the considered risks to the scheme itself and the programme.

The full business case is based on clinical need and is financially well founded. There are three key outstanding risks for which plans are in place to ensure they are resolved in time to enable the case to move forward in the intended timescale.

2 Does the design have enough beds for future demand?

There are enough beds for immediate needs and projected growth but the scheme does not cater for major reconfiguration.

2.1 Why does the development need so much space?

The maximum number of beds that is consistent with modern standards for space and functional content has been planned for the floor. The key issues in driving up the overall space requirement are the need for single rooms (50% specified as a mandatory minimum by DH), the greater spaces between beds in multi-bed rooms (to reduce cross-infection) and the need for en-suite sanitation in all patient bed rooms. This typically entails at least 50% more space than outdated 1960s-1970s designs such as the Lanesborough, which combined with 20% more beds means a 180% increase in space for beds.

2.2 Could additional beds be created if necessary?

Now that the design is effectively locked down, any changes of this nature should wait until the P21+ contract is complete. There are a number of "non-clinical" rooms on the main wards (with proximity to medical gases etc.) which theoretically could be pressed into use as additional bed rooms, including:

- Parents' lounges
- Offices, including multi-disciplinary team (MDT) office
- Shared play and recreation rooms
- Seminar
- Staff rest
- Staff change
- Equipment stores

However, it should be stressed that seminar rooms are essential for accreditation of training courses, and play, teaching and parents' facilities are required for quality accreditation.

There are other, more clinically orientated areas such as treatment rooms and clean / dirty utilities which could possibly be utilised. Lastly there are areas in the central corridor, such as school room, bed store, kitchens, therapy room and equipment stores, although it is unclear whether any piped gas is available[1].

The financial costs would be based on:

[1] In practical terms, a number of areas might be suitable:
- SH-04/05, U1-42 (assisted WC, parents lounge, office) – for a single type A room with en suite
- SH-19/20, U2-22 (assisted WC, parents lounge, office) – for a single type A room with en suite
- SH-23 (Shared play area) for a single type B room with en suite
- SH-01 (Shared play area) for a single type B room with en suite
- ST-01/02/03/04, U4-01 (staff rest, seminar, MDT and multi-use offices, recreation room) for three bed bay and 2 type A single rooms with en suite

- Design costs
- Reconfiguring partition walls
- Rerouting services including medical gases
- Installing bed head equipment and services
- Additional bed-side equipment as necessary
- Modifications to mitigate loss of space for other functions

2.3 What is the knock in effect of carving out more beds space?

The impact of taking these areas would be to reduce those benefits that the scheme is expressly intended to address:

- Reduced clinical efficiency (eg staff having to walk further to get to utility areas, using central change and rest facilities etc)
- Reduced patient and parent experience
- Reduced teaching and training (and possibly threat if seminar room is removed as this is one of those touchstone issues for accreditation)
- And to reduce the flexibility of the building for future extension under the SOC (if the Staff area is taken, which is the point at which a new build might join on)

The benefit would be to create 8-10 beds for additional patient care

3 Demand & activity – how might demand change?

3.1 What happens if oncology increases rapidly?

Oncology demand is unlikely to increase at a rate that cannot be handled within the planned facility.

A significant reconfiguration of paediatric oncology in South West London has been mooted for some years, without results, and without any prospect of reaching a conclusion in the near future. It was therefore considered imprudent to plan for this potential requirement, given the uncertainty of the outcome. However, it would be possible to expand the number of beds available for oncology, albeit at the expense of other sources of demand such as trauma, or general elective activity. Dr Jonathan Round has set out the Trust's position on this:

3.1.1 Primary Treatment Centre (PTC)

St George's is a joint PTC with the Royal Marsden. The current proposals are to increase medical PTC patients from 4 to 6. This will be absorbed within the pre-scheme bed-stock.

The SCN review is due to report early 2015, making it the third review in 6 years. It may make one of just four recommendations

- Status quo

- Relocation from Royal Marsden to St George's
- Relocation to Evelina Children's Hospital at St Thomas'
- Shutting the PTC in South London.

RMH will probably oppose the last three, but are likely to prefer Evelina to St George's if forced to relocate. It is therefore highly unlikely that there will be a large increase in PTC patients after this process, although possible that St George's PTC patients relocate to ECH as part of a larger reconfiguration. This would represent a loss of 6 beds.

3.1.2 Paediatric Oncology Shared Care Unit (POSCU)

The intention is to increase POSCU grading from level 1 to level 2 and maybe 3. Level 2 entails DC and OP work. At level 3 in patients would be seen for overnight chemotherapy. This may require two additional inpatient beds.

POSCU may also increase activity if POSCUs in neighbouring hospitals (Kingston, Epsom & St Helier, and Croydon) close. Each POSCU may have 1-3 patients in at each time. It is uncertain whether patients displaced by a closing POSCU would come to St George's. Nor is it clear that anything will happen unless forced by commissioners. Two extra beds for might be required for each POSCU that closes.

3.1.3 Bringing SGH patients together

The plan is that all oncology patients in St George's should be looked after in the same ward area. This particularly applies to patients undergoing large resections or insertion of lines. The rationale for this is to reduce handover steps, and to limit the number of places a family will have to go. This will not affect overall numbers.

3.2 Other sector wide changes

The BSBV process (now concluded) recommended moving to two or three sites across South West, which would entail a requirement for some 25 additional beds. The debate about these conclusions is being continued under the auspices of the South West London Collaborative Commissioning initiative. However, the actual requirement and the timescale are both unclear at this point, and there is no firm date for resolution or decision. Given the undoubted need to reconfigure children's inpatient service across the sector, it is considered likely to happen at some point. The SOC process has actively considered the need for additional children's inpatient accommodation and this will be the preferred route to satisfy this demand.

3.3 Is there any other non-inpatient activity associated with the case?

The expansion of elective inpatient surgery will also entail outpatient activity.

This has been conservatively estimated at 1 outpatient attendance for each admission. This can be accommodated within the existing facilities and will generate a financial contribution of some £75,000 per annum.

Baseline growth

Specialty	Cases	Income	Margin	Contribution	Cost
Surgical	367	55,000	40%	22,000	33,000
Medical	183	27,500	23%	6,325	21,175
Total	**550**	**82,500**		**28,325**	**54,175**

Catchment capture

Specialty	Cases	Income	Margin	Contribution	Contribution
Surgical	600	90,000	40%	36,000	54,000
Medical	300	45,000	23%	10,350	34,650
Total	**900**	**135,000**		**46,350**	**88,650**
		217,500		**74,675**	**142,825**

Income per case **150.0**

Timing

Element	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Profile	0%	0%	0%	75%	100%	100%
Income	-	-	-	163,125	217,500	217,500
Cost	-	-	-	107,119	142,825	142,825

4 Are the market share assumptions robust and what risk is there that it will not materialise?

The market share assumptions are based on existing trends and are robust.

4.1 Growth Assumptions

The growth assumptions have two principal components:

- Baseline growth at 1.8% for electives as per SW London sector wide assumptions
- Growth from greater catchment penetration (ie repatriation of workload going elsewhere. This has been assumed at 3% per annum.

Combined, these represent approximately 5% per annum, which equates to the average actual growth experienced in paediatric elective inpatient admissions in the past four years. Therefore the overall level of growth is not unrealistic.

4.2 What growth can be expected from greater catchment "recapture"

The implications of catchment "recapture" has been examined in the light of the information available from the Dr Foster data base[2]. This analyses the current referral patterns from individual GP practices. This level of analysis has been instrumental in targeting practices in Balham and South West Lambeth in the past year. This, combined with courtesy calls from SGH consultants to the GPs, has resulted in a more than doubling of referrals from target practices.

A 3% year on year growth from catchment recapture would result in a shift of SGH's overall market share for the core commissioners[3] from 16% to 21% by 2012. This represents an additional 180 cases each year, or a 1.5% annual reduction for the market share of the Trust's neighbouring hospitals[4].

The trust has researched the current referral patterns of local GPs. Annually, around 13,800 referrals are made to hospitals from local GPs. Our share of that varies from GP to GP currently, as does the percentage of share we wish to increase by.

For instance, in Lambeth we expect to grow our market share – which is small compared to Chelsea & Westminster and Guy's & St Thomas from 7% to 8%. In case numbers this equates to moving from 282 to 332. We would expect this to come from market share currently going north of the river.

In Croydon, we are aiming for a 2% rise in market share – an extra 100 cases, taking our number to 988. This market share is likely to be cases currently going to St Helier. A 4% rise is hoped for in Sutton and Merton who are by far the largest referrers for children's services on our patch. We want to see our numbers rise from 24% of our market share of their referrals to 28% - an increase of 250 cases.

In Richmond and Twickenham we are aiming for a 6% increase in our share of the referrals. However, the overall referrals total 1,155, so a movement from 10% to 16% of our share equates to 100 cases. Our most ambitious plans in both numbers and percentage gain are focused on Wandsworth. Our market share is currently 46% of their 2,594 referrals. We aim to in increase this by 12%, which would see our case numbers rise from 1,503 to 1,903.

4.3 How can an increase in market share be achieved?

Better use of the Dr Foster (a healthcare data package) will allow the trust to track its own referrals and those of our local commissioners.

Clinicians are committed to adapting current job plans so that the planned increase can be accommodated. This also fits in with a trust-wide move towards a seven day service as well as supporting recommended consultant cover levels set out in the London Quality Standards. The flexibility on offer allows the trust to offer more services which will be attractive to families, such as outreach clinics. These are already happening in paediatric surgery. Additional services would not all be based at the St George's Hospital site, there are plans to offer more clinics at St John's Therapy Centre, Queen Mary's Hospital and local health clinics.

[2] See appendix "Catchment Recapture"
[3] Wandsworth, Sutton & Merton, Kingston, Croydon, Richmond & Twickenham, Lambeth, Surrey
[4] Kingston, Epsom & Saint Helier, Croydon, Kings, Chelsea &Westminster

4.4 What happens if growth does not materialise?

Our growth plans are modest at 5% and we have every reason to expect that the continued natural growth, coupled with excitement about our plans will deliver the numbers we aspire to achieve.

The trust is aware that it is not enough to create a fantastic environment and develop new services – we need to tell our local GPs that this is what we are doing. The trust has recently appointed a Primary Care Liaison Manager and is soon to increase its marketing resource. Added to this, the incoming Director of Strategy has a wealth of commercial expertise which will help the trust achieve its activity plans. These skills and resource will help the trust build on its already good reputation for children's services and overall quality of care.

Marketing will take place through engagement events, educational talks and active marketing of our new facility. Also we will increase our outreach clinics to places like Queen Mary's Roehampton, St Johns in Battersea and other locations to increase the awareness of the service by referring GPs.

A marketing and communications campaign would:

- Begin with assessment of referral patterns
- Seek to understand why these are as they are
- Promote the range and quality of what we offer
- Make communication easy and effective between consultants and GPs and enable more face-to-fact contact

A full marketing plan will be developed before the new facility is available, and may include the following target groups:

- Core practices in the immediate area that refer a small number of cases elsewhere – with the intention of cementing existing referral patterns
- Core practices in the immediate area that refer a significant number of cases elsewhere – with the intention of diverting flows towards SGH
- Outer practices with existing referral patterns to SGH – to strengthen relationships and increase referrals inwards
- Peripheral practices – to ensure specialist referrals are routed to SGH rather than another tertiary centre

The plan will utilise the data available based on GP practices and specialty level data, so enable specific practices to be targeted by specific clinicians.

4.5 Are we investing in higher margin activity?

The under-19 services within the trust make a positive contribution to finances.

The specific paediatric specialty areas where growth is anticipated generate positive margins[5]:

Specialty	CC	DC	EL	EM	OP
Paediatric Medicine		80%	18%	-27%	23%
Paediatric Oncology				-42%	
Paediatric Surgery		51%	24%	23%	40%
Paediatric ITU	34%			40%	

In addition, other specialties contribute positively for the most part:

- Enhanced Care – positive margin on bed day rate
- Neurosurgery – positive margin for EL NE & DC work
- Paediatric trauma – unable to confirm position in PLICS at this point though the trend suggests that under-19 generate a surplus in each point of delivery

The non-elective medical and oncology services show a negative contribution which is in part due to the pressure on the tariff and the cap on fully reimbursed activity.

5 Will there be sufficient theatre capacity for the anticipated increase in paediatric surgery?

Yes - with 600 additional surgical cases from increased market share, would each year generate some 10 additional cases per month or 2-3 per week. This can be accommodated within the existing theatre schedule because:

- The planned all-day emergency (CEPOD) list for children will remove the need to use elective theatre sessions for emergency operations enabling better scheduling of cases and fewer delays and cancellations.
- More efficient use of elective lists with extended lists and the gradual introduction of Saturday lists.

Any premium costs of additional surgery outside normal hours are covered in business case.

6 Gynaecology – will there be sufficient theatre capacity for the transfer from Level 5 theatres

This is a critical issue and we are planning to resolve this by the end of December 2014. The Theatre Capacity Model is routinely updated and will be revised to accommodate the 5 gynaecology sessions currently carried out on the fifth floor of Lanesborough.

[5] CC= critical care, DC = day case, EL = elective inpatient, EM = emergency inpatient, OP = outpatient

7 How have building costs changed since OBC?

The cost plan has risen from £20m at OBC to £23.8m at FBC. The major changes are tabulated below:

Element	£000	Includes element of:
Pods	(864)	
Lift	(592)	
Theatres	(660)	
Omitted	**(2,116)**	
Windows (to fill pod frontages)	228	Backlog, HTMs & firecode
Cooling (as result of pod omission)	452	Backlog, HTMs & firecode
Plant screening	151	Whole building benefit
Electrical infastructure	433	Whole building benefit
Medical gas supply	239	Whole building benefit
Water supply	239	Whole building benefit
Heating	373	Whole building benefit
Control systems	414	Whole building benefit
Fibre optic cabling	43	
Equipment & furniture	541	Enhanced design
Building alterations	166	Enhanced design
Wow design	140	Enhanced design
Design fees	370	
Trust costs	99	
Inflation	2,058	
Added	**5,946**	**Added**
Total movement	**3,830**	

There are several reasons for this, discussed briefly below.

7.1 Inflation

Inflation in the building sector, according to the Building Cost Information Service of the Royal Institution of Chartered Surveyors has been running at an annual rate of over 5% since 2012, indicating a 10% overall rise in costs. On a £20m cost base, this alone accounts for some £2m of additional cost.

7.2 Whole building engineering elements

Several items have been added to the scheme to reflect the need to address issues with the whole building such as:

- Electrical supply

- Hot and cold water systems
- Heating systems
- Engineering controls
- Stairwells

These have been included where the additional cost is justified because of the need for investment for the rest of the wing, and where the timing is opportune. It may relate to:

- increasing the capacity of the whole building
- remedial works that only make sense at a whole building level
- additional plant/engineering that has a duel effect (ie necessary of level 5 but also helps reduce the load elsewhere)

7.3 Backlog maintenance

The OBC had an allowance for £3.9m of backlog maintenance in the £20m figure. This has been updated to allow for other elements of backlog that have been incorporated into the current iteration of the design. The backlog element of works now totals £6.05m, including inflation and VAT as set out below:

Element	2015/6	2016/7	2017/8	Total
	£000	£000	£000	£000
Internal fabric	134	252	29	415
Engineering – water	1	1	0	2
Engineering – heating	0	0	0	0
Engineering – electrical	38	56	9	104
Roofs	0	0	0	0
Ventilation and air conditioning	311	1,349	11	1,671
Fire systems	113	167	27	308
Windows	404	598	98	1,100
Other	0	0	0	0
Total	**1,001**	**2,424**	**174**	**3,599**
Fees - 15%	150	364	26	540
Contingency - 10%	100	242	17	360
Inflation - 5% (to 2010)	63	152	11	225
VAT -20% (not on fees)	233	564	40	837
Subtotal	**1,547**	**3,745**	**269**	**5,561**
Subsequent inflation	137	332	24	492
(PUBSEC 192 to 209 3Q15)				
TOTAL	**1,684**	**4,077**	**292**	**6,053**

7.4 Enhanced design

Design standards have been deliberately set high with the expectation that the project will be a stand-out design that will act as a reference for other hospital developments. However this does come at a price, for a number of reasons:

- The designers have striven for maximum compliance with the most recent design and building guidance as expressed in Health Building Notes and Health Technical Memoranda.
- Furnishings and finishes have been enhanced with a view to creating an excellent ambience, particularly given the varying and special needs of the client group, as well as first class clinical space.
- Artwork

The estimated additional cost of the enhanced design is £1.05m, tabulated below:

Enhanced Design	£000
Enhanced finishes details	278
Equipment including modular furniture (details not known at OBC)	514
Provision for implications of Artinsite design	141
Enhanced doors - estimate	120
Total	**1,053**

7.5 Contingency

The cost plan currently has a contingency sum of just under £2m.

The P21+ contract will contain a shared, costed risk pool to deal with emergent risks during the course of the project. If the identified risks are not realised, the pool will be shared between PSCP and Trust.

8 How will the development be funded?

The funding plan is tabulated below

Element	2014/15	2015/16	2016/17	2017/18	Total
Total capital requirement	550	11,700	10,100	1,450	**23,800**
funded from:					**-**
Internal capital	550				**550**
Charity donations		1,000	1,000		**2,000**
Backlog maintenance funds		1,684	4,077	292	**6,053**
Loans		9,016	5,023	1,158	**15,197**
Total	**550**	**11,700**	**10,100**	**1,450**	**23,800**

8.1 Borrowing

The borrowing requirement has been estimated at £15.2m. This will be sourced from the Foundation Trust Finance Facility. At the prevailing rate of 2.5% (plus 0.5% buffer for potential rises before the loan application is processed) this entails a composite average charge of some £875,000 per annum.

Interest + principal	Annual	Quarterly
Principal	15,197	15,197
Interest	3.00%	0.74%
Periods	25	100
Payment	873	216

The costs will actually be based on a fixed repayment of principal, with a declining interest charge. Repayments of principal will only start once all the capital has been drawn down. This produces the following cost profile:

Element	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Repayments	0	0	0	(453)	(604)	(604)
Interest	0	(167)	(360)	(444)	(426)	(408)
Combined	**0**	**(167)**	**(360)**	**(897)**	**(1,030)**	**(1,012)**

This still leaves the scheme in financial surplus after 2 years. The loan application process will commence on approval of the FBC

8.2 Backlog maintenance

The backlog maintenance element is estimated at £6.05m, which will be met from within the backlog maintenance budget over 3 years.

8.3 Charitable funding

The Trustees have now committed to a target figure in the region of £2m for the Level 5 scheme.

9 Will Dalby Ward be vacated in time?

This is a key issue for the programme and a plan is being developed to address this by the end of December 2014

A detailed Bed Capacity Model is in use for the Trust and undergoes routine revisions. The space originally earmarked for Dalby patients has now been assigned for Oncology, and the current iteration of the plan is being reworked to identify the beds required to relocate patients from Dalby by June 2015.

There are several potential sources of additional beds, which will be thoroughly investigated in the next two months to firm up the plan for Dalby by the time the GMP has been agreed:

1. Review current bed-stock for productivity and length of stay assumptions to ascertain whether Dalby patients can be accommodated within existing numbers
2. Continue Nightingale nursing home off-site capacity beyond scheduled closure date in March 2015
3. Open 13 bed unit at Queen Mary's Hospital in Roehampton
4. Develop virtual ward at home service

A plan will be finalised by the end of December 2014 to determine with option, or combination of options, to pursue.

10 Will Moorfields be able to vacate Level 5 in time?

This is another key issue, and a business plan to resolve this will be developed by the end of December 2014.

While the primary plan for Moorfields is to move to new theatres on Level One and eventually to a new build elsewhere on site, the interim position is to create space within the Theatre Capacity Model, possibly through flexible working hours that may involve evening and weekend operating.

10.1 Long term plan

Moorfields has long been lobbying the Trust to provide new and integrated accommodation for the entirety of its clinical work on the St George's site. The Development Control Plan identifies the Stage II development on the Blackshaw Rd frontage as the most likely location for a new build. This may be stand-alone, or physically linked to or integral with the planned renal and private patient developments in that zone. This will provide Moorfields with the accommodation it needs for the foreseeable future. The timescale for this is 3-5 years, and will not come on-stream in time to facilitate the Fifth Floor scheme (mid 2016), necessitating an interim solution.

In the meantime Stage I would entail the construction of new outpatient facilities on the south end of the site, which might house the outpatients service.

10.2 Medium Term Plan

The medium term plan is to provide theatre space for Moorfields on Level 1 of Lanesborough. This development will also include additional theatres for the Trust's own use. The rationale for this is three-fold:

- The DCP has identified Level 1 as the "hot" level for all clinical buildings on the site. The DCP envisages the long term development and integration of this level across the site to create an integrated intervention platform with theatres, intensive care, interventional and high-technology diagnostics. The development of additional theatres on Lanesborough Level 1 is in line with this longer term objective.

- The ongoing Strategic Outline Case planning effort to determine the future of children's and women's the Lanesborough Wing has identified the need for additional theatre space for children's surgery, gynaecology and obstetrics, to complement the exising theatres on Level 1. The redevelopment of Level 1 would require 4-6 new theatres to accommodate the anticipated growth in demand and new working patterns such as the introduction of a dedicated emergency (CEPOD) theatre for children. The development of additional theatres on Lanesborough Level 1 is also in line with this longer term objective.
- Moorfields has identified the need for 3 rising to 6 theatres. The development of new theatres on Level 1 is therefore in line with their longer term objective.

The details of the arrangements with Moorfields are yet to be agreed, but in principle this could be achieved by mid-2016 and thus enable the Level 5 scheme to go ahead. Moorfields have also asked for the theatres to be integrated with outpatients, day case places (beds/recliners) and very occasional overnight beds. The outpatients will be accommodated elsewhere for the time being until the long term solution is available, either in their current location (Lanesborough Level 0) or in the outpatients facility in the DCP Stage 1 development.

10.3 Contingency plan

Whilst every effort is being made to accommodate Moorfields' stated requirements, it is conceivable the neither the longer term solution nor the interim plan are agreed, or agreed in time. In this case the Trust has the option to terminate Moorfields' tenancy, which is of an informal nature. Whilst undesirable for a number of other reasons, not least longer journeys for Moorfields' patient, this would have the effect of clearing the site on Level 5 in the required timescale. The eye service could be provided by other NHS Trusts, and the potential providers will be investigated.

It may be possible to accommodate a limited number of Moorfields operating sessions within the Theatres Capacity Plan.

11 What are the key events from this point?

The key events leading up to and including construction are shown below.

Theme	Task	2014/15				2015/16				2016/17				2017/18			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Dalby Ward																	
	Bed capacity planning			■													
	Bed capacity developments associated with Dalby				■	■											
	Dalby closes						◆										
Moorfields theatres																	
	Negotiation with Moorfields			■													
	Business case			■													
	TDA approval				■												
	GMP development				■	■											
	Loan application					■											
	Close staff restaurant						◆										
	Construction						■	■	■	■	■						
	Theatres available										◆						
Gynaecology theatres																	
	Revision of the Theatre Capacity Model			■													
	Development of operational plan to relocate sessions			■													
	Move sessions to new locations				■	■	■	■	■	■	■						
	Theatres available										◆						
Level 5																	
	Business case	■	■	■													
	TDA approval			■	■												
	GMP development				■												
	Loan application				■												
	Mobilisation					■											
	Construction						■	■	■	■	■	■	■	■	■		
	Facility in use														◆		

11.1 Dependencies

The two main dependencies are:

1. Dalby Ward must be vacated by June 2015 to enable the first phase of the construction programme to commence
2. Moorfields Ward must be vacated by late 2016 to enable the final phase of the construction programme to commence

Separate plans are being developed to assure the delivery of these elements.

12 What are the main risks and how are they being mitigated?

Three issues must be resolved for the case to proceed.

1. **Dalby**. The vacation of Dalby Ward is essential for the construction programme to begin, as this provides decant space to enable work to start in the existing children's wards. A plan to vacate the ward by the summer of 2015 is being developed and will be agreed by the end of **December 2014**, leaving six months for implementation.
2. **Gynaecology theatres.** A new home for gynaecology theatre sessions is required to enable the theatres on Level 5 to be vacated in late 2016. A plan to facilitate this will be agreed by the end of **December 2014**, leaving eighteen months for implementation.
3. **Moorfields theatres.** A new home for Moorfields theatre sessions is required to enable the theatres on Level 5 to be vacated in late 2016. A business case to facilitate this will be agreed by the end of **December 2014**, with a fully priced GMP under the P12+ procurement arrangements by mid 2015, leaving twelve months for implementation.

The business case contains a summary of these and other risks to the programme. The steering group maintains structured risk log that is scrutinised on a monthly basis to establish or chase mitigating actions, assess the risk level and escalate where appropriate. This has been updated to reflect the risk of not achieving the anticipated growth from catchment. The P21+ contract contains a shared risk pool to deal with emergent risks during the course of the project. If the identified risks are not realised, the pool will be shared between PSCP and Trust

13 Will TDA scrutiny be required?

If FT status is granted TDA approval will not be required for the FBC, although the TDA will have a say in the loan application

The business case has been prepared for in internal audience but can be reframed to include elements that the TDA will require at relatively short notice. The principal elements that would be added are:

- The full option appraisal as described in the OBC and omitted in the FBC for brevity
- The financial baseline for the financial and economic appraisal
- The TDA checklist – referencing the elements that address key TDA lines of inquiry

The timescale for resolution of the key risks includes an estimate of the elapsed time for TDA approval.

Appendix 1 - CATCHMENT RECAPTURE

Analysis by Commissioning Area

1. Commissioning area: Wandsworth

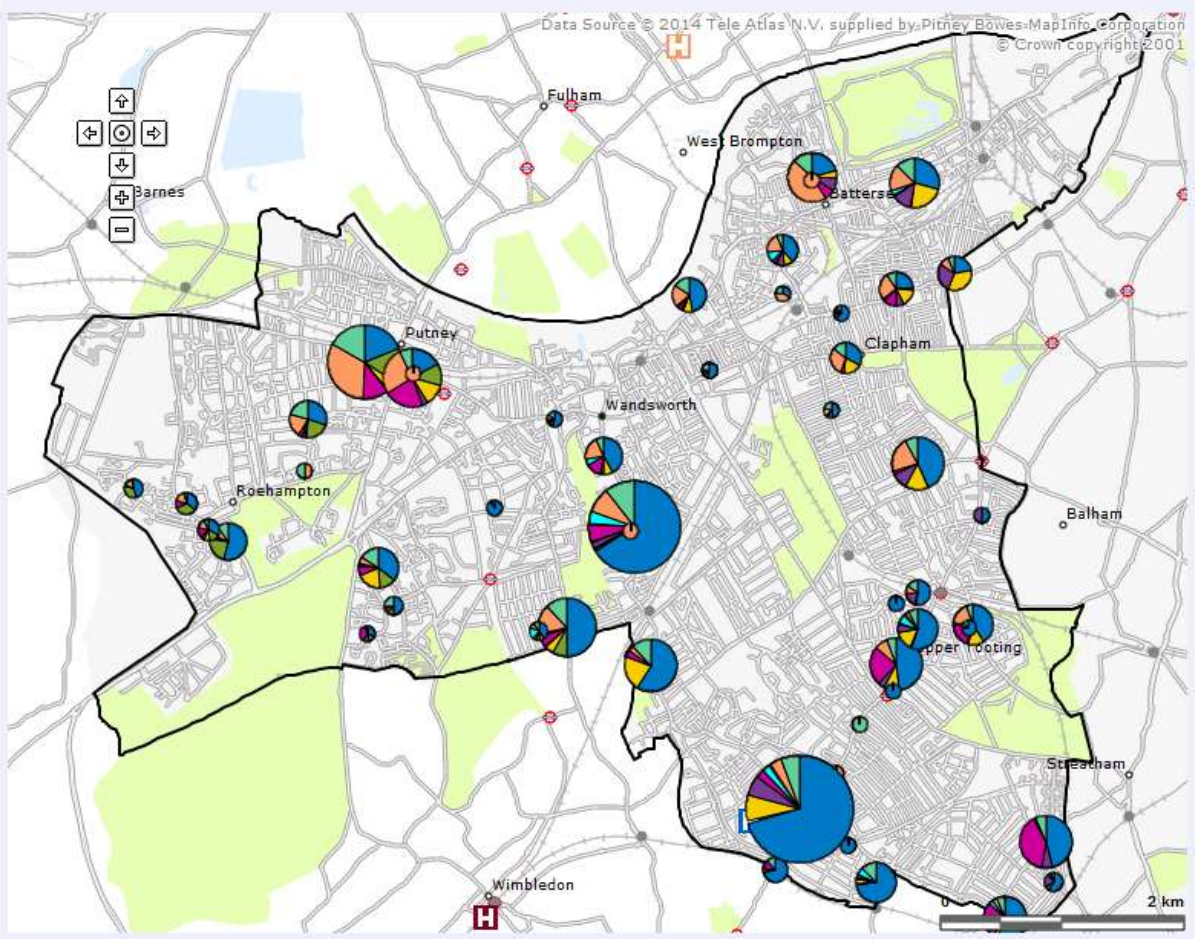
Expected cases: 400

Market share: grows from 46% to 58%

In Wandsworth the aims are to reduce the outflow to other, mainly tertiary hospitals from Wandsworth GPs. The biggest proportional change would come from Guy's and St Thomas'.

Elective Admissions	Wandsworth			
Provider	**Current**	**%**	**To SGH**	**Future**
St George's	1,503	46%		1,903
C&W	465	14%	150	315
G&ST	288	9%	150	138
KC	174	5%	60	114
Epsom & St Helier				
Kingston	164	5%	40	124
Total	**2,594**	**79%**	**400**	**2,594**

Current GP Referral Patterns – Wandsworth



Referrals

166

> 0

Hospitals

- St George's Healthcare NHS Trust
- Wandsworth Pct
- Kingston Hospital NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- Great Ormond Street Hospital For Children NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Others

2. Commissioning area: Sutton & Merton

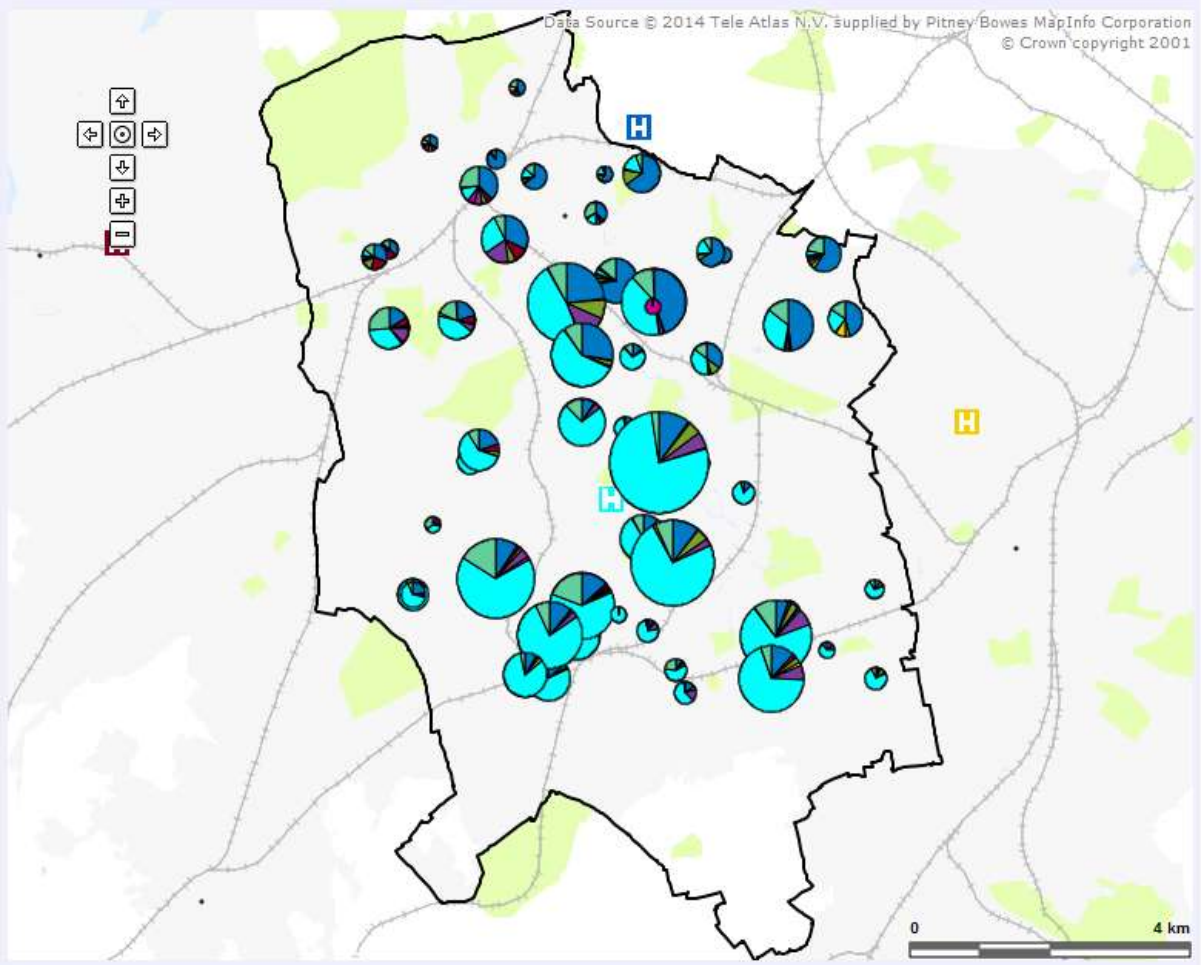
Expected cases: 250

Market share: grows from 24% to 28%

Elective Admissions	Sutton & Merton			
Provider	**Current**	**%**	**To SGH**	**Future**
St George's	1,294	24%		1,544
C&W	37	1%		37
G&ST	185	3%		185
KC	-	0%		-
Epsom & St Helier	2,891	53%	250	2,641
Kingston	129	2%		129
Total	**4,536**	**83%**	**250**	**4,536**

In Sutton and Merton, the aim is to bring in more patients who currently referred to St Helier Hospital

Current GP Referral Patterns - Sutton & Merton



Referrals

199

> 0

Hospitals

- St George's Healthcare NHS Trust
- Kingston Hospital NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Croydon Health Services NHS Trust
- Great Ormond Street Hospital For Children NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Epsom and St Helier University Hospitals NHS Trust
- Imperial College Healthcare NHS Trust
- Others

3. Commissioning area: Richmond & Twickenham

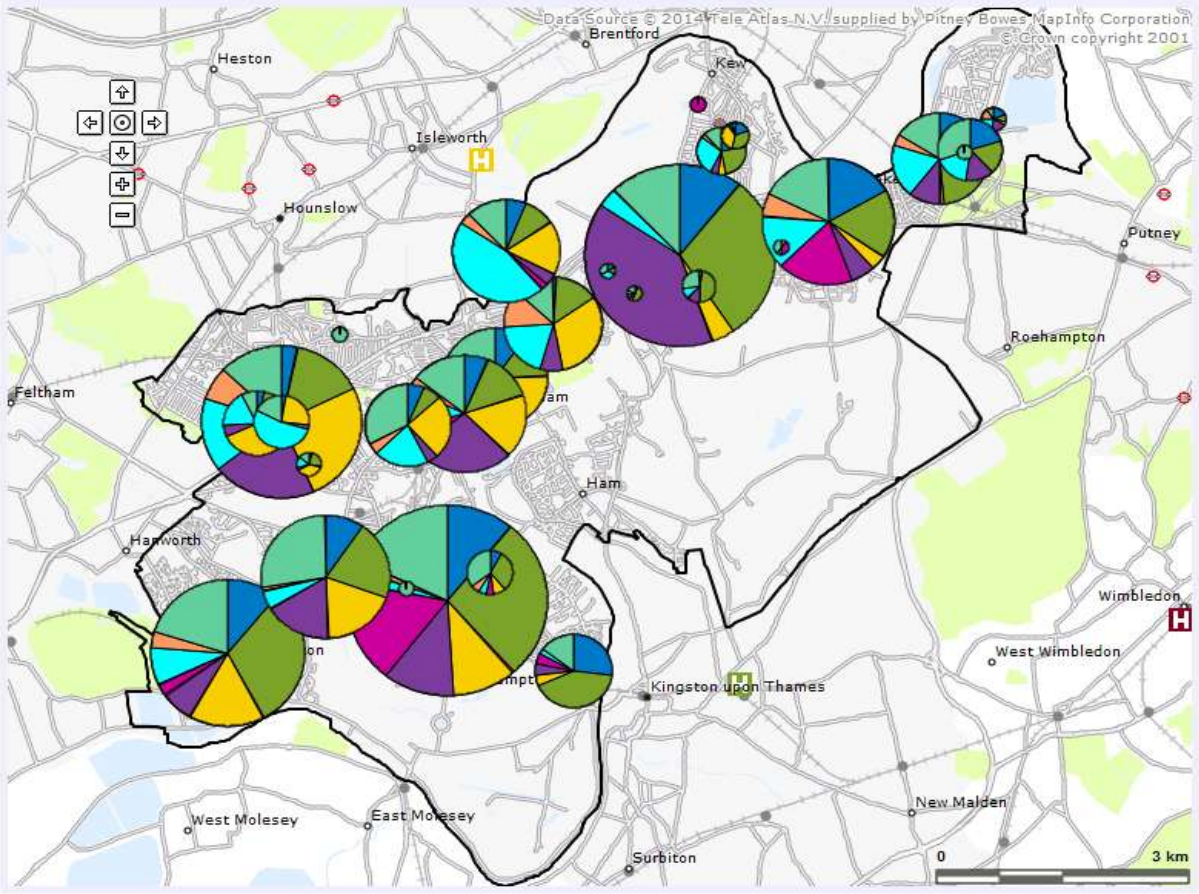
Expected cases: 100

Market share: grows from 10% to 16%

Elective Admissions	Richmond & Twickenham			
Provider	**Current**	**%**	**To SGH**	**Future**
St George's	200	10%		300
C&W	255	13%		255
G&ST		0%		-
KC	305	16%	100	205
Epsom & St Helier		0%		
Kingston	395	21%		395
Total	**1,155**	**60%**	**100**	**1,155**

In Richmond & Twickenham, the aim is to reduce the flow of patients who travel across Wandsworth to access services at Kings College Hospital

Current GP Referral Patterns - Richmond & Twickenham



Referrals

59

> 0

Hospitals

- St George's Healthcare NHS Trust
- Wandsworth Pct
- Kingston Hospital NHS Foundation Trust
- West Middlesex University Hospital NHS Trust
- Great Ormond Street Hospital For Children NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Others

4. Commissioning area: Croydon

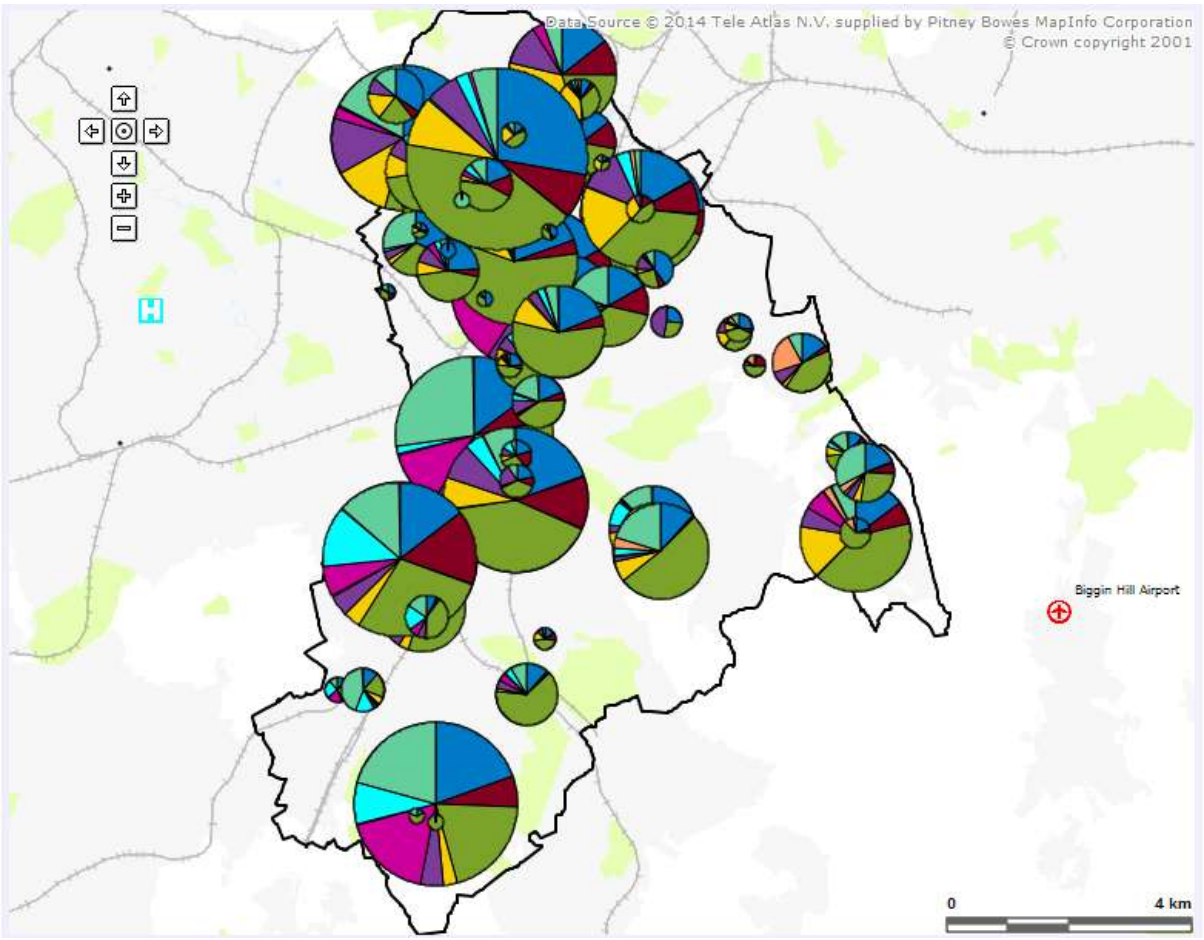
Expected cases: 100

Market share: grows from 19% to 21%

Elective Admissions	Croydon			
Provider	**Current**	**%**	**To SGH**	**Future**
St George's	888	19%		988
C&W	-	0%		-
G&ST	342	7%		342
KC	419	9%		419
Epsom & St Helier	185	4%	100	
Kingston	-	0%		-
Total	**1,834**	**40%**	**100**	**1,749**

In Croydon, the aim is to capture a proportion of patients who go to St Helier Hospital

Current GP Referral Patterns - Croydon



Referrals

84

> 0

Hospitals

- St George's Healthcare NHS Trust
- Guy's and St Thomas' NHS Foundation Trust
- Croydon Health Services NHS Trust
- King's College Hospital NHS Foundation Trust
- Great Ormond Street Hospital For Children NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- Epsom and St Helier University Hospitals NHS Trust
- South London Healthcare NHS Trust
- Others

5. Commissioning area: Lambeth

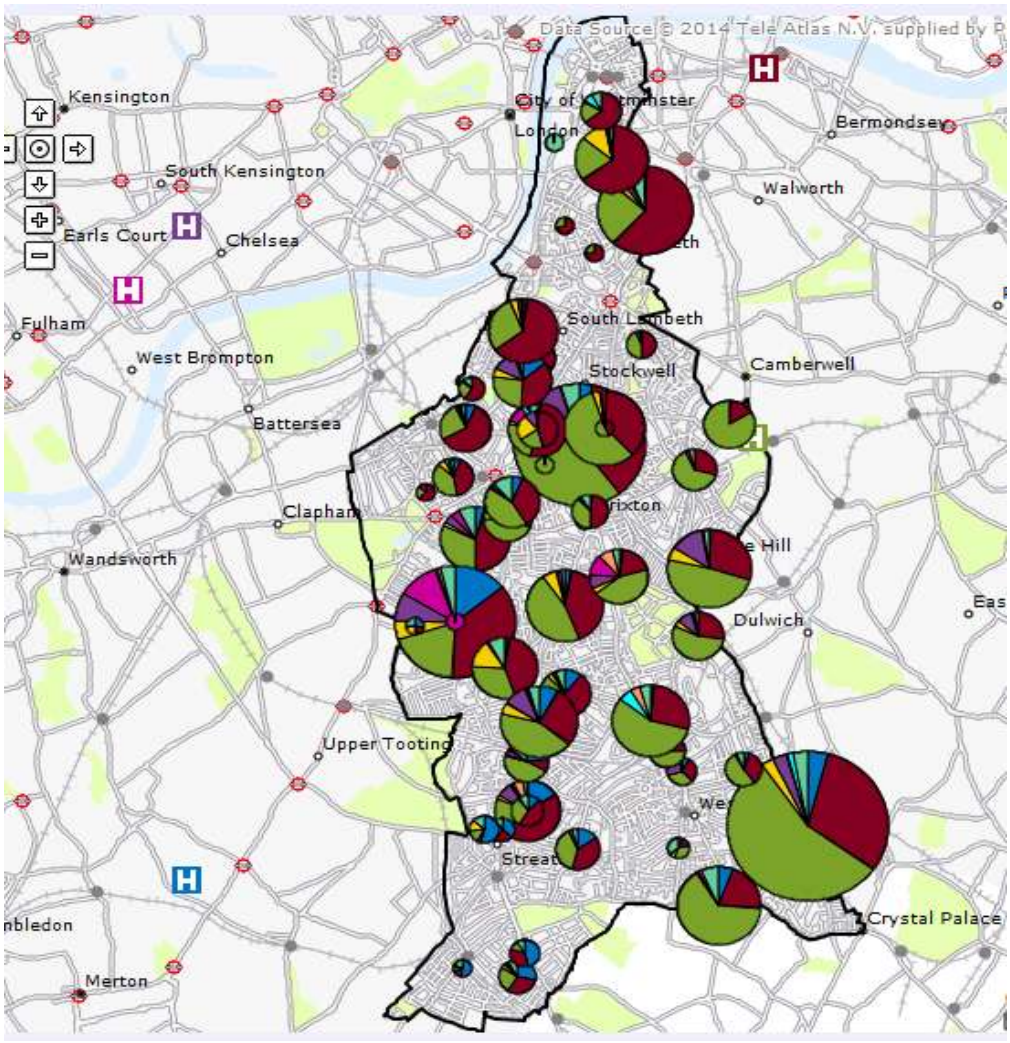
Expected cases: 50

Market share: grows from 7% to 8%

Elective Admissions	Lambeth			
Provider	**Current**	**%**	**To SGH**	**Future**
St George's	282	7%		332
C&W	82	2%	50	32
G&ST	1,512	36%		1,512
KC	1,767	42%		1,767
Epsom & St Helier	-	0%		
Kingston	-	0%		-
Total	**3,643**	**86%**	**50**	**3,643**

In Lambeth, the aim is to reduce the flow of patients going north of the river to Chelsea & Westminster Hospital

Current GP Referral Patterns - Lambeth



Referrals

135

> 0

Hospitals

- St George's Healthcare NHS Trust
- Guy's and St Thomas' NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- Great Ormond Street Hospital For Children NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Others

Summary by Provider

Total target cases: **900** (180 per annum for 5 years, as per FBC activity and financial projections)

Provider	Total
Chelsea & Westminster	200
Guy's & St Thomas'	150
Kings College	160
Epsom & St Helier	350
Kingston	40
Total	**900**