Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26 November 2015
	Agenda Item:	10.4
	Enclosure Number:	12

Meeting:	**Trust Board**		
Title:	**Review of Ludlow Hospital Capital Scheme**		
Author:	**Julie Thornby, Director of Corporate Affairs**		
Accountable Director:	**Mike Ridley, Chairman and Jan Ditheridge, Chief Executive**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Audit Committee	6 October 2015	
	Resources and Performance Committee	21 September 2015	
	Informal Board	29 October 2015	

Purpose of the report		
This report attaches the independent review report into the failed assurance processes which led to the cancellation of the Ludlow Hospital redevelopment in 2013. Alongside this are Trust reflections on lessons learned, setting out steps taken by the Trust since the cancellation of the scheme. The Board is asked to consider the review and any further action needed.	**Consider for Action**	✓
	Approval	
	Assurance	✓
	Information	✓

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
✓	✓	✓	✓

Summary of key points in report

In 2013, the Trust Chairman asked the Trust Development Authority to commission an independent review of the failed assurance processes that led to the cancellation of the Ludlow Hospital redevelopment scheme. The Trust Development Authority commissioned that review, the aim of which was to establish the reasons for the failure to deliver the scheme and the lessons to be learned. The independent review report is attached.
The other part of this report has been prepared in the Trust and sets out what is now in place to mitigate against the risk of such events happening again.

Key Recommendations			
The Board is asked for comments on the independent review, on the arrangements now in place in the Trust, and any further actions or assurances needed.			
Is this report relevant to compliance with any key standards? YES OR NO			**State specific standard or BAF risk**
CQC	NO		
IG Governance Toolkit	N/A		
Board Assurance Framework	YES		Sustainability risks
Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**	
Patient safety & experience			
Financial (revenue & capital)	Yes	Service, reputational and financial risks	
OD/Workforce			
Legal			

Review of Ludlow Hospital Capital Scheme

1. Introduction and Context

At the Shropshire Community Health NHS Trust meeting in September 2013, Trust Chairman Mike Ridley asked the Trust Development Authority (TDA) to commission an independent review of the failed assurance processes that led to the cancellation of the Ludlow Community Hospital redevelopment scheme (the scheme).The TDA, which oversees all NHS Trusts, commissioned the review in December 2013. The aim was to establish both the reasons for the failure to deliver the scheme, and the lessons to be learned.

The review document is attached. The final section sets out lessons to be learned for the three parties to the Full Business Case (FBC) for the hospital redevelopment i.e. Shropshire Community Health NHS Trust, Shropshire Clinical Commissioning Group (CCG) and the Strategic Health Authority (SHA – now disbanded). The report states that there was a shared responsibility between these bodies to ensure that the case for the redevelopment was viable for the whole of the Shropshire health community.

The lessons to be learned stated in the report include that the Trust and other parties needed to:

- have greater clarity on activity/income and how additional activity would be provided
- properly quantify and assess risks and mitigations
- subject business cases to rigorous testing

We have shared the report with Shropshire Clinical Commissioning Group, and with The Shrewsbury and Telford Hospital Trust for their views.

This paper sets out reflections within the Trust, including what is now in place to prevent similar events happening again.

The purpose of this report is to ask the Board to consider the independent report, and whether there are further actions or assurances required.

2. Lessons Learned and Issues Addressed By the Trust

Shropshire Community Health NHS Trust has a new management team, which has been recruited since the events referred to in the “Lessons Learned” report took place. This includes a new Chief Executive and Director of Finance.

A range of measures have been put in place in the Trust, and across the local health economy, to mitigate against the risks illustrated in the failed assurance for the new Ludlow Hospital. These include:

2.1 New executive team with more capacity and focus on change, developments and stakeholder engagement

A new executive management team structure is in place, with more time and focus for major changes and developments. This includes an additional executive team role of Director of Strategy to strengthen the Trust's ability to plan developments and a Director of Nursing and Operations with new emphasis on leading development and change from an operational perspective. The Chief Executive has strengthened engagement with other organisations across the health economy.

2.2 Governance and stakeholder involvement for all developments

The Trust now has a Transformation Board which oversees all our major developments, and monitors progress on them, including the involvement of stakeholders, and on supporting aspects such as workforce and IT.

2.3 Participation in the Future Fit Programme

The Trust is participating fully in the Future Fit Programme, led by the two CCGs and involving all local health bodies. The Programme is co-ordinating development work taking place in the health economy, with workstreams in which all the local health bodies take part on for example, financial and workforce implications.

2.4 Activity and risk identification

The Trust recognises the importance of securing contractual commitments in the transfer of activity, and quantifying risks and mitigations, and will follow these two important principles as part of its contribution to all developing plans/business cases, including for Future Fit. Across the local health economy, commissioners and providers are finding innovative ways to manage activity from acute services through into community services, for example in the recent joint work on musculo-skeletal (MSK) services.

We also flag up risk identification explicitly in projects, in partnership with others where relevant eg in relation to aspects of Future Fit. Agreement with the CCG to progress community activity modelling in 'Future Fit 2' demonstrates new impetus for clarity across the health economy, although it is recognised this work is challenging, and risk identification will continue to be required.

2.5 Earlier and Stronger Testing of Business Cases

The Trust's Resources and Performance Committee carries out detailed review and testing of business cases for major new developments – for example for the Trust's new electronic patient record. The Director of Strategy prepares a regular Business Development paper for the Committee which allows the members to question projects and developments in the early stages, and results in extra assurance being sought for example about what agreements have been made and levels of risk.

2.6 More Robust Business Planning Process

The Trust has established an annual business planning process that actively reviews existing plans and establishes clear objectives for the coming year within the context of its five year plan. This process includes reviewing priorities within each service area and bringing these together in a submission to the Board. The process also ensures that the Trust can incorporate strategic initiatives and policy changes in its planning.

2.7 Further Work Needed – Governance of Multi-Partner Contracting

There is a need for more robust governance arrangements around contracting, especially with commissioners, when multiple organisations are involved. Discussions are taking place with commissioners about more robust contract governance.

3. Conclusion

The Board is asked for comments on the independent review, on the arrangements now in place in the Trust, and any further actions or assurances needed.

NHS
Trust Development Authority

NHS Trust Development Authority

An independent external review into the failed assurance processes that led to the cancellation of Shropshire Community Healthcare NHS Trust's 'Ludlow Community Hospital' redevelopment scheme.

tda Trust Development Authority
Quality. Delivery. Sustainability.

Table of contents

1. The purpose of the review

The Chairman of Shropshire Community Health NHS Trust (ShropCom) asked the NHS Trust Development Authority (NTDA) to commission an independent review of the failed assurance processes that led to the cancellation of the Ludlow Community Hospital redevelopment scheme (the scheme). The NTDA asked Neil Chapman (career history included as appendix 1 to this report) to conduct this review. The review was commissioned in December 2013 with a view to reporting in March 2014. The aim of the review was to establish both the reasons for the failure to deliver the scheme and the lessons to be learned.

2. Method of working

During the early part of the review I read all of the documents relating to the Scheme that had been considered by the Boards of Shropshire County Primary Care Trust (the former PCT), Shropshire County Clinical Commissioning Group (the CCG), ShropCom and by NHS Midlands and East (the former SHA). This included business cases, Board reports and reports from independent experts. I then undertook a series of structured evidence based interviews with senior staff from each of the organisations who were signatories to the Full Business Case (FBC). This included staff that had subsequently moved on to other NHS organisations. The interviews lasted between 60 and 90 minutes. Most were face to face, although circumstances dictated that a small number were conducted on the telephone. There were no refusals to meet me. A complete list of the interviews is attached as appendix 2 to this report. I would like to put on record my thanks to all of the individuals I talked to. Without exception they were open, honest and generous with their time. The evidence gathered from the interviews has been cross referenced and checked to the documentation. There were few inconsistencies, and as such, conclusions have been relatively straightforward to draw.

3. Background

3.1 The scheme consisted of a new community hospital (replacing and expanding the space available in the existing hospital which was considered no longer fit for purpose) with space for two GP surgeries (that would have relocated from town centre premises). Planning began back in 2007, led by the former PCT. Planning transferred to ShropComm when it was created under the Transforming Community Services initiative (TCS) in July 2011. The scheme went through a full set of approvals (see below). There was an 11 month delay in the start of the scheme whilst the Department of Health (DH) agreed to underwrite the payments to the 3rd party in event of ShropComm ceasing to be able to pay.

3.2 The capital equivalent value of the scheme was £22.6m repayable over 25 years. The annual lease payment was approximately £1.5m. The scheme involved a 3rd party financier – Amber Infrastructure Holdings Ltd.

3.3 Full Business Case Approved by;

Approved by the ShropCom Board on 17 May 2012
Approved by West Mercia PCT Cluster Board including Shropshire PCT on 22 May 2012
Approved by the SHA Board on 24 May 2012
Supported by the CCG – letters of support May and November 2012.
Supported by Shrewsbury and Telford Hospitals NHS Trust (SaTH) in a letter dated 17 May 2012
DH agreed to underwrite payments to 3rd party financiers in April 2013

3.4 In order to finalise the proposal in May 2013 ShropCom sought final confirmation regarding activity assumptions and health economy plans from partners as outlined in the original business case. The NTDA, which came into operation in April 2013 to oversee NHS Trusts, made a request in line with its capital approvals process, to the Trust to complete their checklist and for refreshed confirmation of support from health partners. The Trust initiated an internal review of the FBC which identified an annual revenue gap of £1.1m. This revenue gap was made up of £742,000 activity reduction, £340,000 accounting issues and £11,000 of new cost pressures. The CCG commissioned an external review from Finnamore to validate these findings.

3.5 The ShropCom Board decided that they could not bear this financial risk alone and formally requested the £1.1m in commissioning financial support from the CCG for the scheme.

3.6 The CCG held an extraordinary Board meeting on 21st August 2013 and concluded that it was unable to provide any additional financial support for the scheme.

3.7 The Trust held a series of consultation events and workshops during the period 21st August to 17th September 2013 to try to find ways to bridge the financial gap but was unable to get close to a viable position.

3.8 On 19th September 2013 the ShropCom Board met in public session and formally voted not to proceed with the scheme. At this meeting the ShropCom Chairman stated that the Trust would be discussing with the NTDA a process for reviewing the failure to deliver the scheme so that lessons could be learned.

3.9 The projected development cost of the scheme was £2.4m

4. The Reasons for the scheme being cancelled

The financial basis of the Full Business Case (FBC) was that the scheme would generate £3.5m of additional income for ShropCom, of which £2.5m was from patient care income transferring from neighbouring acute hospitals at full tariff. Of this additional patient care income, £1.5m was to come from additional outpatients and diagnostics and £1m from day cases. After meeting the direct costs associated with this extra activity there was £1.5m left to meet the lease costs of the new hospital. In overall terms the scheme was to break-even and would not improve the financial position of ShropCom. This was the financial basis on which the FBC eventually received full approvals in May 2012.

The review of the FBC that was undertaken in May 2013 revealed that the forecast level of increased activity was no longer fully achievable. There were many reasons for the change in view about the original activity assumptions, which are outlined in section 5 of this report. This produced a £750,000 shortfall, and when added to further adverse movements arising from guidance received from HMRC on the treatment of VAT and the changed accounting treatment of the interest element within the lease charges, this left an overall shortfall of £1.1m. The CCG decided that they could not afford to provide that level of additional financial support and ShropCom were therefore unable to proceed with the scheme. Since that decision was taken in September 2013 there had been further reviews of the levels of activity that could be transferred to a new hospital in Ludlow, and this has led to further reductions to the income numbers that were included within the FBC. As such, subsequent events have provided further justification for the decision not to proceed with the scheme. ShropCom and the local commissioners worked hard to try and find a way of making the scheme affordable without detriment to other core services. This process took a number of months but was unfortunately unsuccessful. My conclusion is that ShropCom made the right decision in stopping the scheme. With the benefit of hindsight, the remaining question therefore is whether the decision to approve the FBC in May 2012 was a reasonable one?

5. Key findings about the original activity assumptions

All parties to the transaction agreed that the planned increases in activity and patient care income included in the FBC required truly transformational changes to the way in which outpatient services and day cases are provided in Shropshire. ShropCom employed experts in the fields of strategic healthcare planning and financial modelling. These expert advisors used best practice, being achieved elsewhere in the NHS to bring care closer to the patient, in their work on the Ludlow FBC. It was acknowledged that the Shropshire health community faced a major challenge in treating Ludlow residents closer to home given the wide range of clinical specialities involved, small patient numbers and the high mileages and long travel times for clinicians. Despite the failure to deliver the scheme the external advisors maintain that the plans were and are achievable, albeit needing to be at the leading edge of what is being done elsewhere. This would have required a commitment from all parties to drive through transformational change.

The FBC received all necessary approvals in May 2012. This included letters of support from the CCG and from SaTH. However there were areas of the business case which were agreed, but implications of which were not fully understood. These areas became apparent during the final checks that were completed by the NTDA and the Trust in May 2013. There was no clear agreement on the following;

- The ownership of the additional activity and income;
- The deliverability of the additional activity at the new Ludlow Hospital.

Ownership of the additional activity

As part of the FBC there was a clearly stated assumption that ShropCom would receive the tariff income for the additional activity done at Ludlow Hospital. The net contribution of £1.5m would be used to meet the lease charges on the new building. At the outset SATH supported the project; however the issue of income was not fully described at that point. A clear position from SATH on income and activity came later through the process. SATH assumed that they would retain the tariff income and pay ShropCom for the use of the new facilities at Ludlow. As stated above, it was clear in the FBC what was required to make the scheme financially viable and that SaTH had signed a letter of support. However, in mitigation, the letter of support was only an agreement “in principle” and stated that the costs associated with the use of the space in the new facility at Ludlow would be based on a methodology yet to be agreed upon. In addition, SaTH maintain that all of the discussions had been about multi-provider use of the new hospital and did not rely on just their use. There is no evidence of any formal agreement with Hereford hospital. This lack of agreement about the ownership of the activity transferring is not apparent from the FBC, or from the attached letters of support. Towards the end of the checklist review process, both ShropCom and SaTH were both aware of this ambiguity, with the benefit of hindsight the FBC should not been sent for approval without the issue being resolved.

Deliverability of the additional activity at Ludlow

There are differences of opinion between the parties to the FBC about the deliverability of the planned additional activity at Ludlow. Two key questions should have been answered before the FBC was submitted;

- What was the breakdown of the activity to be transferred from the acute providers, principally SaTH and Hereford.
- What were the arrangements being put in place at those hospitals to staff the clinical sessions at Ludlow, and how were the operational challenges that this provided (i.e. small patient numbers/ a shortage of doctors in the relevant specialities at the acute providers/ long distances and travel times for doctors in those specialities) to be solved.

These questions remained unanswered in May 2012, and as such, each of the parties to the FBC let the case go forward without being certain about the economic consequences for the health economy, or how the operational solutions would be delivered on the ground. Each of the parties seemed to take the view that the risks where being borne by another organisation and as such were not prepared to stand in the way of the development. For example:

- ShropCom took the view that the activity numbers were ambitious but achievable, and that the assumptions were clearly stated in the FBC and that all parties were signatories. They felt that the CCG should commission additional activity at Ludlow and ensure that the acute providers honour their commitment to transformation.

- SaTH agreed in principle with an expanded role for Ludlow Hospital but were not committed to transferring the numbers of outpatients and day cases required within the FBC. There was no plan on how to staff additional clinics at Ludlow. It was felt that the risk lay with ShropCom given that they were commissioning the new facility. There was no intention on SaTH's part to sign an agreement with the third party developer for the use of space at the new Ludlow Hospital. SaTH were not put under any pressure by the CCG.

- The CCG were aware of the difficulties involved in delivering the additional clinical services at Ludlow, but did not insist on seeing a firm agreement between ShropCom and the acute providers or an operational plan to make the change happen.

In mitigation the Business case was developed when the organisational structure of the NHS was going through a period of major change. This also led to a significant turnover in senior staff who were key to the development of the scheme, including Chief Executives and Directors of Finance at each of the organisations who were party to the FBC. In addition, the scheme was held up at the DH for 11 months due to changing opinions on privately financed schemes (PFI).

6. Lessons to be learned

It should have been clear to all parties to the FBC that the case would stand or fall on the ability to re provide services worth £2.5m per annum in Ludlow. Given this, all parties had to be clear on the ownership of the activity/income transferring and on how the additional activity would be provided at Ludlow, in particular about how the required clinical staffing would be achieved. There was no certainty on these points and all parties to the transaction (ShropCom, the CCG and the SHA) which allowed the FBC to secure all necessary approvals before it was eventually rightly stopped upon review in 2013. Each of the organisations had a responsibility to ensure the case was viable for the whole of the Shropshire health community. The failure to proceed is a shared responsibility. There are three specific lessons in this report for organisations charged with the responsibility of approving business cases. Firstly, letters of support from commissioners and neighbouring providers, though often used in the NHS, are worthless unless they are clear about how changes in activity and income flows will be achieved. Secondly, risks and mitigations need to be

properly quantified and assessed. Finally, the approving organisation needs to subject the business case to rigorous testing, using independent experts where required. There were shortcomings in each of these areas in relation to the Ludlow case.

In mitigation, it seems that lessons have been learned. The clinical services review entitled “The Future Fit Programme” is a wide ranging assessment of the need for hospital and community beds in Shropshire, including their location. The outcome of this review will include a range of options for public consultation and is due out in October 2014. The healthcare planning and financial modelling work done for the original FBC was of good quality and will not be wasted, as it is being updated and will inform the new review. All parties involved in the new review are determined to secure full agreement on the service needs, the desired location and on the means of operational delivery before a new capital case is made for the redevelopment of Ludlow Community Hospital. If that is achieved then the decision to cancel the original scheme will be seen as courageous and having led to a better outcome for the local health community. I am sure that The Future Fit Programme is the right way forward and I would like to wish all of those involved every success.

Neil Chapman

Independent Reviewer

Appendix 1

Neil Chapman – Career History

Neil Chapman has been an NHS Finance Director for the last 30 years. He was the District Treasurer at Worcester District Health Authority from 1985 to 1991 before moving to Leeds where he was the Director of Finance for Leeds Teaching Hospitals (£1 billion turnover), and its predecessor organisations, for 23 years. Neil is a Chartered Accountant and has an Economics degree from Nottingham University.

Appendix 2

List of Interviewees

Shropshire Community Health NHS Trust

- Mike Ridley – Chairman
- Jo Chambers – Former Chief Executive
- Julia Bridgewater – Former Chief Executive
- Trish Donovan – Director of Finance
- Julie Thornby – Board Secretary
- Stuart Rees – Former Director of Finance
- Chris Calkin – Former Interim Director of Finance

Shropshire Clinical Commissioning Group

- Dr Caron Morton – Accountable Officer
- Dr Sal Riding – GP Member and Clinical Director of Long Term Conditions
- Paul Tully – Chief Operating Officer

Shrewsbury and Telford Hospitals NHS Trust

- Neil Nisbet – Director of Finance
- Trish Finch – Planning
- Adam Cairns – Former Chief Executive

NHS Midlands and East (Former SHA now disbanded)

- Dermot Fraser – Estates
- Helen Vinters – Finance

Strategic Health Partnership (Advisors to ShropCom)

- Chris Wood – Partner
- Mike Wilson – Partner

Provex (Advisors to ShropCom)

- Martin Davies - Partner