Children's & Women's Strategic Outline Case
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 strategic outline case for the children's and women's hospital development in the Lanesborough Wing.

For each query we have responded with a statement of the extent to which the query can be answered.

2 What is being done to engage stakeholders?

Stakeholder engagement is a priority for the SOC and onwards as the OBC and FBC are developed. The views of internal and external stakeholders will be key in developing the strategic direction for children's and women's services. Planning is underway to fully engage with stakeholders to maximise the opportunity for them to participate and contribute.

A stakeholder event was held in October 2014 to share our vision with local commissioners and other key parties, including maternity service providers. The feedback from the event features as a 'Q&A' section in a summary document of the SOC which will be used to outline our plans when meeting with other stakeholders.

Once the SOC has been approved, our key stakeholders will be contacted to ask for their involvement as we move towards the OBC. A range of engagement opportunities will be offered such as presentations, listening events, surveys and briefings.

This will ensure that our FBC will reflect the views of the these groups:- patients/service users staff; commissioners; special interest groups, such as NCT; MSLC (midwife supervisory liaison committee); Wandsworth Youth Council; Healthwatch; OSCs; MPs; GPs; local authorities, other maternity providers and South West London Commissioning Collaborative. We will reflect what we have heard and show how feedback is informing our plans as we progress. A specific area on our trust website will be set up so that stakeholders can access and comment on our latest published documents. A dedicated email address has been established as a central point for feedback; candwhospital@stgeorges.nhs.uk

We will also be seeking support from the Trust Development Authority, NHS England and the Treasury.

3 Why is the Trust losing market share?

Local demand is rising, yet activity is restricted due by the capacity of facilities.

3.1 Overview

Over the past 10 years there has been a 12% growth in the population of Wandsworth and the proportion of women of child bearing age has increased by 7%. In addition to the activity growth in our local area, the market from neighbouring areas, such as Merton and Lambeth has also continued to grow. It is therefore necessary to understand why despite apparent growth we continue to see a reduction in activity.

The local birth rate is comparatively high due to the population being younger than the national average. In the period from 2002 – 2012, the birth rate in Wandsworth was 38% - greatly above the national average for England of 22%. A total of 21,000 annual births are likely by 2016/17 in south west London including very complex births. The number of obstetric admissions for Wandsworth residents has risen by some 25% in the past 5 years and for Sutton & Merton the figure is 15%.

In 2013/14, the maternity service safely delivered 4944 births and was awarded an outstanding rating by the CQC for quality of care. In the current financial year at the end of month 6, the service has delivered 2455 births, against a plan of 2,550. However, the "attrition rate" is increasing – indicates that mothers are increasingly booking their delivery at St George's but choosing to deliver elsewhere in the event.

We want to increase the number of women giving birth at St George's from just over 5,000 to 7,500. We expect to reach this by providing capacity for local women who are currently choosing to go elsewhere, by securing our natural market share rather than seeking to take that of another provider.

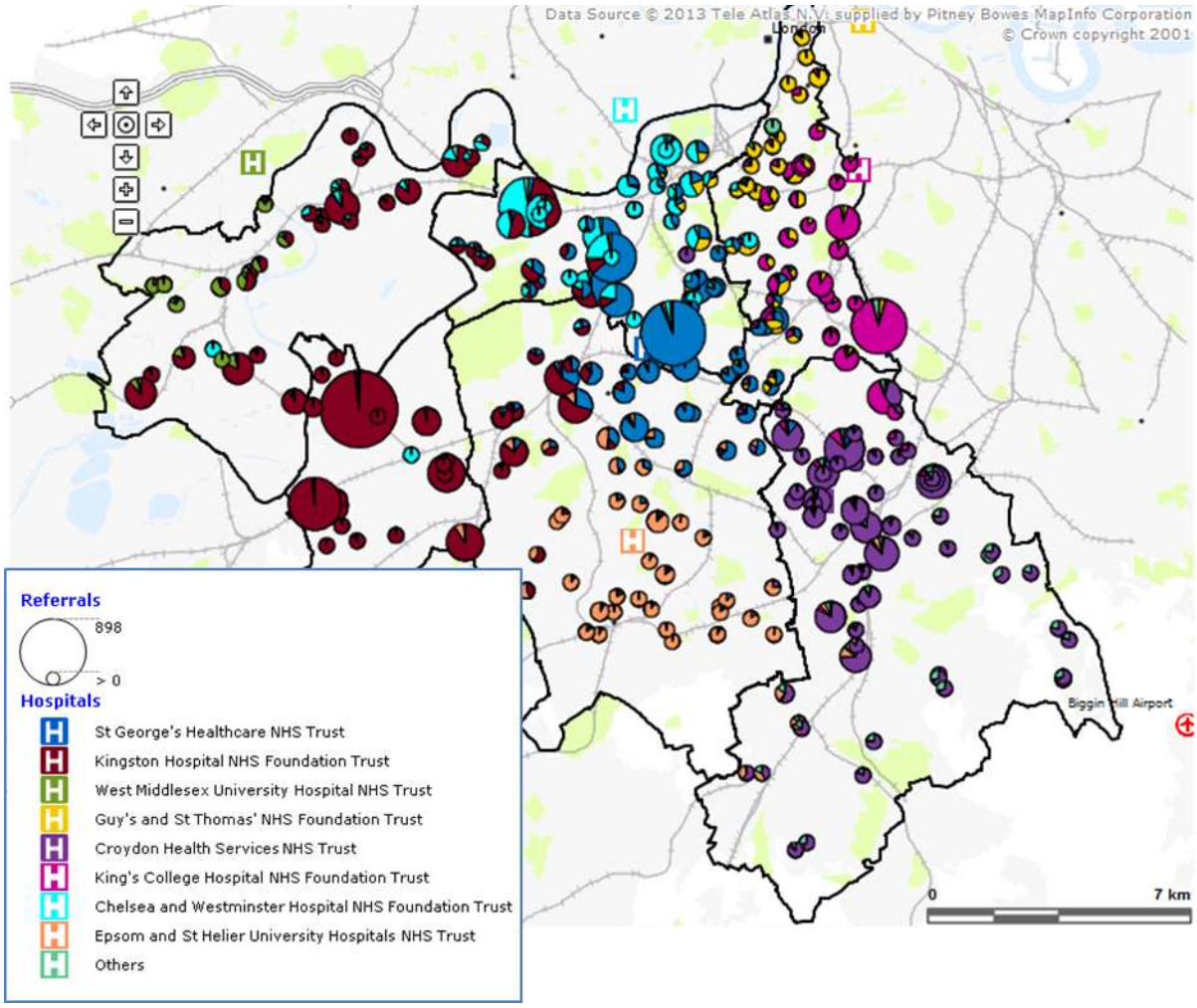
3.2 Where has obstetric growth gone?

The capacity limitations of the current facility demonstrate that it cannot cope with the demand from the local population. It is clear that the restriction on births at St George's has forced women to go elsewhere for childbirth. While St George's remains static at under 5,000 births per annum (as does Kings College Hospital) other hospitals are significantly above this figure.

- Kingston - 5,900
- St Thomas' – 6500
- Chelsea & Westminster – 5,300

All three have received investment for expansion and modernisation of their units helping to increase their market share, whereas St George's capacity has not increased or received investment in presentation of the unit over the same time period.

The overall distribution of obstetric admissions is mapped below:

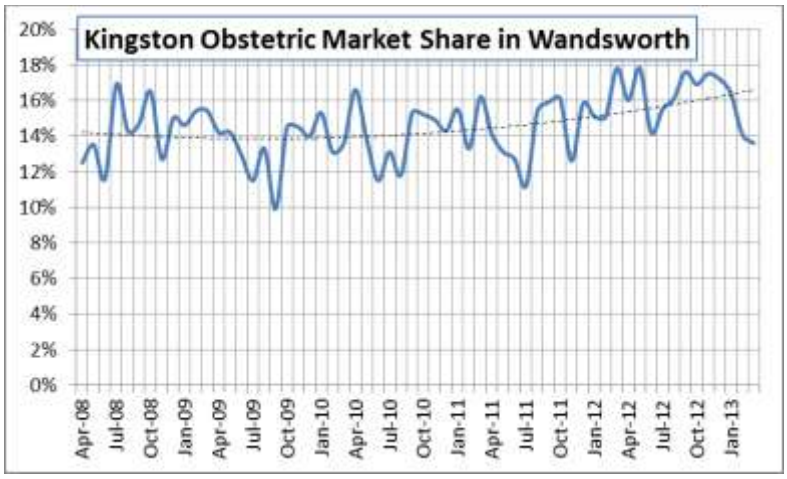


This is analysed below for Wandsworth, Sutton & Merton, and Lambeth

3.2.1 Wandsworth

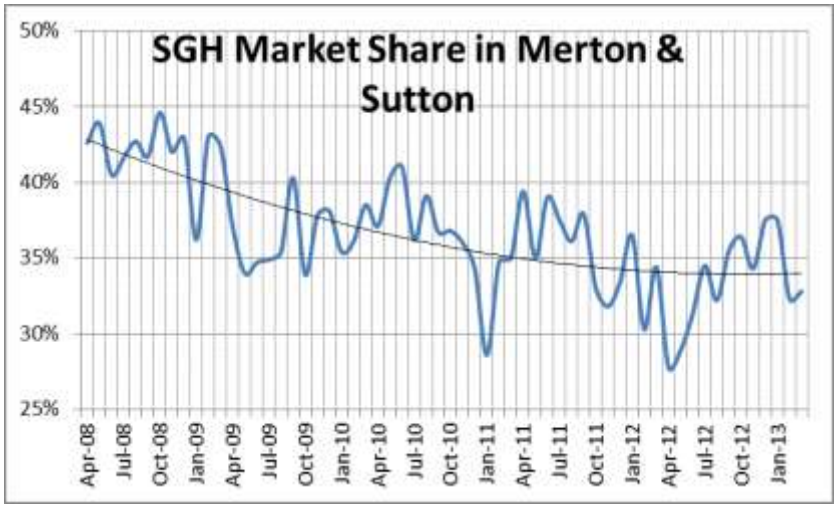
In Wandsworth, the core borough for the Trust's secondary services, average market share has declined by 5% from 50% in April 2008 to 45% in March 2013.

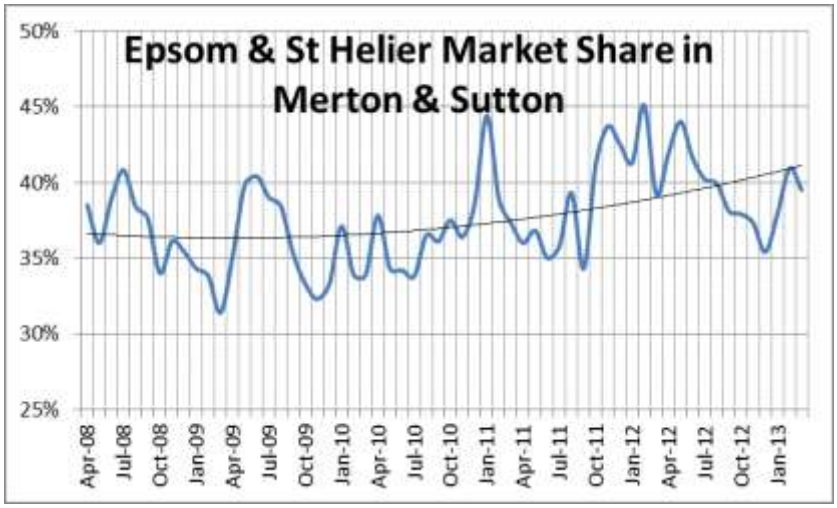
The principal organisations gaining from this have been Chelsea & Westminster, and Kingston

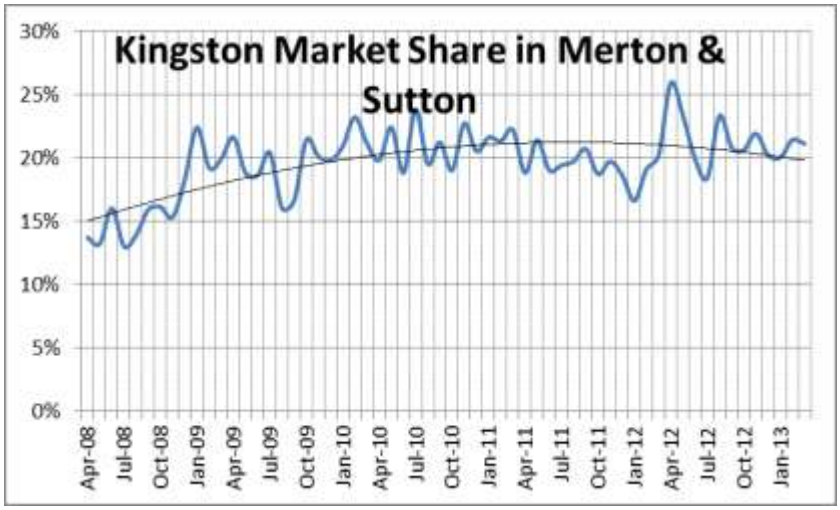


3.2.2 Sutton & Merton

Sutton & Merton show a similar picture, a 10% drop - with Epsom & St Helier and Kingston each gaining 5%

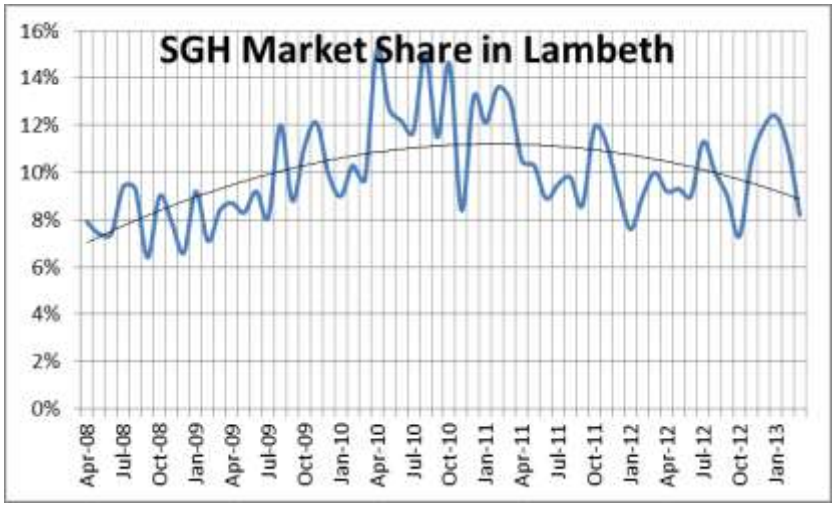


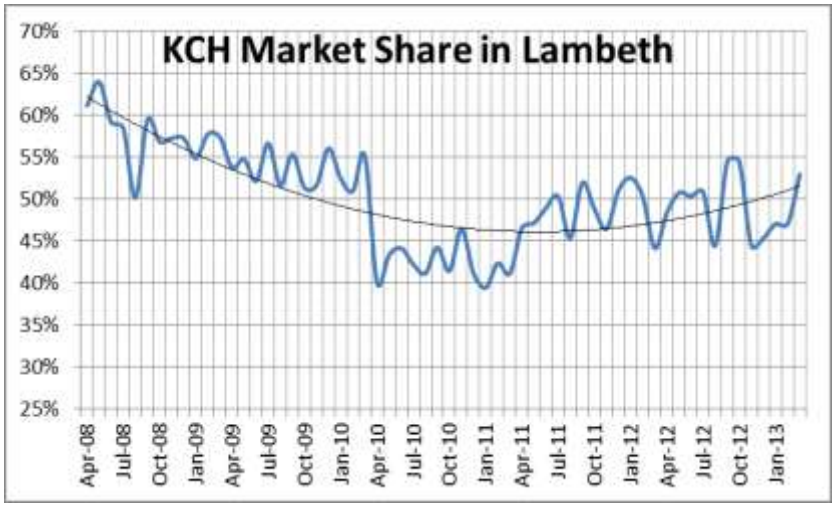


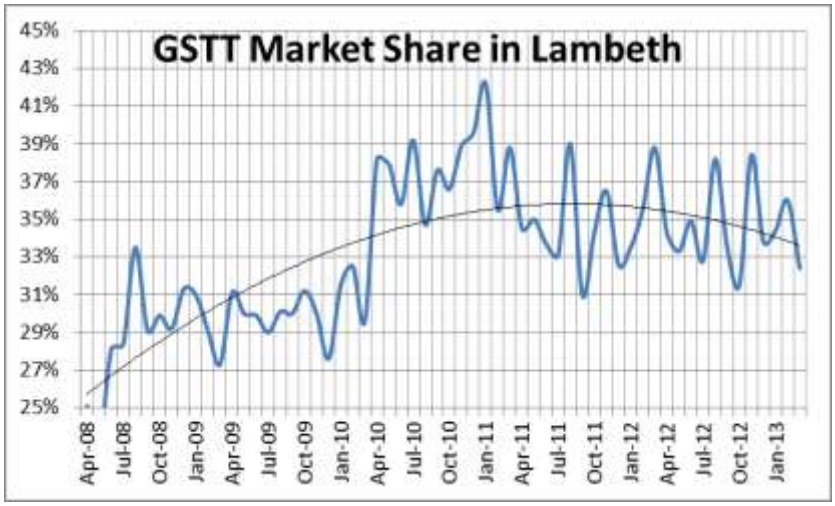


3.2.3 Lambeth

In Lambeth, Guy's & St Thomas' have taken market share from both St George's and King's College Hospital.







3.3 What is the commissioner perspective?

We are fully in line with the known commissioner intentions and broader strategy.

We have taken an active role in the 'Better Services, Better Value' (BSBV) programme. This work is now being developed through South West London Collaborative Commissioning and we remain involved and supportive of its aims. Through BSBV and now the Commissioning Collaborative there have been extensive discussions with neighbouring hospitals and local commissioners regarding the future configuration of children's services in SW London.

The drivers for this have been improving the health of children, reducing lengths of stay and making more efficient use of medical and nursing staffing, concentrating staff where the needs are to ensure children are cared for by the appropriately trained staff throughout the day and night. Our plans will help to achieve these aims and will enable us to take a lead role in facilitating these developments, developing quality and capacity, and facilitating easy movement of expertise across the area via the development of an effective managed clinical network."

The ongoing collaborative commissioning exercise in southwest London is likely to emphasise the need for strong managed clinical networks in maternity and paediatric care. St Georges I in a strong position and intends to play a leading role in the development of these networks and developing our facilities as a key tertiary centre are central to this process

4 Can the planning programme respond flexibly to changes in demand?

The planning process is in its early stages and there is plenty of scope to adjust planning assumptions as it proceeds.

The SOC is just the start of a planning process that leads to an investment decision. The SOC is concerned with establishing the strategic context and the case for change, along with a *prima facie* assessment of the potential for one or more options to deliver the required change. It will be broad in scope and relatively light on detail. The SOC is not an option appraisal as such, but should set out the broad affordability envelope for the scheme. It should therefore take a flexible approach to potential options, and the content of the scheme.

The following stage is the Outline Business Case, which is the vehicle for identifying serious options for detailed consideration. At this stage, the functional content should be narrowed down and agreed, and concrete options explored to deliver the scheme. This requires significant design and costing input. There may be substantial variation between SOC and OBC in terms of the scope and content of the scheme. The OBC will identify a preferred option for detailed design. By the end of the OBC process the content is substantially fixed.

At Full Business Case stage, the preferred option is pursued and the financial, economic and commercial aspects firmed up, as well as the detailed design upon which the final costings are made. At this point the scope and design should be fixed.

The overall process may take two or more years to reach fruition. This leaves some time fro the Trust to consider the required content, and to clarify with external stakeholders and influencers the strategic issues that may affect the build requirements. However, it may not be possible to achieve complete certainty in the strategic environment, which generates an element of risk in the planning process. This can be overcome to some extent by coordinating the planning with the development control planning for the whole site, so that the latter can be flexed in anticipation of significant changes in building requirements. For example:

1. Anticipated activity lower than planned for the scheme –
    - Identify in advance other compatible clinical services that can occupy the space
    - Reassess timing and scope of other elements of DCP
2. Anticipated activity higher than planned for the scheme –
    - Build in "soft" space and expansion zones to enable marginal expansion
    - Build in potential to expand the building envelope
    - Identify space in adjacent buildings to expand into

In the meantime, plans are being developed to increase capacity on the labour ward to 6,000, to enable a staged approach to regaining lost market share

5 Are we investing in profitable services?

Both services have been challenged financially. However, growing these services is a way of increasing contribution by leveraging the fixed cost base and concentrating on service lines that make a positive contribution.

5.1 Women's services

Women's services have a mixed picture of profitability, based on the Trust's marginal cost analysis and service line reporting figures. Clinical genetics, gynaecology day cases and newborn services generate significant contributions. However, gynaecology inpatients are in deficit and obstetric admissions are revenue neutral. The contribution for each POD using the marginal cost analysis is tabulated below[1]:

Specialty	CC	DC	EL	EM	OP
Clinical Genetics					50%
Gynaecology		38%	-15%	-15%	60%
Newborn Services	18%			18%	18%
Obstetrics				0%	52%

SLR shows the rate of return in obstetrics for Q2 of this financial year at -0.4%. The gynaecology service shows the rate of return in Q2 14/15 at -18.0%.

[1] Based on Trust marginal cost analysis

A plan of action is in place to ensure all service lines make a positive contribution. With regard to obstetrics, the major elements of cost are medical staff and midwifery staff. The medical staff is now based on 168 hours/week presence on the labour ward. This will not increase significantly if activity rises up to 7,500 births. Midwifery staff will increase in line with activity. Corporate overheads will not rise with activity. This means that every additional case over the current level of activity has a 30% advantage in terms of margin, meaning that facilitating more births at the site will be beneficial.

5.2 Children's services

The main paediatric specialty areas where growth is anticipated generate positive margins, based on the marginal cost analysis[2]:

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%	

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. The risk associated with emergency admissions is to a degree mitigated by the successful implementation of the paediatric assessment unit.

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

For paediatric trauma, it is not possible to confirm the position at this point though the trend suggests that under-19 generate a surplus in each point of delivery.

6 Where are services provided now and where will they be?

The Trust is committed to providing a more community based approach to care wherever possible.

6.1 Women's activity

Women's services currently hold general gynaecology clinics offsite at Queen Mary's Roehampton and have committed to the provision of a further 2 weekly clinics at the Nelson Community Hospital in 2015/16.

Within obstetrics, clinics are held on St George's site as well as community midwife clinics at Tooting Health Centre, Balham Health Centre, Doddington Health Centre, Tudor Lodge Health Centre, Brocklebank Health Centre and Lavender Children's Centre.

[2] Based on Trust marginal cost analysis

Scoping work is underway to look at increasing the provision of postnatal care to patients across Merton at the Nelson Local Healthcare Centre.

6.2 Children's activity

A well as inpatient, day case and outpatient paediatric surgery and medicine, the following child focused services are also under the St George's banner:

- Continuing care team (to be integrated in January 2015) - small team under block contract
- Orthotics at QMH (a small part of a larger service this is provided by non SGH service and is not specifically for children)
- Therapies both with SGH and CSW (integrating in January 2015)
- Health Visiting – CSW
- School Nursing – CSW
- Trauma and Orthopaedics - Surgical
- ENT - Surgical
- Plastics - Surgical
- Maxillo-facial - Surgical
- Lymphoedema – Medicine
- Neurosurgery - Surgery

7 Workforce – where will we get the staff from?

The key points of the strategy for paediatrics and midwifery are set out below:

- Engage with all trust wide recruitment / workforce initiatives (Jennie Hall is launching a programme of work around this)
- Employing a dedicated recruitment nurse/midwife – this has only just been introduced but learning from other parts of the trust that have utilised this indicate that it is successful in reducing time to start and also ensuring new recruits are supported through the recruitment process and do actually start in the trust
- International recruitment from the European Union. There is a cost associated with international recruitment, this is however a cost that we are already incurring
- To recruit at risk, in advance of the new beds / facilities coming on line
- To over recruit against establishment to ensure turnover is covered
- To review current incentives for staff and consider a range of incentives that may attract staff, e.g. Retention premiums, payment for accommodation, payment for travel, 'bring a friend' initiatives, recognition awards
- Improve marketing of the service and 'sell' the positives of working at SGH and the developments that are occurring

- Improve retention rates, by understanding why staff are leaving and addressing these issues where possible
- Improve the student experience and ensure there is an increase in the proportion of students that take jobs in the hospital