Sherwood Forest Hospitals NHS
NHS Foundation Trust

Emergency Care & Medicine
Single Front Door at King's Mill

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Version – Final

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Executive Summary

This business case has been developed using the Treasury's 'Five Case Model' for public sector business cases as a framework.

Overview
This business case seeks approval to invest £653k of the £1.2m received as part of a successful bid to the Prime Minister's challenge fund, in the development of a 'Single Front Door' at King's Mill Hospital. The revenue implication of implementing the scheme is approximately £28k (to fund the additional Unitary Charge resulting from the estates changes), which will be required on a recurrent annual basis.

The aim is to create a single entrance, a single reception, a single triage area, a single waiting area and flexible consulting rooms. This requires modification of estates, as well as changes to staffing models and working practices.

A similar 'Single Front Door' scheme is planned for Newark Hospital, but further work is required to redefine the scope and reduce costs. To prevent delays to the King's Mill scheme, a separate business case will be produced for Newark, once further financial information is available.

Recommendations
This business case recommends investing the £653k in the King's Mill scheme, on the following basis:

- Qualitative benefits will result, as set out in the business case
- The funding of £1.2m is now in place
- A commitment has been made to support the Single Front Door scheme as part of the Better Together programme – this is only possible with the investment in estates outlined here
- The expenditure of £653k at King's Mill Hospital leaves £547k funding for a Newark scheme, which is currently being redesigned to ensure it can be delivered to budget
- The King's Mill scheme has already been value engineered to reduce its cost
- Revenue costs of £28k can be absorbed in the Estates budget

Background Information

The strategic context
The Single Front Door initiative is part of the mid-Nottinghamshire 'Better Together' programme and a key part of the local primary care strategy, available here:

MA-NS_challenge_fund v1.3.pdf

Better Together has developed as a coordinated response to the sustainability challenges facing mid-Nottinghamshire. It is a partnership of the health and social care organisations in the area, working together to deliver whole system change in a 3 – 5 year timeframe.

A central part of Better Together is improving Urgent Care, with a specific aim of overcoming the following local challenges:

- Insufficient alternatives to acute care;

- Management of patient choices when not an emergency could be improved;
- Increased capacity is required in Primary or Community Care;
- Length of stay is long at present, particularly around discharges into social care;
- Low understanding of, and trust between, organisations involved.[1]

The Single Front Door is one of a number of complementary initiatives that the Better Together programme is developing to address these challenges. Other initiatives include:

- Changes to primary care provision to support responsive urgent care;
- Care Navigation system for healthcare professionals, enabling patients to be directed onto the most appropriate care pathway as part of access to right care first time;
- Crisis Response services providing a bridge of care for patients in their home setting until mainstream services can be mobilized.[2]

Current Position

The case for change

Extensive engagement with the public has shown that patients find accessing urgent primary care confusing and inconsistent. At King's Mill hospital (KMH), there is a 24 hour Primary Care service ('PC24') providing urgent care, co-located with our Emergency Department (ED). Patients are currently about to make a choice of which service to visit, but with separate entrances (approximately 20 metres apart), patients often find it difficult to assess which service is the most appropriate. Once within either department, patients are booked in at separate reception desks and wait in the respective waiting rooms. Following triage or review, patients are moved between the two services based on clinical need.

Not only is the current setup at KMH confusing and fragmented for patients, the Better Together programme has determined that more patients could appropriately access PC24 (rather than ED), which would relieve pressure on ED. In addition, there are safety risks due to delays, if patients access the wrong service first time. During peak hours in the evening and weekend, there are often more clinicians available than consulting rooms, which create bottlenecks in the service. Collaborative working to improve the situation is hampered by physical separation (three sets of access-controlled doors) between ED and PC24. The impact of this lack of integration is that patients are effectively asked to self-select their care.

Proposed Service Development

Scope

In light of the challenges faced at KMH ED and the PC24 services, this Business Case is for the redesign of the estates to enable an improved service model, with a range of associated qualitative benefits that this document describes.

The decision to change the service model and the design of the model itself are out of scope. They have been determined as part of the Better Together programme, for which alternative governance arrangements are in place. This business case is for investment in the re-design of the estates in support of the revised service model, utilising funding already received for this purpose, from a successful bid to the Prime Minister's Challenge Fund.

Proposed Capital Development

[1] 'The Primary Care Challenge' – Better Together, 2014
[2] Ibid

Investment objectives
The aims of the investment are to ensure that the estates at KMH support an urgent care model that:

- Improves access to primary care services
- Reduces demand on the Emergency Department through reduced avoidable attendances
- Improves patient experience
- Improves patient safety
- Facilitates the increased use of a 'see and treat' model, to decrease waiting times and improve flow through the department
- Improves patient flow between primary and secondary care

Critical success factors
The critical success factors (CSFs) for this project are as follows:

1. This estates project must be configured in a way that supports a single entrance, a single reception, a single triage, a single waiting area and a consistent approach. The service model itself is out of scope for this business case and is determined as part of the Better Together programme;
2. The estates must facilitate integrated working and remove existing barriers to partnership working (across ED and primary care) that are created by the physical configuration of the building;
3. The estates must facilitate the required 'see and treat' model

Specifically, the estates changes must facilitate the following approach:

- the reception of patients should be at a single point where booking information is collected once on System One and follows the patient to whichever service they are referred. There will be no duplication of clerking in either ED or PC24;
- the initial clinical triage will be jointly operated between ED and PC24 with a single agreed triage process. Every patient will be allocated a NEWS score;
- the triage will determine the next steps of the patient pathway and the urgency of their condition (time to be seen);
- at triage patients will be streamed to either ED or PC24. A number of patients may be referred back to their GP or simply discharged;
- patients will be able to move, or be moved, swiftly between ED and PC24 (and vice versa), if the initial triage is found to be incorrect – their clinical records will transfer with them;
- changes must facilitate improved communication between ED and PC24. E.g. through a dedicated phone line with multiple access points in both areas.

Option Appraisal – Identification and Selection

Options appraisal
The options considered are:

1. Option 1 – Do nothing
2. Option 2 – Full rebuild of ED and PC24 at KMH
3. Option 3 – Revision of the physical estates at KMH, to deliver the CSFs described above within the £1.2m envelope provided by the PM challenge fund, whilst leaving part of the budget available for works at Newark to support a similar model. This is the 'optimal model'

1. Do nothing
The strategic case identifies a number of issues and opportunities at Kings Mill which cannot

be fully achieved without some alteration to the current configuration of the estates.

At Kings Mill patients report confusion on arrival at the entrance to ED or PC24 and are unsure which option to choose based on their condition. It is reported that on occasion the choice of service accessed is based on the shortest queue. Additionally it is felt that with improved primary care triage more patients can be directed to Primary Care thus reducing pressure on emergency and urgent care.

The 'do nothing' option is unable to deliver the CSFs described. Furthermore, given the identified opportunities which can be achieved with some alterations to the physical environment, the 'do nothing' option has not been progressed.

2. Full rebuild

Total rebuild of Kings Mill ED was considered. Kings Mill is a new, purpose built ED, built under the Private Finance Initiative (PFI).

Activity/attendance figures for Kings Mill ED demonstrate a steady growth of around 4-5% per annum. Attendance at PC24 over the same period has seen significantly higher growth. Whilst recognising this increase in activity, the wider Better Together programme has a target of reducing ED attendances by over 15% in a five year period.

The cost of a total rebuild would therefore be disproportionate, running into millions of pounds and be far beyond the budget available for this project. Given these factors the full rebuild option is not considered to be an affordable or cost effective option.

3. Optimal model

The optimal model is to develop the estates (without requiring a full rebuild), to meet the critical success factors described above. Specifically, the following changes are included in this option:

- Extend existing waiting area and reposition reception desk to facilitate improved patient flow;
- Refurbish existing areas to provide an additional assessment room, additional consulting rooms and additional treatment rooms;
- Rationalise office and staff support space.

Preferred option

The preferred and agreed option is **Option 3**. Within this option there are a number of variables and opportunities for value engineering that need to be considered. These are explored in the Financial Analysis.

Benefits Appraisal

Outcomes and benefits

This section describes the main outcomes and benefits associated with the implementation of the works described above. Organised by investment objectives, these are as follows:

Investment Objectives	Main benefits criteria by stakeholder group

To enable improved access to primary care services, reduced demand on Emergency Department (ED) services and improved patient flow	**Patients:** • Potential for patients to be seen by the appropriate person sooner, as a result of a single triage and early professional judgment about the most appropriate care • Improved patient education over time, as they are informed (through experience) of the most appropriate care setting for particular needs **Clinicians:** • Removed duplication of functions due to a single point of access and single triage / streaming process • Staff will be deployed to the appropriate areas of the department depending on case mix. This will increase flexibility and productivity of staff • Reduced pressure on ED staff as a result of greater use of primary care (and other) services when appropriate **Administrators:** • A single reception will remove existing duplication, improving staff efficiency and productivity • Better patient experience is expected to lead to greater staff experience, due to increased levels of patient satisfaction and decreased levels of patient frustration
To enable improved patient experience and patient safety	**Patients:** • Patients will have a better experience of using services, as a result of less confusion about which service to access and less movement between services • Patients will be less likely to incur delays (with associated safety risks), as they are triaged and streamed to the right service first time • Improved space and waiting areas • A single waiting area reduced the number of patient areas to be monitored, improving patient safety. **Clinicians:** • Greater staff satisfaction resulting from improved patient experience and safety • Improved space and waiting areas **Administrators:** • Greater staff satisfaction resulting from improved patient experience and safety • Improved space and waiting areas

Constraints

Funding totalling £1.2m has been secured as part of the Prime Minister's Challenge Fund. This funding has already been transferred to the Trust and needs to be spent during 2015/16. The Single Front Door initiative is part of a wider programme of Better Together Urgent Care interventions, designed to reduce ED attendances and emergency admissions. Implementing this scheme is therefore considered to be a priority by the wider health economy. The funding for this project, combined with a similar scheme at Newark (to be considered separately) is limited to the £1.2m already received and no other budgets exist to

support this capital investment.

Performance and Activity

N/A

Financial Analysis

Capital costs
This section provides an estimate of costs for the scheme at KMH, based on the preferred option (the 'optimal model'). Two cost estimates are provided (including fees, equipment and VAT), based on the costs pre and post value engineering (described below).

Cost	**A - Capital costs** *(pre value engineering)*	**B - Capital costs** *(post value engineering)*
Project works	£680,000	£638,000
Equipment	£15,000 (approx.)	£15,000 (approx.)
Total	**£695,000**	**£653,000**

Agreed risk allocation and charging mechanism
Much of the contractual risk is transferred to the PFI management team (via the Schedule 22 process) and the appointed Contractor (via the PFI team administered contract documents). However, in order to minimise the management uplifts (and therefore overall costs) the PFI team have not levied their 4.25% standard risk uplift and the risk of financial overspend on the construction works currently remains with the Trust. A construction contingency allowance equivalent to 6% of the overall project value has been included within the costs for the project however (this is circa £40k for KMH).

Outline specification
A number of cost reductions have already been incorporated into the specifications for the estate works, as a result of initial indications suggesting that the £1.2m budget would be exceeded when adding the cost of the KMH scheme to the Newark scheme. (Further work is required to develop a financial case for the Newark scheme and this will need to be considered separately to prevent further delays to the KMH scheme).

The works at KMH to be procured comprise the following:

- Extension of existing waiting area and repositioning of reception desk to facilitate improved patient flow.
- Refurbishment of existing areas to provide:-
    - 1 additional assessment room.
    - 3 additional consulting rooms.
    - 2 additional treatment rooms.
    - Rationalised office and staff support space.

Value engineering
In summary, the main cost reductions incorporated for the KMH scheme were:

- Omission of brise soleil (external window glare protection).
- Reduction in size / height of new extension.
- Reduced scope of refurbishment (including mechanical and electrical services).

Revenue
Current estimates suggest revenue costs of £28k, resulting from an increase to the Unitary Charge (UC), payable on an annual basis for the remainder of the PFI contract.

Overall affordability
The capital cost for the KMH scheme is affordable, due to the funding received via the Prime Minister's Challenge Fund.

The revenue cost of approx. £28k annually will need to be funded from the Estates budget without any expectation of savings generated by the scheme.

Additional costs or savings to the Trust resulting from a change in service model (as part of the wider Single Front Door project) are unknown and out of scope for this business case. Whilst this represents a risk to the wider project, this needs to be highlighted and held at a Better Together level, due to the collective design and ownership of the wider Single Front Door initiative as a whole.

Assessment of Dependencies and Interdependencies

Dependencies
The project is subject to following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme:

- A key dependency in this proposal is the working relationship between SFH and CNCS (the provider of PC24 and GP OOH services). The proposal has been jointly developed under the independent chairmanship of the Proactive and Urgent Care work-stream lead from the CCG;
- The success of this estates project is dependent on the wider Better Together single front door project and the associated activities involved. In particular, if the required service and staffing changes are not achieved, the re-configured estates will not be utilised to their optimal value;
- The success of the service change facilitated by the estates change is dependent on hospital services providing diagnostic testing and support to CNCS. These arrangements are already in place and working well;
- The paediatric short stay assessment unit (which includes the increased presence of paediatric consultants in ED) is out of scope for this business case, but integral to the delivery of streamlined services at the 'front door' for children and families. The single front door will not change the access arrangement to the GP OOH service provided for children at KMH, but will facilitate streaming of children from ED to PC24 when appropriate.

Risk Analysis

Main risks
The main business and service risks (design, build and operational over the lifespan of the scheme) associated with the scope for this project are shown below, together with their counter measures.

Main Risk	Counter Measures
Design and development • Risk of planning permission not being granted • The service model that this project supports may result in an unforeseen change in activity levels, as well as additional staffing costs, the funding for which is currently unidentified • Risk that the cost of the works required to deliver the optimal solution exceed quoted costs	• Risk did not materialise as planning permission was granted. • The decision to proceed with the wider Single Front Door project has been made as part of the Better Together programme. Any ongoing impact of the changes planned will need to be considered within the Better Together governance. • A contingency pot of 6% has been built in to the quote
Implementation risks • Unexpected complications resulting from ground / site / services conditions • Ongoing revenue costs resulting from the project works are an additional cost pressure	• Surveying works during the design development process and shared risk management with the appointed contractor • A decision is required to determine how the revenue costs will be funded (see Financial Case below)

Operational risks
• Project not delivered to timescales or specification within the cost envelope due to:
  ○ Unexpected complications during works
  ○ Insufficient in-house resource
	• A construction contingency allowance equivalent to 6% of the overall project value has been included within the costs for the projects at both sites.

Workforce and Leadership

Whilst there are some benefits and risks to staff resulting from the improvements to the estates (see relevant sections for details), the more significant implications are as a result of the service change. This, however, is outside the scope of this business case, but rather part of the wider Better Together programme.

Benefits Realisation Plan

This project is expected to yield the following benefits:

Type	Direct to Organisation(s)	Indirect to Organisation(s)
Quantitative (or quantifiable)	Reduced attendances at 'inappropriate services', achieved by the single front door streaming patients to the most appropriate service. The impact of this is unknown (see 'Risks')	Potential for reduced emergency admissions, due to improved patient streaming and long term education of patients about the most appropriate service for their needs (see 'Risks')
Cash releasing	We are not expecting the investment to result in cash releasing benefits for the Trust. However, this should be tempered by the fact that the funding has been secured to invest in this scheme, on the basis of the benefits (particularly qualitative) to the wider health economy	Over time we expect the revised service model to contribute to a reduction in emergency admissions as a result of a greater use of primary care. This should bring financial benefits to the wider health economy, but these cannot be quantified at this time (see 'Risks')
Non-cash releasing	Efficiency gains for staff, who will need to spend less time transferring patients from one service to another (due to improved estates and improved service model)	Efficiency gains for CNCS staff
Qualitative (or non-quantifiable)	Staff satisfaction will improve as a result of more streamlined processes and increased patient satisfaction	Increased patient satisfaction as a result of improved environment, reduced confusion and reduced presentation at an inappropriate service

The full process for benefits realisation has yet to be agreed but an audit process has been put in place by the lead nurse in ED to monitor patients referred to PC24 through a revised triage process. The audit covers those patients referred to PC24 and their presenting complaint along with those returned to ED and the reasons.

Plans to measure the benefits (resulting from the service and estates changes) will need to be taken forward by the Better Together Single Front Door team. It is likely that the full benefits realisation process will require a formally constituted clinical audit, run through the Trust clinical audit function.

Project Management Plan

Project management arrangements
Estates projects are managed in accordance with the Capital Procedures manual. The five stages in the project management approach are available here:

SFHT PM Task Narrative Stage 1 (13
SFHT PM Task Narrative Stage 2 (15
SCH PM Task Narrative Stage 3 (27
SCH PM Task Narrative Stage 4 (6.
SCH PM Task Narrative Stage 5 (14

Project reporting structure
The clinical and patient related aspects of the project are managed through a Single Front Door project group which reports to the Proactive and Urgent care Steering Group which in turn reports to the Better Together Programme Board.

The Single Front Door Group is chaired by the Urgent & Proactive lead from the CCG and has membership drawn from SFH Trust and CNCS (PC24). The Proactive and Urgent Care Steering Group is chaired by the Medical Director from SFH Trust and has membership drawn from the wider Health and Social care system. The Programme Board is independently chaired and has membership from across the health and social care system.

The Estates Team have been involved in discussions regarding the development of the single front door, from a very early stage in the process. There has been good attendance at the fortnightly Single Front Door meetings, where discussions about requirements have taken place and plans have been drawn up and scrutinised by group members. Membership of the Estates team has included representatives from SKANSKA, the Facilities Provider, PFI provider and Architects.

Project roles and responsibilities
The Proactive and Urgent Care Lead for the Better Together Programme will maintain an overview of the progress of the clinical and patient aspects of the project supported by the project implementation team (operational) at SFH Trust and PC24 respectively.

The Project Manager for the Trust in the development of the estates work is Ian Dennis, working with Auburn Ainsley.

Project plan
Project timelines are as outlined in the following embedded document:

KMH Front Door Programme Rev. D (3

Risk management
The Capital Procedures manual which guides the Trust's approach to estates works contains a Risk Management Policy and Procedure. This is available here:

CDM - Policy & Procedure for the Ma

Post project evaluation arrangements
In accordance with the above narrative describing Stage 5 of the project approach, this project will be subject to a post project evaluation. As stated, "For larger projects (over £1m. in value), a formal Post Project Evaluation (PPE) process should be undertaken, including a workshop with all project stakeholders to establish and share lessons learned.

All recommendations from the PPE should be communicated adequately, to ensure that these are factored in to future project management processes".

The post project review procedure is available here:

Post Project Review Procedure.DOC

Contingency plans / business continuity
The Trust's business continuity plans apply in the case of issues arising during the project works.

Procurement Strategy

The procurement
Tenders have been obtained via the PFI team, in accordance with the PFI contract Schedule 22 variation procedure.

The tender process has been akin to a competitive single stage selective tendering process, managed in accordance with the Trust's standing financial instruction requirements and the Trust Estates Department Capital Procedures documents (which cross reference the NHS Capital Investment Manual and "Blue Book" for consultant appointments).

Five Contractors were invited to tender for each, and all five have returned tenders. A tender review and amendment process was undertaken with the two lowest Contractors, as their tenders were within 2% of each other (the other tenderers were all circa 20% higher than the lowest tender and were therefore discounted by the PFI managing team). The estimated costs resulting from the tender exercise are described above.

Key contractual arrangements
As Kings Mill Hospital is located on a site that is within the remit of the PFI contract, procurement considerations are significantly influenced by the PFI variation procedure (Schedule 22). In this context, procurement is determined by a number of factors, including:-

- Any Contractors working on the site do so under the permission and control of the PFI site teams (CNH / SFS / Medirest).
- Any work undertaken to the Estate must comply with the PFI contractual requirements and "site standards".
- Management of Contractors under Trust appointment incurs management cost on the part of the PFI team, irrespective of who has appointed (e.g. Permit to Works, Isolations, Independent Tester to verify compliance, etc.).
- Any contravention of the PFI team site working procedures or specification requirements invalidates elements of the Life Cycle and FM obligations under the PFI contract, representing significant risk to the Trust in employing their own Contractors.

Procurement of capital projects via the PFI team, applying Schedule 22 of the PFI contract, is the standard approach for the Trust.

Agreed implementation timescales
In summary, the estimated timescales are as follows:

- Planning Submission – received.
- Tender Pricing – received early March 2015.
- Contractor Appointment – preferred Contractor established. 3 weeks mobilisation required once project approved, currently aiming for start on site in early May 2015.
- Completion on Site – anticipated as late August / early September 2015.

Exit Strategy

N/A

Conclusions

The scheme has the following costs:

Capital: £653k
Revenue: £28k

The capital costs will be met by the funding already received from the PM Challenge Fund, whilst the revenue costs will be met by the existing Estates budget that covers the Unitary Charge.

It is therefore recommended that the Single Front Door estates project proceeds, as described within the business case, on the basis that the £1.2m has already been received and the anticipated qualitative benefits that will result from the works.

A number of risks and mitigations have been highlighted, particularly in relation to the unknown impact on activity and staffing of the associated service change. However, it is recommended that these risks are escalated through the Better Together programme, which is where the overarching governance for the wider Single Front Door project sits. This will allow a collective decision to be made about risk ownership and mitigation.