

Meeting title	Trust Board
Report title	Investing in a high quality healthcare environment
Meeting date	26 th June 2015
Lead director	Daniel Elkeles, Chief Executive
Report author	Daniel Elkeles, Chief Executive
FOI status	Disclosable

Report summary	This document outlines the current state of the Epsom and St Helier Trust estate and its link with current performance. It makes the case for significantly improving the trust's estate, and requests approval for further work to explore the options for providing twenty-first century healthcare facilities.
Purpose	Approval
Recommendation	The Board is asked to: SUPPORT the case for investing in a high quality healthcare environment; AGREE to engage with patients, the public and wider stakeholders, starting during the summer; And AGREE to consider what our estates options are

Corporate objective links	Understanding the options for improved estate will help ensure all the trust's corporate objectives are met: safe and effective care, positive patient experience, responsive care, financial sustainability and working in partnership.
CQC standard	Safe, effective, caring, responsive and well-led.
Identified risks and risk management actions	This work requires constructive public engagement to ensure it delivers effective solutions for the trust; this has been built in to the next steps.
Resource implications	None
Legal implications	N/A
Equality impact assessment	N/A

Report history	N/A
Considered by other committees	Long-term estate strategy Programme Board, 4 th June
Appendices	None.

**Epsom and St Helier
University Hospitals**
NHS Trust



Estates Strategy

**Investing in a high quality healthcare
environment**

Trust Board
26th June 2015

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Executive summary

Epsom and St Helier University Hospitals NHS Trust (the trust) is a safe and effective trust, with a good performance record. The low mortality rates, good patient feedback, excellent A&E waiting times and a substantially improved financial position all reflect this. The trust is a key employer and asset to the local health economy and its performance is testament to the work of its people. We are committed to this continuous improvement and we are determined to deliver quality healthcare services to every patient, every day. We are also committed to retaining both Epsom and St Helier hospitals for at least the next five years, and we aspire to continue to be the major provider of hospital care for the populations we serve in ten years.

The trust faces significant challenges over the next ten years, including delivering further improvements in the quality of care and patient safety. An improved estate will not in itself address issues facing the trust; it will however facilitate everything improving alongside improvements across our organisation. **We know that the poor quality of the estate is restricting the quality of care we can deliver, reducing the patient experience, and contributing to infection rates that are not as good as they should be** (in part because an older estate makes it more difficult to maintain a hygienic environment and isolate patients when necessary).

Our patients, staff and communities deserve to receive and provide care in buildings that are fit for the provision of modern healthcare, but the uncertainty of numerous previous service reviews has meant we have been left with buildings that are no longer fit for purpose.

Because of this, we have jointly funded, with Surrey Downs CCG and Sutton CCG, work to examine the quality of our estate to better understand the degree to which it is acting as a brake on performance, and how it can be improved. We have looked at our current estate performance both quantitatively and qualitatively to understand how we are performing. We have then compared this with examples of excellent newly built NHS estate that show what is possible with twenty-first century healthcare buildings.

Examples of the patient experience

*At Epsom Hospital, a patient who was admitted with a stroke received immediate treatment and then had to be **wheeled outside on a trolley** to get to Langley Wing, past visitors and moving vehicles.*

*At St Helier Hospital, a child was admitted through our Emergency Department. After initial assessment, **the child had to be wheeled through long underground tunnels** to reach the children's inpatient wards. This journey had to be repeated when an emergency CT was needed.*

Examination of the best buildings in the NHS identifies that modern health facilities, at their best, support patient privacy and dignity, high quality care, a healing environment, ease of maintenance, improved safety, infection prevention, environmental sustainability, and affordability. They are characterised by some key space, layout and size standards which we cannot attain in our current buildings.

The current estate falls far short of what patients should expect from 21st century healthcare facilities. Although our planned investment will provide some short-term improvements, there are significant structural constraints that mean we can only make basic repairs such as keeping the rain out and renewing out of date heating systems. While these improvements are welcome, they merely hold back the tide for a few years. Some 95% of St Helier hospital was built before the NHS was founded in 1948, and, put simply, the basic size and layout of our wards – which were state of the art in the 1930s – are now outmoded and, critically, incapable of being modernised as the wards are the wrong shape, size and dimensions to meet current standards.

Co-location of relevant services is very difficult and often impossible, meaning that patients often have to be transferred distances within the hospital when they are ill and at their most vulnerable. Whilst everything is done to make sure patients are as comfortable as possible, this is something that we need to address for the future. It is impossible to change some of wards and areas to meet modern standards without wholesale demolition and rebuilding. We currently spend significant money and effort to minimize the impact of our estate on patients, £1million more than we would with a modern estate, but it is not enough and the challenges posed by our poor quality estate are ever increasing.

In this first phase report, we consider whether it is possible, on the current estates footprint that we have, to re-provide the facilities as they are on each site and meet the requirements for a modern estate. To do this we think would cost over **£500m**.

This is a vast amount of money and before embarking on making the case for this level of expenditure **we need to look at all the options available to significantly improve the quality and function of our buildings over ten years**, with the aim of transforming into a trust with some of the best hospital buildings in the NHS. This includes ensuring that we can finance any proposed option and that it is affordable to the system; without this, we cannot make commitments to new buildings.

To do this, we are proposing engaging our partners, patients and the public to understand their needs and priorities. This will include working with local people on what is important to them from hospital buildings and estate. Alongside this, we are also proposing undertaking an assessment of the options available to us, before any decision-making process begins.

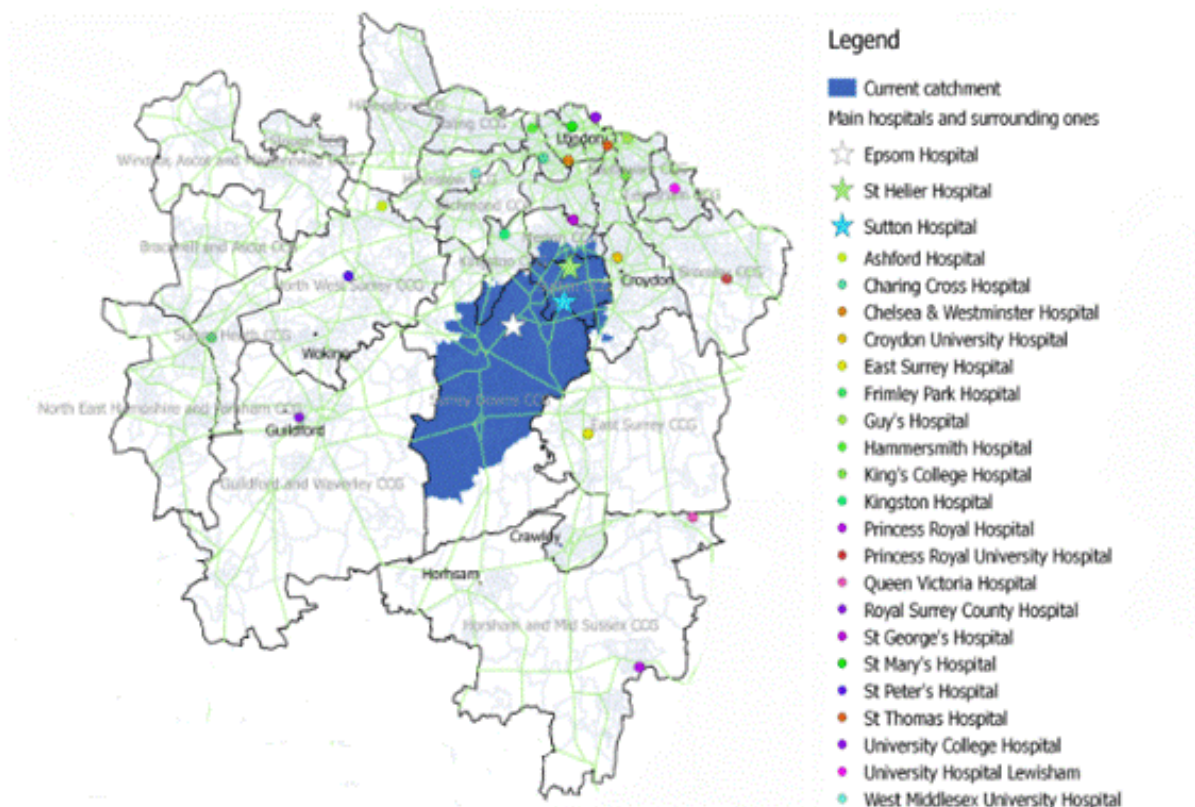
1 Why we are looking at our estates strategy for 2020–2030

1. **Epsom and St Helier University Hospitals NHS Trust is a safe, and increasingly financially stable provider. However, we are becoming limited by our estate, and want to ensure we treat our patients in buildings that are fit for twenty-first century healthcare.**
2. There have been multiple plans over many years to re-develop the trust, including rebuilding the estate and downgrading hospitals; in 2010, £219m was proposed as investment in St Helier Hospital. The uncertainty about estate investment has limited development of the trust, and prevented the resolution of wider system-wide issues.
3. We are committed to retaining both Epsom and St Helier hospitals for at least the next five years. We are also determined to gain agreement for a major long-term investment in the estate so the quality of our buildings matches the quality of care we provide.
4. **We have funded this work jointly with Surrey Downs Clinical Commissioning Group (CCG) and Sutton CCG** to explore the long-term options for our estate. We are working closely with all our health and care partners in the local area and all of us are committed to ensuring we can provide the best possible care, long term, for local people in the future.
5. This is intended to ensure we can find a solution that supports the trust and its partners in delivering the highest quality of care to local people, supports all organisations in achieving financial stability, and aligns with broader strategic priorities.
6. All three parties govern the work through a joint Programme Board, which includes our Chief Executive, CCG accountable officers and CCG chairs. The work also aligns with broader strategic work, including the programme exploring the options for the South West London health economy (which is represented on the programme's Finance and Activity Modelling Group).
7. This joint work is intended to shape our plans for the next ten years and to ensure we have a modern, twenty-first century facilities to deliver healthcare.

1.1 Who we are

8. The trust primarily delivers services from its two main sites at Epsom Hospital and St Helier Hospital (which includes Queen Mary's Hospital for Children) and owns Sutton Hospital, although most of the site is vacant and few services are provided there.
9. Epsom Hospital serves a local population of approximately 200,000 in Surrey, St Helier Hospital a population of approximately 285,000 in South West London. In addition, the trust provides renal services for all of South West London and Surrey and provides planned orthopaedic surgery for all of South West London and parts of Surrey.
10. There are **four main commissioners of services at the trust**: Surrey Downs CCG, Sutton CCG, NHS England and Merton CCG; the trust therefore has to operate across multiple administrative NHS boundaries.

Figure 1: Current catchment size



11. The trust currently provides services from all of its sites. **Epsom Hospital and St Helier Hospital are district general hospitals**, each providing a 24/7 consultant-led A&E, acute and general medicine, surgery (non-elective only at St Helier Hospital), maternity, paediatrics and outpatients. In addition:
- **Epsom Hospital** hosts the South West London Elective Orthopaedic Centre, an NHS treatment centre providing regional elective orthopaedic surgery services for four South West London trusts. Epsom Hospital is also a paediatric oncology shared care unit (POSCU), an emergency stroke unit and has a 20-bed private patients unit.
 - **St Helier Hospital** provides a regional renal service, a stroke unit, undertakes all the emergency surgery for the trust and is the main pathology centre for the trust.
 - **Sutton Hospital is mainly vacant** and only provides a few outpatient services plus phlebotomy. In 2014/15, the trust sold some of the site to Sutton Council but we still own 6 hectares of land. Our site is adjacent to the Royal Marsden's Sutton site.

Figure 2: Current service provision (at June 2015)

Service	Epsom	St Helier	Sutton
Accident and Emergency ¹	Major	✓ (24/7)	x
	Minor	✓ (24/7)	x
	Urgent care centre	x	✓ (24/7)
Medicine ²	Emergency	✓	x
	Elective	✓	x
	Outpatient	✓	✓ (Few)
Surgery	Emergency	x	✓
	Complex elective	✓	x
	Non-complex elective	✓	x
	Day case	✓	x
	Outpatients	✓	x
	Endoscopy	✓	x
Critical care	Intensive treatment unit	✓ (Level 2)	✓ (Level 3)
Women	Ante/post natal care	✓	x
	Consultant-led births	✓	x
	Midwife births	✓	x
	Gynaecology ³	✓	x
Paediatrics ³	Inpatient medicine	✓	x
	Inpatient surgery (>8 years)	x	✓
	Neo-natal intensive care unit	✓ (Level 1)	✓ (Level 2)
	Daycase	✓	x
	Outpatients	✓	x
Cancer	Surgery	✓	x
	Chemotherapy	✓	x
	Radiotherapy ⁴	x	x
	Paediatric oncology shared care unit	✓	x
	Renal	x	✓
Specialist	Stroke	✓ (emergency stroke unit and stroke unit)	✓ (Stroke unit)
Other	South West London Elective Orthopaedic Centre	✓	x
	Private patients	✓	x
	Radiology ⁵	✓	x
	Pharmacy	✓	x
	Pathology	✓ (Hot)	✓ (Full)

Note: Level 1 = Moderate dependency; Level 2 = High dependency; Level 3 = Intensive care

¹Including paed (both) and ophthalmology (St Helier only), ²Cath lab being developed at St Helier, ³Trust also run a community paediatric service, ⁴Service provided by Royal Marsden

⁵Includes MRI and CT, ⁶Emergency gynaecology at St Helier only

12. The trust currently provides services for a non-elective catchment population of around **482,000** people, and in 2014/15, had approximately **885,000 patient contacts**, which comprised:
- **630,000** outpatient appointments
 - **35,000** emergency inpatient spells
 - **7,500** elective inpatients (of which 3,600 relate to the South West London Elective Orthopaedic Centre, on behalf of the trust and its partners) including 190 paediatric elective inpatients
 - **58,300** daycases (of which 1,700 relate to the South West London Elective Orthopaedic Centre)
 - **4,900** births, and
 - **150,000** A&E attendances (about 410 per day), of which 70% were minor attendances
13. As of May 2015, the trust has around **1,062 beds** in total, comprising:
- **830** overnight beds
 - **20** private beds
 - **61** escalation beds

- **135** day beds
- **16** day chairs

14. Of these, **911 are overnight beds** (including regular overnight beds, private beds and escalation beds); 86% are used for non-elective activity.

1.2 Quality and safety

15. The trust's mission is to **put the patient first by delivering great care to every patient, every day**, focusing on providing high quality, compassionate care that:

- Is safe and effective.
- Creates a positive experience that meets the expectations of patients, their families and carers.
- Is responsive and delivers the right treatment, in the right place, at the right time.

16. **The trust is already delivering safe, good quality care to patients.** The health watchdog, the Care Quality Commission's (CQC's) Intelligent Monitoring, looks at data on a wide range of indicators for whether the care people are receiving is safe, caring, effective, responsive to their needs and well-led (for example death rates, serious errors and patient surveys). This has consistently concluded that the trust performs well, with all of the trust's hospitals scoring highly.

17. The trust achieves a **consistently good hospital standardised mortality ratio (HSMR)** (the difference between the mortality rate that would be expected for the trust given the local population, types of operations performed, etc. and its actual observed mortality rate). The trust consistently achieves **a HSMR score less than 100**, which means mortality rates at the trust are within the expected range.¹

18. The trust achieved **more of the London Quality Standards for Urgent and Emergency Care than its neighbouring trusts**, meeting 136 of the standards, reflecting the high quality of its urgent and emergency care services.

19. The **trust's performance is strong against many of the Government's key healthcare standards**. Strong performance includes:

- **97% of patients recommending the trust** to friends and family² for A&E.
- Exceeding the **A&E waiting time target of 95% seen within 4 hours** (95.6% in 2014/15)

¹ Dr Foster intelligence (2014/15)

² February 2015

20. Other achievements include receiving an authoritative report from the Royal College of Physicians that showed **St Helier Hospital is providing great care to patients who have suffered a fractured hip** (a service where patients receive care in a dedicated ward, specifically designed for them); **receiving praise for care for trauma patients** (people with multiple serious injuries that could result in death or serious disability) following a thorough external inspection; and **opening a state-of-the-art urology centre at Epsom** in 2015 to deliver world-class care.

1.3 Our strategy for the next five years

21. The quality the trust has been able to achieve has provided the platform for planning over the next five years. Between now and 2020 we have committed that:
- Both **Epsom Hospital and St Helier Hospital will continue to provide consultant led, 24/7 A&E, maternity and inpatient paediatric services.**
 - In addition, **St Helier Hospital will provide specialist and emergency care** such as acute surgery for our most sick patients, and **Epsom Hospital will expand its range of planned care.**
 - Work will continue with patients, GPs, commissioners and partners to **provide significantly more care in community settings**, closer to home for patients, so that they only have to come to hospital when they really have to.
22. **Our people are central to delivering our mission.** Along with greatly improving substantive staffing levels, the trust is seeking to engage, empower, develop and equip our teams to perform to their full potential, with clear responsibility and accountability, establishing an organisational culture that reflects our values and behaviours. People who actively wish to come on the change journey will be helped and rewarded, through supporting them in their education and continuing professional development. The trust aspires to be a high quality organisation, both an 'employer of choice' and a 'provider of choice'.
23. We intend to refresh and embed values to create a 'one team, one trust' culture and focus on the delivery of five objectives; these will ensure high quality, compassionate care is provided to all patients:
- Delivering **safe** and effective care with respect and dignity
 - Creating a positive **experience** that meets the expectations of our patients, their families and carers
 - Providing **responsive** care that delivers the right treatment, in the right place at the right time
 - Being **financially sustainable**
 - Working in **partnership** with our patients, commissioners, other health and care providers, local authorities, the voluntary sector, the NHS TDA, NHS England and

Monitor in the interests of patients and a sustainable local health and social care economy.

24. To deliver this vision, we are focused on four principal challenges:

- Further **strengthening staffing** in key areas and improve staff health and wellbeing.
- Building on successes and further **strengthening the delivery of clinical care**, including ensuring a 'one team, one trust' culture and consistent, evidence-based operating practices.
- **Improving our estate** with major investment over the next five years to address immediate issues, and a long-term aspiration for twenty-first century facilities.
- Maintaining our **robust financial performance**, delivering a recurrent surplus each year.

1.4 Patient First

25. The trust launched its Patient First Programme in December 2013, to help us maintain focus on continually improving the quality of the care that we give our patients and achieve our goal to 'put the patient first'.

26. **The philosophy of this programme is to empower all our staff to take action locally, through a shared understanding of what matters to our patients.** We gather feedback from patients from a wide range of sources, and turn this feedback into 'journey maps', which highlight the scenarios that patients tell us have a negative on their experience (for example waiting a long time for ward staff to answer the phone), but also share best practice from around the world and communicate how the trust is doing against national measures of quality. By seeing things from our patient's perspective, staff can see the everyday issues that impact on our patients and identify what they can do to make improvements.

27. The Patient First Programme has so far been a great success, and has been the catalyst to a number of improvements, including:

- New lanyards that help people identify doctors more easily
- The introduction of a la carte menus on the wards
- Photo boards on all of our wards with the names and roles of the staff working on the wards
- Self check-in 'kiosks' in the Outpatient department for patients

28. You can find out more and get involved at www.epsom-sthelier.nhs.uk/patientfirst.

1.5 History of development at the trust

29. The trust was formed in 1999 following a merger of Epsom Health Care NHS Trust and The St. Helier NHS Trust. In the past decade there have been multiple attempts to secure sustainable, high quality health services for the local populations of Epsom and St Helier:

- As part of *Better Healthcare Closer to Home*, an **strategic outline case was developed in 2005 for the development a 'critical care hospital' on the Sutton Hospital site** as part of a suite of 'critical care' and 'local care' centre developments. This was rejected by the then Secretary of State for Health, who in December 2005 announced that she expected the local NHS to take forward a plan **to rebuild St Helier as a critical care hospital on Metropolitan open land opposite the current hospital site**. However, in 2006, this redevelopment was abandoned due to planning restrictions, though plans to develop St Helier Hospital continued.
- In 2006, the trust closed the A&E at Epsom General Hospital for those trauma and emergency surgery cases arriving by ambulance, and moved these to St Helier Hospital. In 2008, the trust announced **plans to move paediatric and maternity services from Epsom General Hospital to St Helier Hospital** but these plans were put on hold pending a review of the trust's future.
- **In October 2006, a local private individual put forward a proposal to buy Epsom General Hospital and redevelop the site** but the trust Board rejected this in 2007.
- **In 2009, the local NHS recommended a more limited rebuild of the existing hospital site at St Helier.** The Strategic Health Authority agreed that the outline business case – costing £219m – could go to the Department of Health for approval in 2010, but the plan was then put on hold pending a South West London-wide review of acute services.
- In December 2010, the Board concluded that it was unable to meet the requirements for achieving foundation trust (FT) status; as a result, a “Transactions Board” was established to find alternatives. Ultimately, two proposals received support in principle. St George's NHS Trust was to merge with St Helier Hospital and Ashford and St Peters Hospitals NHS Trust was to acquire Epsom Hospital. **This would have resulted in the disbandment of the trust in 2012.** However, both of these proposals failed because they could not meet the financial requirements established by the organisations concerned.
- *Healthcare for South West London* (2009-10) and more recently *Better Services, Better Value* (2011–13) explored whether there should be a reduction in the number of A&Es in South West London but neither programme was able to move through to a proposal for change. *Better Services, Better Value* was proposing to consult on a number of options, including **a preferred option that would result in downgrading both Epsom Hospital and St Helier Hospital to local hospitals**, which would not provide A&E, obstetrics or paediatric services. This did not proceed due to CCG opposition. In part, the proposals in BSBV were based on the poor fabric of our buildings and the costs to the NHS of upgrading these.

30. **In the absence of firm commissioning plans, the trust has been unable to get support to proceed with the re-development of St Helier Hospital or Epsom Hospital.**

31. The commissioning strategies of Sutton, Merton and Surrey Downs CCGs must form the basis of any further proposals. We are involved in the work in South West London to develop a solution for the South West London area. However, **there are no current service reconfiguration proposals in South West London, and we aspire to be the major provider of hospital care for the populations we serve.** Given the changing environment, we need to find a viable proposition for our future that delivers quality care for our patients.

1.6 Our buildings

Epsom Hospital





Source: ESTH



32. Epsom Hospital was originally a workhouse; an infirmary was first opened on the site in 1851. In 1948, when the hospital joined the NHS, it had 330 beds (including 60 maternity beds opened in 1941) and one operating theatre. Headley Wing was opened in 1955, the Wells Wing in 1971 and the Denbies Wing in 2000. The South West London Orthopaedic Centre opened in 2004.
33. Epsom Hospital currently has around **433 beds**, comprising 304 overnight beds, the 71 bed South West London Elective Orthopaedic Centre and 58 day beds.
34. **The oldest buildings at Epsom Hospital date from the 1930s with most buildings (67%) being more than 30 years old.** These buildings have been through a number of refurbishments to allow the hospital to meet clinical standards. Whilst it has a low percentage of un-utilised space, **42% of the occupied floor space is reported as being not functionally suitable.**
35. The Denbies and Bradbury Wings are the only modern buildings on the site and the only in the trust that fully meet the expectations the trust has of its estate.

Title plan



Key:  Freehold land transferred to a charitable organisation in 1999  999 yrs. Leasehold

- Predominately Freehold. Area shaded yellow on the plan is leased from St. Kilda's Trust for a period of 15 yrs. and includes Woodcote Lodge which is used for staff accommodation. There is an outstanding lease renewal with the Trust "holding over" which includes an access road to staff carpark. The lease would need to be renewed should the Trust wish to remain in occupation (Negotiations are in hand.) The access arrangements are a constraint that would need to be considered should this area be reconfigured/ developed in the future. The area shaded pink is also leasehold (999 yrs).
- The current strategy is to co-locate all clinical services towards the front of the site to improve the patient pathway. It also aims to improve utilisation of the spare capacity by developing/ reconfiguring areas within the hospital, to consolidate all medical activity at ground floor level/ front of site, with office/ admin and residential to the rear of the site. Other residential options are to be considered including off site/ partnering with other providers, which could provide further capacity.
- Proposed capital expenditure predominantly relates to spend to enhance the patient experience and other high priority requirements.
- Large estate investment/ backlog maintenance items forecast (c £6.2m) over the next 5 years; this relates to critical infrastructure risks (e.g. plant and equipment).

Age profile		Wards/rooms profile (13/14 data)		Investment (forecast 2015-20) ¹			
Pre 1948	15.9%	Total number of overnight beds (inc. EOC)	375	2015-16	£0.83m	2018-19	£4.28m
1948 - 1964	11.6%	Number of single rooms ²	69	2016-17	£9.84m	2019-20	£5.20m
1965 - 1984	39.6%	Number of en-suite rooms	52	2017-18	£6.22m		
1985 - 1994	6.2%						
1995 to present	26.7%	% of single rooms ²	18%	Cost to eradicate backlog (as in 2014)			£16.6m

Source: Title Plans; ESHUH Estates Strategy 2015-2020; Trust Report Final 2014; Interview with ESHUH Strategic Asset Manager
We have not verified this data and are relying on information provided by the Trust. In particular we have not verified the site data or legal title. Investment forecasts assume a sale of the Sutton site

St Helier Hospital and Queen Mary Hospital for Children



Source: ESTH

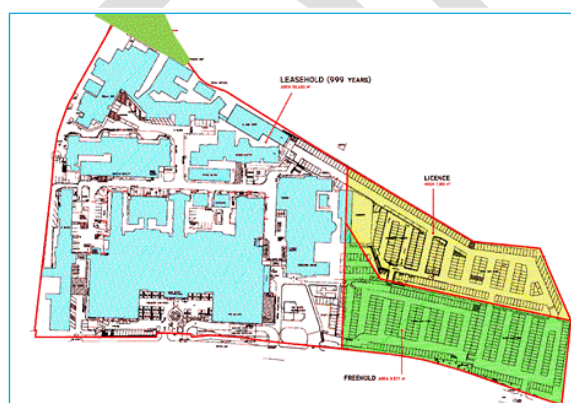
36. St Helier Hospital was opened in 1938 with 638 beds. It consisted of six buildings including the main block and Ferguson House. The hospital was modernised and re-equipped in the 1970's. The A&E opened in 1977 and the new maternity unit was opened in 1987. Queen Mary's Hospital for Children was originally in Carshalton and opened in 1909. QMHC moved to the St Helier Hospital site in 1993.
37. St Helier Hospital currently has **629 beds**, comprising 536 overnight beds and 93 day beds and chairs.
38. All buildings at St Helier Hospital and Queen Mary Hospital for Children are located on leasehold (999 years) land, where the local authority is the ultimate landowner as opposed to the trust. There is a freehold area and a shorter 60 years leasehold area, both currently used for parking. **Current estates condition varies significantly across the site and there has been underinvestment in the estate given the uncertainty about the future of the hospital.** Over 90% of the buildings are over 65 years old and 37% of the occupied floor space is not functionally suitable.

Figure 5: Examples of quality of St Helier Hospital buildings



Figure 6: St Helier Hospital site

Title plan



Site details and plans for development

- c70% Leasehold, which houses the main hospital buildings. The parking area, shown yellow, is leased from the local authority, which expires in 2025, with a restricted use for parking only (there is an option to extend this lease to 999 years). Temporary consent for the decked carpark expires in 5 years.
- Given the trust's previous strategic reviews, the buildings have suffered "planning blight" which has resulted in previous underinvestment and now require significant capital expenditure to bring the buildings up to current standards.
- The current strategy aims to improve certain areas by phased upgrades and refurbishments - predominantly centred around a new main reception / entrance (£1.29m planned for 2017/18); consolidation of outpatients and access improvements (£2.9m 2017/18); infilling and widening of wards between blocks B & C (£4.76m 2018/19) and a series of further ward upgrades (2 wards per year over the next 5 years at £5m).
- Given site constraints, the phasing and coordination of this work will be critical to minimise disruption and down time and deliver within the current budgets.
- Proposed capital expenditure spend predominantly relate to spend to enhance the patient experience and other high priority requirements.

Key:

999 yrs. Leasehold Freehold 60 yrs. Leasehold (until 2025 - licensed for parking by local authority)

Age profile		Wards/rooms profile (13/14 data)		Investment (forecast 2015-20) ¹			
Pre 1948	91%	Total number of overnight beds and chairs	536	2015-16	£1.00m	2018-19	£9.81m
1948 - 1964	3.5%			2016-17	£5.25m	2019-20	£8.90m
1965 - 1984	0.1%	Number of single rooms	121	2017-18	£8.67m		
1985 - 1994	1.1%	Number of en-suite rooms	26				
1995 to present	4.3%			Cost to eradicate backlog (as in 2014)			£30.3m
		% of single rooms	22.6%				

Source: Title Plans; ESHUH Estates Strategy 2015-2020; Trust Report Final 2014; DRE visual site inspections and site visit/interview with ESHUH Strategic Asset Manager
We have not verified this data and are relying on information provided by the Trust. In particular we have not verified the site data or legal title. Investment forecasts assume a sale of the Sutton site

¹ Includes improvement in existing buildings, education in backlog per site (as per Estates Strategy), and sale of Sutton site - Excludes overall Trust Budget

Sutton Hospital



Source: ESTH

39. Sutton Hospital in its current form was opened in 1931 as a District Hospital. Between 1948 and 1967, a number of buildings were added to the hospital including a maternity wing, additional wards and an outpatients department, such that, by 1967, the hospital had 282 beds. A day surgery unit was added in 1983 and an orthopaedic surgery unit in 1991 with mental health services co-located on site. Services started moving off the site following the 1999 creation of the trust, and now only a few outpatient services and phlebotomy (taking blood) remain. The rest of the site is vacant.
40. The Sutton Hospital site has a number of relatively small buildings, mostly dating from the late 19th and early 20th century and some are locally listed. The trust has closed most of these buildings and **over 90% of the total floor area is closed** in line with the current estate strategy that aims for site disposal at some point in the future (raising funds for our planned estate investment). Therefore, whilst expenditure will have fallen, the trust will still have a responsibility for maintaining the buildings that are still occupied and the site as a whole.
41. As the Sutton site has been vacated, we have consolidated services at our remaining sites to improve use of existing estate.

Figure 7: Sutton Hospital site

Plan



Key:

■ Retained freehold following the sale of the land to the Council (solid land is outlined blue)

Site details and plans for development

- Freehold land remaining after the recent sale of land to the Council is 6 ha. There are some locally listed buildings on site, although we understand this should not adversely impact planning. Most buildings have been closed pending a sale of the site in accordance with Trust's current strategy, although some clinical services do remain as well as the nursery.
- The site adjoins the Marsden and the Institute of Cancer Research.
- Existing Use Value of land in LTFM is £21.6m. Sale of 1.6 ha of land to the local authority concluded at £8.5m. (Outlined blue on the plan).
- Estates Strategy predicated on a sale of Sutton by 2016/17 with the receipts reinvested back into the two remaining sites.

Age profile

Pre 1948	31.7%
1948 - 1964	35.9%
1965 - 1984	23.9%
1985 - 1994	1.8%
1995 to present	6.7%

Wards/ rooms profile

Total number of overnight beds	n/a
Number of single rooms	n/a
Number of en-suite rooms	n/a
% of single rooms	n/a

Investment (forecast 2015-20)

N/A. Whilst some ongoing investment is required, the previous forecasts overstate the amount, given the majority of buildings have now been closed.

Source: ESHUJH Estates Strategy 2015-2020; Trust Report Final 2014; Interview with ESHUJH Strategic Asset Manager;

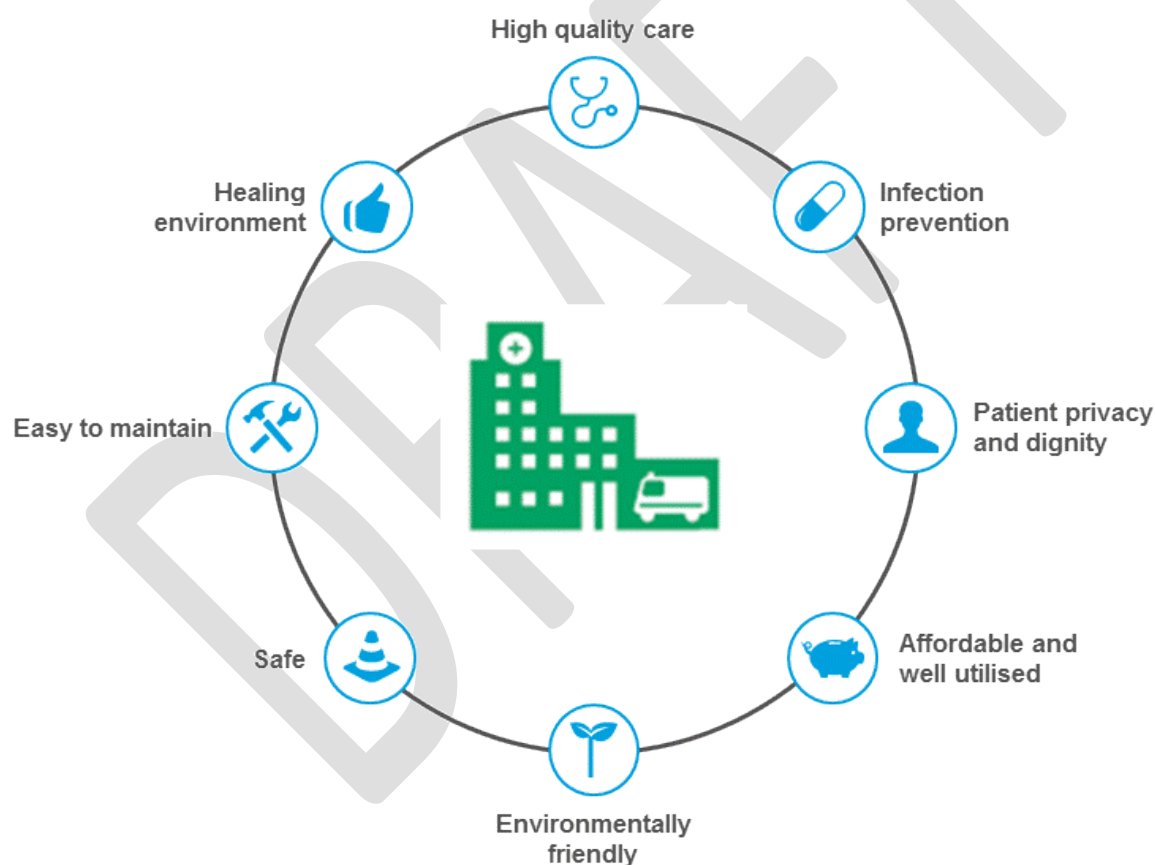
1.7 Current estates challenges

42. Despite our recent successes, **patients who attend our trust for treatment are receiving care in inadequate facilities**. Our patients, staff and communities deserve to receive and provide care in buildings that are fit for the provision of modern healthcare, but the uncertainty of numerous previous service reviews has meant we have been left with buildings that are no longer fit for purpose.
43. The remainder of this document sets out our case for new hospital buildings. We describe the key features of good hospital buildings, and what it means for our patients not to have these features. We have developed this document to provide an objective analysis of the extent to which our estate is a limiting factor to the quality of care we can offer.
44. The Trust Development Authority (TDA) has recently written to the trust to give its support to the trust proceeding on the development pathway to become a foundation trust. It is therefore also important to secure a plan for estates as part of the trust's overall strategy, to make sure the trust can continue to deliver high quality healthcare for its local population.

2 What should hospital buildings look like in 2020–2030?

45. We aspire to provide care in buildings that match our mission to put the patients first and provide great care to every patient every day. In recent years, the NHS has been building superb new facilities across the country. We have reviewed Department of Health building Notes, which give best practice guidance on the design and planning of new/adapted healthcare buildings, as well as some of the best examples of current NHS buildings, to identify their defining features.³ A modern, twenty-first century estate supports excellent patient care, is a positive environment for both staff and patients, and is safe, in sound condition, energy efficient and offers enough space for the delivery of care.
46. **We have an ambition to develop our estate to reflect these key features**, which are described further below.

Figure 8: Key features of twenty-first century estate



³ Department of Health, Building notes

High quality care

- The estate should **reflect the clinical needs of patients**, have been designed as a result of a clinically led estates strategy, and support the achievement of quality standards (eg, effective delivery of consultant-delivered care). There is increasing evidence that consultant delivered care 24 hours a day, seven days a week, reduces mortality and complications for patients⁴. Delivering these standards of consultant delivered care is much more challenging in buildings that are not well designed and flexible or with the space to properly accommodate the numbers of patients who need the services.
- Efficient internal adjacencies and relationships provided that ensure **smooth patient flow through the hospital**. In well-designed hospitals the key services often radiate from a central core which minimises distance for people to travel and makes running hospitals more efficient
- Excellent sight lines and easy observation of dependant patients by staff.
- An estate that supports clinical and service changes, offering **flexible spaces** that can be changed easily as patient needs and clinical models change.
- The new hospitals that have been built have applied this to a range of services including maternity, paediatrics, emergency care, outpatients and diagnostics. They all demonstrate that achieving the highest quality of care efficiently requires high quality buildings.
- Buildings are **dementia friendly, designed to support those with cognitive impairment**, minimizing the risk of falls or anxiety in the increasing number of dementia patients that will need to be treated in hospitals in the future.

Infection prevention

- The design of the estate should facilitate effective **infection control** (eg, ensuring sufficient spaces between beds, appropriate clean and dirty clinical flows, plenty of single rooms). Best practice is now for over 50% and ideally over 75% of rooms in a hospital to be single and en-suite
- The wall, floor and ceiling finishes, along with the fixtures, fittings and furniture are all specified in accordance with infection control best practice (eg, self-cleansing surfaces, antibacterial finishes, easily wipe able, joint free etc.).
- The physical areas and rooms across the estate are large enough to effectively support the delivery of patient care and reduce infection risk, and are in line with, or in excess of, national space standard guidance.

⁴ NHS England (2013) *NHS Services, Seven Days a Week Forum: Evidence base and clinical standards for the care and onward transfer of acute inpatients*

Patient privacy and dignity

- High levels of patient privacy, dignity and comfort (eg, single bedrooms and/or small-bedded bays).
- **Separate sex wards** (or bedded areas), toilets and washing facilities.
- Designated and segregated patient, staff and service routes.
- **Appropriate and adequate, well located support facilities** (eg, WC/bathroom facilities, clean / dirty utilities, storage, waiting areas etc.).

Healing environment

- The **environment is pleasant** – it should be well lit, with appropriate temperature control, with adequate ventilation, with good acoustic performance and odour free. Ideally all rooms should have windows that look out onto either landscaped courtyards or onto open space
- The **buildings and internal and external spaces are aesthetically pleasing**, with appropriate colour schemes, well furnished, enhanced by art, plants, landscaping, and with views out.
- The estate **seamlessly incorporates modern technologies** that enhance the quality of care and the patient experience (eg, IT, patient entertainment, nurse call, specialist medical equipment etc.).
- Buildings are **temperature controlled**, with heating and air conditioning to ensure that wards are not too cold in winter or too hot during the summer.

Easy to maintain

- The estate should be in **sound condition**, operationally safe and be expected to perform adequately over its expected life.
- The estate should have **robust infrastructure**, with appropriate resilience, that facilitates current and future requirements.
- **Backlog maintenance levels should be negligible** and be addressed within the yearly maintenance programme.

Safe

- The estate should be designed, constructed and maintained in a way that ensures the building meets **key safety requirements**, for example in relation to fire safety; infection control; legionellae; health and safety and food hygiene.
- **Good provision for the disabled** – covering physical, cognitive, mental, sensory, emotional or development impairment/s.

Environmentally friendly

- **Energy efficient** in terms of energy and water consumption.
- Should have a good **recycling facility** on site.
- Makes good use of **renewable energy sources** where appropriate
- Is **sustainable and low carbon**, meeting the NHS Carbon Reduction Strategy.

Affordable and well-utilised

- The estate should be **cost effective** to maintain and clean.
- **Good energy performance**, meaning operating costs associated with heat, power and water are as low as possible.
- The **available space is used in an appropriate way** (ie, for the delivery of patient care) and the estate has **high levels of overall utilisation** (ie, all areas being cleaned, maintained, heated etc. are being well used throughout the day and week).

2.1 Examples of twenty-first century estate

47. There are examples across the UK of hospitals that perform well across these key indicators, showing the potential of twenty-first century estate that is built in accordance with best practice guidance. We have selected three examples of good estate to illustrate what can be achieved. These vary in their size and focus and none are an identical parallel to our specific issues, but all are high-quality buildings from which care is delivered.
48. The examples selected are:
 - **Northumbria Specialist Emergency Care Hospital:** the first purpose-built emergency care hospital in England
 - **Peterborough City Hospital:** a modern acute hospital that has been MRSA-free since it opened
 - **New South Glasgow Hospital:** one of the most technologically advanced health campuses in Europe
49. Each is described in more detail below.

Northumbria Specialist Emergency Care Hospital



50. This state-of-the-art hospital will be the first purpose built emergency care hospital in England, with emergency care consultants on site 24 hours a day, seven days a week. The hospital will serve a population of 550,000 and is part of a trust including three general hospitals and seven community hospital sites.
51. The development is a new-build 3-storey development, providing 30,000m² of clinical and support space, and opens in summer 2015. The site is considered exemplary. Sir Bruce Keogh, the NHS Medical Director, said: "This project sets the standard for other NHS organisations in the country. It will bring something really special to the people of the region, it reflects great ambition. Today, I have seen a glimpse of the future." Its key strengths are described below.

Figure 9: Key features of Northumbria Specialist Emergency Care Hospital

Efficient patient pathways and optimum functional adjacencies	<ul style="list-style-type: none"> The design focused on creating exemplar patient pathways, adjacencies, nursing efficiencies and sight lines, to ensure the best care can be delivered from the new facility. This 'inside-out' design approach resulted in the uniquely planned circular wards. Diagnostics are co-located in the emergency care department – MRI and CT scanners are co-located in A&E making sure specialists get test results faster – evidence shows this improves outcomes for patients.
State of art systems and energy efficient	<ul style="list-style-type: none"> Incorporates state of the art mechanical and electrical systems, with excellent resilience. The new facility has been designed to be energy efficient and sustainable, including features such as biomass boilers, CHP, low energy lighting and water saving equipment.
Excellent patient experience	<ul style="list-style-type: none"> Higher proportion of single rooms with en-suites - addressing the patient privacy and dignity agenda, as well as patient comfort. Bedrooms are largely outward facing, providing good levels of natural daylight and pleasant views of the surrounding countryside. Central nursing points in ward areas ensures excellent patient observation.
Healthy, healing environment	<ul style="list-style-type: none"> Best practice infection control standards. Significant public realm space. Aesthetically pleasing environment internally and externally.

Peterborough City Hospital



52. Peterborough City Hospital opened in 2010. It is an acute hospital, co-located on a health campus with a care centre and mental health unit, including an emergency care centre, specialist rehabilitation unit and high-tech diagnostic unit.
53. The hospital was a new-build, 4-storey development, providing 64,000m² of clinical and support space. The hospital has a full range of specialties including a cancer centre, cardiology centre, a dedicated women's and children's unit, and adult and paediatric emergency centres.

Figure 10: Key features of Peterborough City Hospital

Excellent clinical functional adjacencies	<ul style="list-style-type: none"> • Excellent clinical adjacencies – with all main departments being accessed from a central concourse, allowing for easy, quick navigation through the building. • Co-located with other health facilities to aid patient pathways e.g. on a health campus with a city care centre and mental health unit
Healthy, healing environment	<ul style="list-style-type: none"> • An aesthetically pleasing internal environment with large amounts of natural light, good acoustic performance, natural ventilation, colour, artwork etc. • Enclosed tranquil landscaped gardens and courtyards. • The hospital has not had an outbreak of MRSA since it opened.
Excellent patient experience	<ul style="list-style-type: none"> • 1st UK hospital to have “cruciform” wards – these 4 bedded bays create personal space around each bed for patients and maximise daylight and views. • Design of building maximised patients views onto ‘green’ space. • Way-finding artwork to help patients and visitors navigate the building
Safe, Sustainable, and energy efficient	<ul style="list-style-type: none"> • Designed and built to achieve low maintenance costs. • Designed to have a life expectancy in excess of 40 years. • Specified to be environmentally friendly throughout its whole lifecycle. • Recyclability was a key design requirement.

New South Glasgow Hospital



54. New South Glasgow Hospital is one of the largest hospitals commissioned in the UK and one of the most advanced medical campuses in Europe, incorporating the largest A&E department in Scotland and offering major specialist services, including transplantation and vascular surgery.
55. The new development brings together maternity, children's and adult hospitals onto one site. It is a new build 14-storey development, providing 170,000m² of clinical and support services. The hospital opens in June 2015. The site is considered exemplary for four main reasons.

Figure 11: Key features of New South Glasgow Hospital

Cutting edge building design and technology	<ul style="list-style-type: none"> • Designed around modern 21st century healthcare and in accordance with latest design guidance and best practice. • Incorporate state of the art technology - both in terms of clinical equipment provision and support services e.g. there are a fleet of robots that deliver linen and other good via a network of underground tunnels – segregating service flows from patient flows and segregating clean and dirty flows.
Efficient patient pathways and optimum functional adjacencies	<ul style="list-style-type: none"> • Well connected to major arterial routes and public transport. • Excellent clinical adjacencies – will speed up the flow of patients through the hospital and improve staffing efficiencies. • Makes efficient use of space and facilities – e.g. co-location of support services and grouping of functional areas with similar system requirements
Excellent patient experience	<ul style="list-style-type: none"> • 100% single rooms for adult beds, all with own en-suites - addressing the patient privacy and dignity agenda., as well as patient comfort. • All adult bedrooms are outward facing, providing good levels of natural daylight and good views across the city. • The children's hospital is 80% single rooms, 20% multi-bedded bays – which is best suited to paediatric clinical needs. • The children's hospital incorporates parent accommodation.
Healthy, healing environment	<ul style="list-style-type: none"> • Best practice infection control standards • Significant public realm space, landscaped gardens and parks. • The hospital is modern and filled with art and soft textures to distract people from their ailments and includes interactive wall installations within the paediatric areas.

3 Appraisal of current and planned estate

3.1 Comparison of our current estate with others

56. We have compared the performance of our estate with two groups of hospitals:

- **Neighbours:** These are nearby hospitals that offer a comparison of our estate in the local context.
- **Peers:** These are hospitals from across the country that the Department of Health has identified as being a reasonable comparator for our estate, and are generally multi-site district general hospitals.

Functional suitability

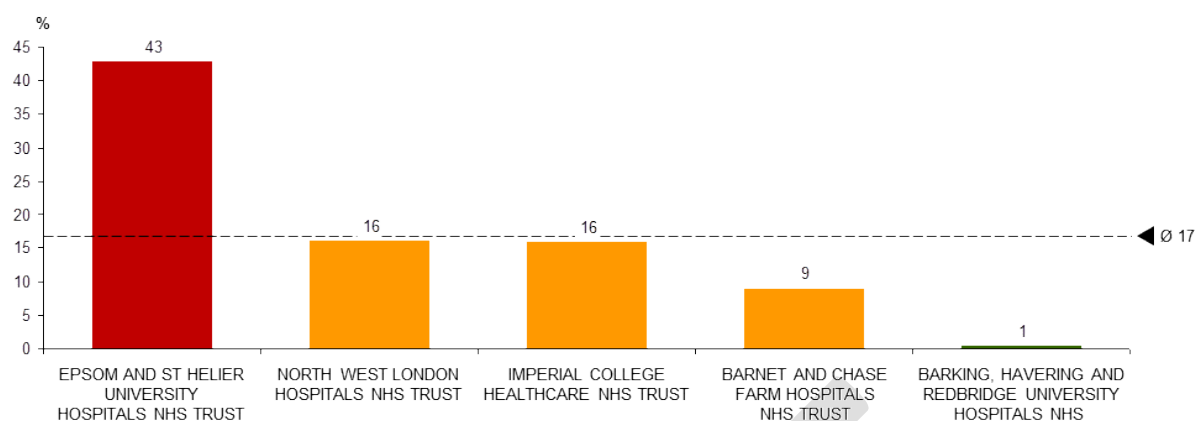
57. Functional suitability is an assessment of how well an Estate functions in the following areas:

- internal space relationships, which considers ease of observation of patients by staff, single sex accommodation and security
- support facilities, which considers whether there are adequate toilets and bathrooms, storage, seating and waiting space; and
- location, which looks at whether clinical departments are well located relative to one another and access via lifts and outdoor areas

58. Assessment of functional suitability is normally done by department, or building. The assessment will determine how effectively the buildings support the delivery of the service.

59. **The quality of the estate at all three hospital sites is below average compared to our peers. Over 40% of the estate is considered functionally unsuitable for modern healthcare delivery.**

- At Epsom Hospital, 42% of the estate is functionally unsuitable. The Wells Wing and Headley Wing are the oldest structures on the site and require major improvements to satisfy the needs and demands of modern healthcare.
- St. Helier Hospital has 37% of space functionally unsuitable. Significant infrastructure improvements are required to both the external fabric of the buildings at St Helier, as well as the mechanical and electrical services.
- As clinical services have mainly been re-located from Sutton, its functional suitability is less accurate, as c.90% of the total floor area at the site now closed, however half of the estate would be deemed unsuitable for modern healthcare.

Figure 12: Occupied floor area that is considered functionally unsuitable⁵

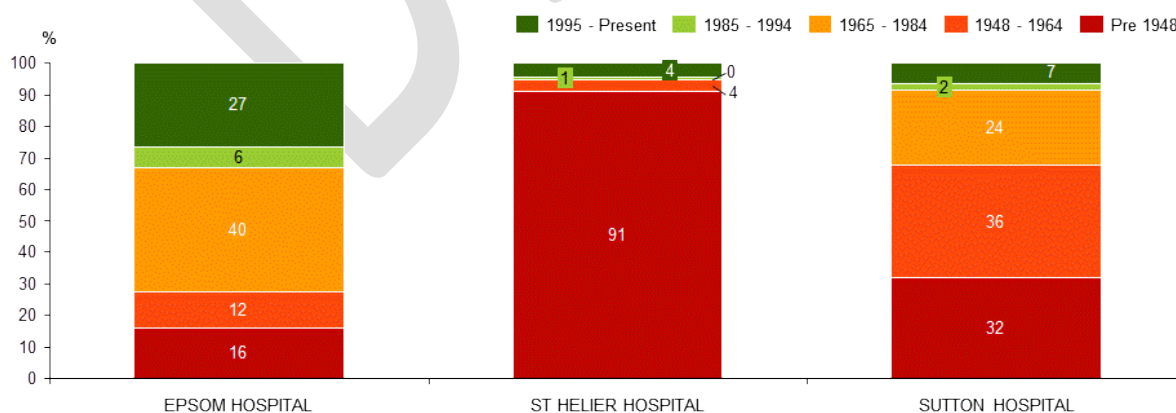
Note: The inclusion of Sutton may skew the results as from 13/14 ERIC returns

60. The quantum of functionally unsuitable space results from the age and poor quality of the estate, along with years of under investment – due to uncertainty and differing estate strategies over the years. **Fundamentally, the Trust is still using estate that was built when standards of medical knowledge and care were completely different to what they are now.**

Age of estate

61. The **estate is ageing**: 65% is over 40 years old and 55% is over 65 years old.
- Over 90% of the St Helier Hospital site is over 65 years old, which without significant investment and on-going modernisation would be unsuitable for the delivery of modern healthcare.
 - Sutton Hospital has the second highest proportion of old buildings, with some dating back to 1856. (However, most services have been re-located off Sutton.)
 - Epsom Hospital has the lowest percentage of very old buildings. However, only c.30% has been constructed within the last 30 years.

Figure 13: Age profile of estate



⁵ 2013/14 ERIC return

62. Whilst age in isolation does not necessarily mean building are not fit for purpose, any ageing estate is more costly to maintain, operate and ensure statutory compliance and functional suitability - all problems facing the trust.
63. **Compared with both our neighbours and peers, we have an older estate.** 55% of our estate was built before 1945 and 65% before 1974 – this is significantly higher than any of our neighbouring trusts or our estate peers.

Figure 14: Age profile of estate, compared to neighbouring hospitals⁶

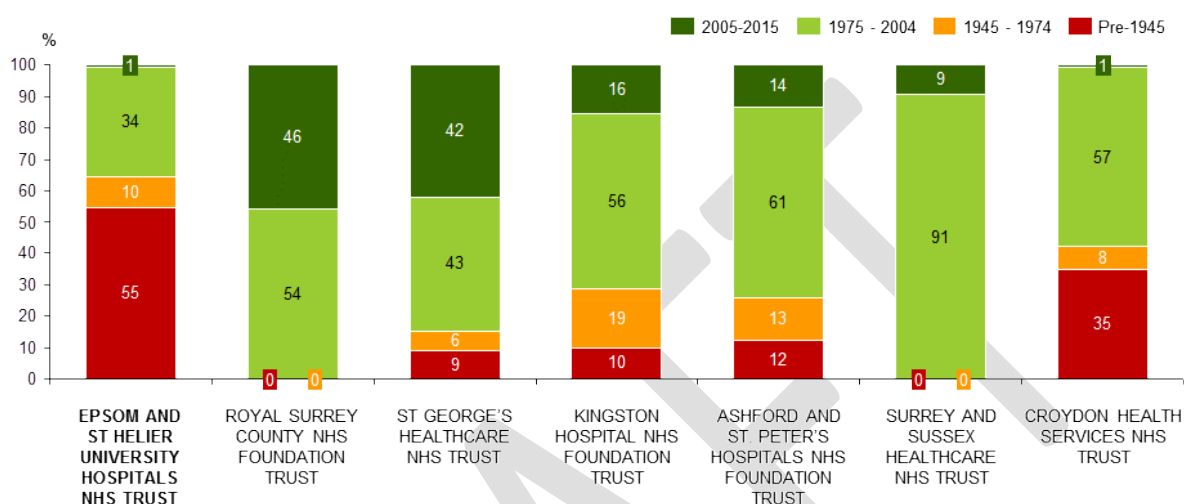
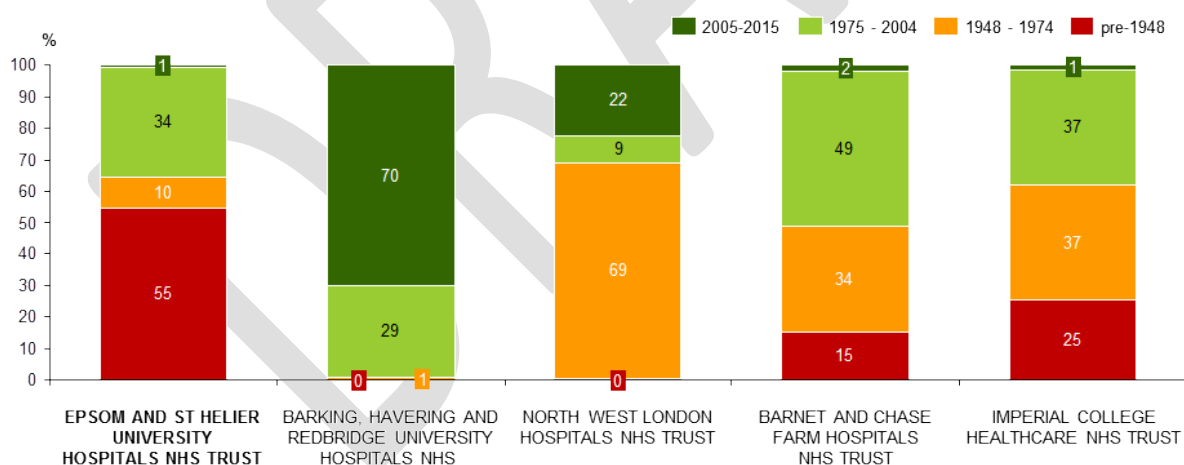


Figure 15: Age profile of estate, compared to peer hospitals⁷



⁶ 2013/14 ERIC return

⁷ 2013/14 ERIC return

Backlog maintenance⁸

64. **There is a significant backlog maintenance issue across the estate totalling £52.4m** (in 2013/14). Of this, in excess of £34.5m is associated with critical infrastructure.
65. St Helier has the highest level of backlog maintenance, which is linked to the fact it has the highest proportion of older estate. Backlog maintenance is lowest at Sutton, where most of the site is closed.
66. Compared with its peers, we have the second-highest level of backlog maintenance per square metre.

3.2 Comparison of current estate with features of twenty-first century estate

67. Comparison of the current estate with the criteria defined above reveals that there are issues across most areas, which are described below.

High quality care

68. Efficient internal adjacencies and relationships between key clinical departments ensures that patients have a smooth journey through a hospital, and evidence has shown that correct internal adjacencies also improve patient outcomes as clinical staff are able to access the required equipment and facilities easily and quickly. **Currently the layout of our sites means key departments are not co-located, which can affect clinical service delivery.** There are a number of examples of this, at both of our key sites.
69. At St Helier:
 - The pathology and pharmacy departments are some distance away from the outpatients department, meaning patients with mobility issues have to struggle to get from their appointment with the consultant, to collect their prescription.
 - The Intensive Therapy Unit is not located next to the Operating Theatres, meaning that the time of senior doctors is taken up walking between the two areas, when it could be spent caring for patients.
 - The A&E department is not near to the radiology department, meaning patients with suspected broken bones have to be transported from A&E to radiology and then back again, extending the time they have to spend in hospital.
 - Renal, paediatric and women's health units are all in separate buildings. Whilst there are underground tunnels connecting them, there is only a single lift to transport patients and staff between blocks. They require frequent servicing as a result of their age, and break down several times a month, meaning we have a two-strong team on standby to carry patients between floors while a lift is out of service
70. Whilst at Epsom:

⁸ Backlog maintenance expenditure is that required on a building to undertake essential repairs, or prevent equipment or building failures that have not been expended or addressed yet.

- We have wards that are in buildings not connected to one another, meaning that patients, however sick, have to be transported outside, in all weathers.
- There is no dedicated outpatient area, meaning patients coming for appointments are dotted around the site, with nowhere suitable for them to wait, often waiting in the hospital corridor
- There is no privacy for patients being transported to the radiology department from wards.

71. Although improvements continue to be made each year by the trust as part of the capital works programme, **significant investment and re-configuration works will be required** to totally address the issue and provide site layouts that have the correct internal adjacencies to fully support high quality patient care.

Infection prevention

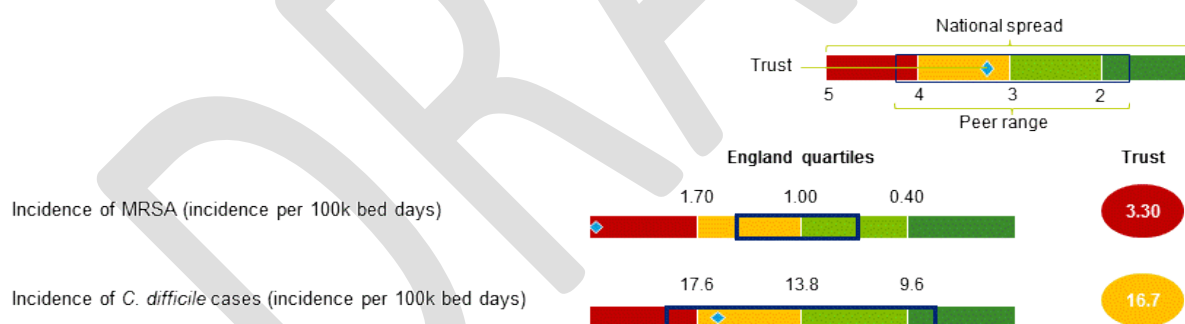
72. **The poor quality of our estate has been identified as a likely cause of infections at the trust. Our infection rates are currently relatively high** when compared to both the England average and peers, especially for MRSA.

- Despite significant effort by the cleaning staff and clinical teams, the trust performs poorly at present for hospital infections, lying in the bottom quartile for MRSA and third quartile for *C. difficile* both nationally and in its peer group.⁹
- Lack of space between ward beds is a likely contributor to the spread of infection. The trust had 4 outbreaks of norovirus in 2013/14 affecting 10 wards and 5 outbreaks affecting 7 wards in 2014/15, for example, in which this may have been a factor.
- An audit of the trust's *C. difficile* cases between April 2014 and January 2015 identified ongoing issues with lack of adequate isolation facilities (single rooms) leading to a delay in isolation of patients and therefore increasing potential for spread. Studies undertaken by the trust have highlighted the ward areas where there is greatest demand for more isolation facilities.

⁹ Public Health England (2014)

73. **The trust does not consistently meet NHS infection control bed spacing standards at present, which it is likely also contribute to infection rates.** The current Department of Health guidance¹⁰ recommends that a bed space should be 3.6m wide for new builds and major refurbishments to facilitate unimpeded care by healthcare staff. This is coupled with a recommendation from the Department of Health that a hospital should aim to provide at least 50% of its inpatient bed stock as single rooms. A recent audit of beds across the trust last year showed that on the Epsom Hospital site only 2 out of 217 non side-room beds met this standard (0.01% of applicable beds) and 22 out of 376 applicable beds on the St Helier Hospital site (0.06%). A conservative estimate from an audit undertaken recently suggested a loss of approximately 30–40% of the existing bed state in order to become compliant with these regulations, given the existing architecture of the trust.
74. Insufficient bed spacing facilitates the spread of healthcare associated infections, prevents adequate cleaning around beds, and makes it difficult to undertake patient care with sufficient space to avoid coming into contact with the environment (especially during aseptic procedures). In 2014/15, a failure to isolate a patient with MRSA due to inadequate numbers of side rooms was implicated in 3 MRSA bacteraemias.
75. We do everything we can to manage the infection risks posed by our estate. Our cleaning bill is currently £5m a year, an estimated £1m more than it would be if we had an estate better designed for infection prevention. This will become an increasingly challenging issue in the years ahead and will not enable us to meet the much higher standards we aspire to.

Figure 16: Trust infection performance¹¹



Healing environment

76. Over half of our estate was designed over 40 years ago, at a time when design requirements were significantly less, and by modern standards, must be considered poor - hence **in many areas our estate fall below the standards you would expect of a modern healthcare environment because it was designed decades ago.** For example, our buildings do not provide temperature control on wards, meaning patients and staff can be left cold in the winter and overheated during the summer.

¹⁰ Health Building Note 00-09

¹¹ Public Health England (2014)

77. In the last decade, significant advancements have been made in the level of natural light required into a space, the levels of ventilation and airflows that are required, the acoustic performance of space to ensure privacy is maintained, and the ability of users to locally control their environment. The trust has benefited little from these advancements to date.
78. The trust is seeking to address some of these issues as part of yearly maintenance work and localised refurbishment work; however, to bring the whole estate up to modern standards would require a wide scale refurbishment and significant investment. Even then, existing building and infrastructure limitations would prevent a best-practice solution being achievable.
79. Modern research has shown that buildings that have plenty of natural ventilation and natural light, that are aesthetically pleasing and well designed, and that have good external landscaping and views out are considered to be 'healthier' buildings that support healing and promote wellbeing. **Our estate scored below the national average on condition and appearance in patient-led assessments in 2014.**

Patient privacy

80. The trust has expended a great deal of capital to improve the privacy and dignity of patients at their sites over the last decade; this has included the elimination of Nightingale wards and same sex accommodation. **However, the majority of the bedded accommodation at the trust continues to be provided via 4- or 6-bedded bays. Only c.21% of beds are provided as single rooms¹²; of these, less than half have their own en-suite.** Ideally, single rooms should have an en-suite toilet, hand washbasin and shower or bath to ensure proper containment. As a minimum standard, single rooms must have an en-suite toilet and hand washbasin.
81. It should be noted that increasing the number of single rooms and complying with en-suite requirements, would significantly reduce the bed numbers provided at the current sites due to both a) the space requirement for a single room and b) the current footprint of most wards prohibits efficient conversion into single bedrooms. The location of the limited number of single bedrooms provided is also an issue for the trust, as many are not located where they are needed clinically.

Easy to maintain

82. We have a much higher level of space that is not functionally suitable (43%) compared to our peers and high levels of backlog maintenance (£52.4m, of which £34.5m is associated with critical infrastructure). It is important to recognise that this £52.4m is required just to bring the trust estate up to Category B standards – that is, an acceptable (not good) condition. In many instances, this investment would not address the reasons for the space being deemed functionally suitable for the delivering of modern day healthcare. Significantly, we would need to spend significant more to make the buildings and infrastructure suited to the provision of twenty-first century healthcare.

¹² This figure is NHS beds only, private patient beds are excluded.

83. The age of our estate means maintenance is a continual issue that needs funding and resourcing. As the estate continues to age over the coming years, it will be increasingly hard and costly to maintain it in an acceptable condition.
84. **We have a maintenance team of over 50 people currently who are required to constantly repair and maintain the ageing plant that we have.** The boilers at St Helier are so old that a team of four is needed to constantly assess them for safety and efficiency, and to prevent any breakdowns.

Safe

85. We have spent a considerable sum of money over the last few years to ensure compliance with changing regulations in respect of fire, health and safety, asbestos and safe water systems, and we continue to invest in improvements to ensure compliance, with immediate high priority areas including fire and safe water systems.
86. As stated above in respect of maintenance, the age of our estate means ensuring full statutory compliance with the latest regulations is a continual issue that needs funding and resourcing. Again, **as the estate continues to age over the coming years, it will be increasingly hard, disruptive and costly to ensure full statutory compliance.**

Environmentally friendly

87. Energy and utilities performance is an important element of assessing the condition and efficiency of a site. **Energy performance across all our sites is below an acceptable level.** The problem with our estate is that when the buildings were designed and constructed energy conservation was not a major consideration, it has only become more prominent in the more recent past.
88. Given the age and condition of the buildings at St Helier and Epsom, providing truly environmentally friendly buildings will be a challenge for the trust.
89. Our most recent estimate is that we are spending £1m a year more on energy costs than we would in a new building

Affordable and well utilised









90. As stated above, the maintenance, cleaning and upkeep of our ageing estate is costly, and **as the buildings and infrastructure get older, it will cost significantly more to keep them in an acceptable, working condition.** It will require continual investment, and the trust will be investing significant sums of money in an estate that is ageing and has a diminishing life expectancy.
91. It is critical that our estate is affordable in all respects and the challenge facing the trust in the coming decade is how this is balanced against an ageing estate that is in poor condition and in many respects deemed functionally unsuitable.

92. Though our estate has low cost of capital (as our buildings have been fully depreciated), the age of our estate means we face very high ongoing investment costs and we are spending significant amounts of money investing in maintenance. Reducing this maintenance cost would enable us to invest in patient care. For example, all the money from the land sale on the Sutton site will have gone into replacing the roof, windows and cladding the walls at St Helier and at Epsom hospitals. We would have far rather been able to spend it on new facilities such as a new renal, cardiology and intensive care which would enable us to expand the range of treatments that we can offer

Potential impact of estates on our performance

93. Summarising how well we perform against the features of twenty-first century healthcare reveals that there are some areas where our estate is limiting the quality of care we provide.

Figure 17: Current impact of estate on our performance

 High quality care	<ul style="list-style-type: none"> The layout of the sites means departments are not co-located when they need to be, adversely impacting service delivery and patient flows through the hospitals. Although improvements continue to be made each year, significant investment and re-configuration works would be required to totally address the issue.
 Infection free	<ul style="list-style-type: none"> NHS infection control bed spacing standards are not met across the estate. The configuration of the existing buildings makes it problematic for these standards to be met – full compliance could only be achieved via a significant reduction in bed numbers. Physical areas and rooms across the estate typically are not sized in accordance with current national space standards – this is a result of the buildings being designed many decades ago, prior to such standards being introduced.
 Patient privacy & comfort	<ul style="list-style-type: none"> Although mixed sex accommodation and Nightingales wards have been eliminated across the estate, the majority of beds are still provided via 4 or 6 bedded bays, only circa 21% are single rooms¹, of these less than half have their own en-suite.
 Healing environment	<ul style="list-style-type: none"> Over 65% the estate was designed 40+ years ago, at a time when design requirements were significantly less and by modern standards (e.g. lighting, thermal comfort, ventilation, acoustics). Wide scale refurbishment / investment can address some of these issues, but are limited by the structure of our buildings. The estate scored below the national average on condition and appearance in patient led assessments in 2014.
 Easy to maintain	<ul style="list-style-type: none"> Over time buildings and their infrastructure deteriorate and work is required to bring them back to an acceptable condition – over £50m needs to be spent on the current estate to bring it into an acceptable (not good) condition². Significantly more would be required to be spent to make the estate 'fit for twenty-first century care'. The age of the estate means maintenance is more costly and always on-going.
 Safe	<ul style="list-style-type: none"> The ageing estate / infrastructure means continual significant investment is required to ensure a suitable level of statutory compliance, specifically around fire, safe water services and asbestos.
 Environmentally friendly	<ul style="list-style-type: none"> Energy performance for all sites is below the NHS acceptable level. We continue to make significant investment to address this, however, the age of the buildings means it is very costly to address as when the buildings were designed (40+ years ago) energy efficiency was not a major consideration and this is reflected in the current buildings design / construction.
 Affordable & well utilised	<ul style="list-style-type: none"> The ongoing maintenance, cleaning and upkeep of the trust's ageing estate is costly - as the buildings and infrastructure are older it costs significantly more to keep them in acceptable, working order and requires continual expenditure and resource. Operating costs are high because of poor energy performance, typically resulting from the ageing estate.

¹ – This figure is NHS beds only, private patient beds are excluded.

² – This is the figure reported in March 2014 and includes Sutton.

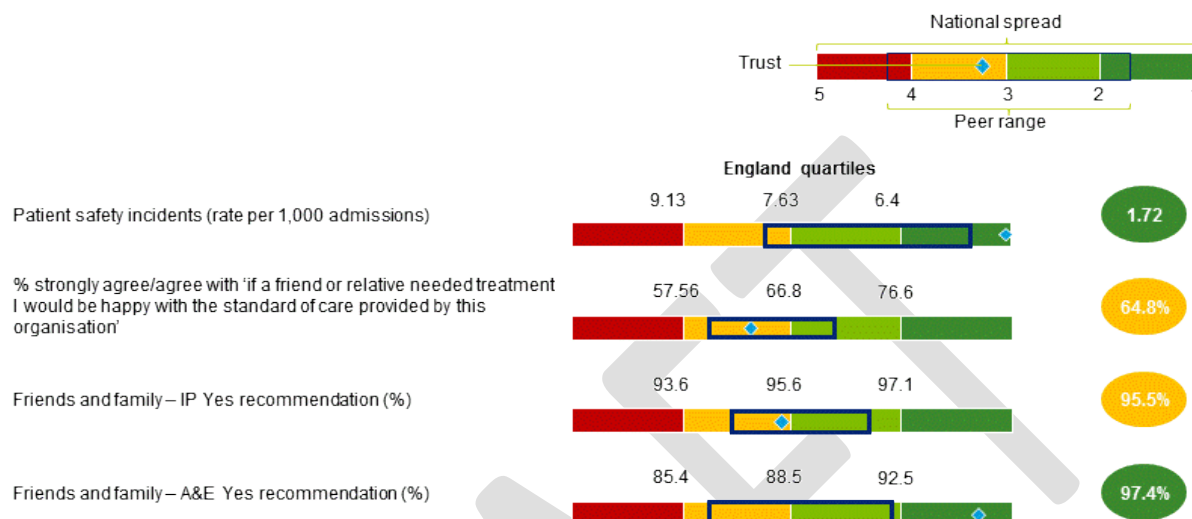
3.3 Impact on patient experience

94. **Patient experience may be impacted by old and poorly designed buildings**, which create issues such as making some of the buildings hard to access and navigate, especially for those with mobility issues, excessive walking between departments and buildings on the sites, and lack of privacy and dignity for patients on multi-bedded wards.
95. **The trust scores below average on the inpatient friends and family test** and below average compared to peers. However, the trust scores very highly on the A&E score, suggesting that the quality of the estate may be a factor in driving the lower inpatient score.¹³

¹³ NHS Staff Survey, Friends and Family Test (2013). The Friends and Family Test (FFT) is a single question survey that asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

96. The current strategy focuses investment into the estate to enhance the patient experience, such as the new entrance and layout at St Helier, and the consolidation of clinical accommodation. However, given the age and condition of the buildings at St Helier and Epsom, providing flexibility to enhance the patient experience further beyond a five and ten year period will be challenging without significant additional investment.

Figure 18: Trust patient experience¹⁴



3.4 Plans for redevelopment to 2020

97. The trust's current Strategic Direction is to operate from two principal sites with a range of services and outreach activities.
98. Though no formal decisions have been made, the trust's current estate strategy assumes the **disposal of the remaining land at the Sutton site** (part of the site has recently been disposed of) to release capital to **invest further into the other two sites**, Epsom and St. Helier.
99. There are various development control plans in place over the next five years for these two remaining sites, **investing £89m over five years** from 2015–2020. However, £55m of this is needed to address critical backlog and bring estates up to basic standards.
100. Of this total investment, **£29m will be spent across the trust** to develop a new catheter lab, replace equipment, invest in IM&T, achieve statutory compliance and improve the internal and external environment. Major investments include:
- replacement of equipment and diagnostics
 - expansion of audiology service, relocation of ophthalmology and reconfiguration of pathology
 - improvements to way finding
 - replacement of lifts and paging system
 - meeting compliance standards for fire, water services and asbestos

¹⁴ Organisation Patient Safety Incident Reports, NRS (2014); NHS Staff Survey, Friends and Family Test (2013)

101. At **Epsom Hospital**, the current strategy is to co-locate all clinical services towards the front of the site to improve the patient pathway. It also aims to improve utilisation of the spare capacity by developing and reconfiguring areas within the hospital. This will entail **£26.5m** investment, primarily in maintenance, ward refurbishments and site reconfiguration. Major changes include:

- consolidation of outpatient services
- creation of intermediate care beds in the Langley Wing
- providing a new entrance and reception
- an expansion of the urgent care centre

102. At **St Helier Hospital**, the plans aim to improve the hospital through a range of upgrades and refurbishments. The trust is investing **£33.5m** in the site, again primarily in maintenance, ward refurbishments and site reconfigurations. Major changes include:

- infilling and widening wards between blocks B and C
- consolidation of outpatient services and improvements to access
- providing a new entrance and reception

103. We expect this to deliver improvements in the quality of the estate, improving quality and safety, but **it will not be sufficient to address some the larger issues or deliver twenty-first century buildings that support the highest quality of care.**

3.5 Overall comparison of the trust in 2015 and 2020 with twenty-first century estate

104. To summarise this assessment against the features of a twenty-first century estate described in Section 2, we have considered our estate against each feature, reflecting how well it supports our aspiration.

105. **When the performance of our estate is compared with these features of twenty-first century estate, there are some significant gaps.** Our current estate does not facilitate twenty-first century care in the way we would expect across all the features we have considered.

106. This means patients are receiving care in inadequate facilities whilst the trust is delivering services in facilities that are expensive to run and maintain and are unfit for the delivery of modern healthcare.

107. Moreover, **the fabric of the estate only enables the trust to make progress in some of these areas.** The current estate strategy goes as far as it can with the current buildings and makes some improvements, including improving infection prevention, safety, environmental performance and affordability. However, it would not bring the estate up to the standards we would expect to support twenty-first century care.

108. **This means we will still, in 2020, not have buildings that fully support the high quality care.** Limitations will remain with promoting infection prevention, patient dignity, delivering a healing environment, maintaining our estate and delivering care safely. The fabric of our buildings means achieving high-quality buildings is not possible without major transformation.
109. **Delivering twenty-first century healthcare will require a step change in our estate. Achieving our aim for our buildings, we will need to do more than refurbish. We will need to consider ways of transforming our buildings to ensure they provide us with modern facilities that support the highest quality of patient care.**
110. The trust therefore needs to look at options for re-developing and re-building its estates to allow it to continue to deliver high quality health care to its local population.

4 What activity we need to provide for in 2020–2030

111. We know that over the next five years, our estate will fall short of our aspiration for twenty-first century estate. Therefore, we need to understand whether we will be able to redevelop our estate to meet our aspiration.
112. This section outlines the type of buildings we will need in 2020–2030, and suggests whether we might be able to afford the significant investment that will be entailed.

4.1 Activity

113. In 2014/15, the Trust faced unprecedented levels of demand, primarily in non-elective services. Whilst this was effectively managed through systematic capacity and operational planning, the Trust will continue to face such challenges in the years to come.

Demand for healthcare will continue to grow, driven by a number of factors, including a growing and aging population, increased prevalence of long-term conditions and multiple morbidities and increasingly higher expectations for standards of care.

114. We understand that public resources are constrained and we are working with our commissioners to identify ways to meet this rising demand more productively and efficiently. We have considered a range of evidence to understand the potential productivity gains that we could expect over the next few years. Such improvements could include:
- **Reducing non-elective admissions.** Much of this reduction could be delivered through the development of services outside the hospital including multi-disciplinary teams in the community and enhanced community beds.
 - **Reducing the number of follow-up outpatient attendances.** This could be achieved by delivering care differently, for example, through community teams or nurse-led care.
 - **Reducing the length of stay for people in hospital.** This could be delivered through initiatives such as 7-day working, which would mean that more people could be discharged at the weekend. Further, it could also be supported through advances in technology and medicine and more efficient discharge processes which mean people need to spend less time in hospital after operations.
115. A number of these initiatives will have an impact on the number of patients we see and the total number of beds we require, understanding of which will be important in planning our future estate. There is significant uncertainty in how the future will play out and so we need to consider a range of activity growth and bed requirements to recognize this. As such, we estimate that the bed requirements could range from a 5% decrease (c.45 beds) to a 7% increase (c.60 beds) from the current bed base.
116. Broadly, we therefore estimate **we will probably need approximately the same scale of hospital in 2020–2030 as we currently have.**
117. However, a significantly improved estate will be key to delivering efficiency improvements required in maintaining this steady level of capacity.

4.2 Finance

118. Financial stability and sustainability is central to ensure that patients continue to receive good quality, safe and effective care. Over the last few years, the Trust has improved its financial position significantly, following the emergence of a deficit in 2011/12. At the end of the financial year, the Trust has met its plan and posted a small surplus of £79k. The underlying deficit was offset by £7.2m of one off measures and the £5m profit on the sale of land at Sutton Hospital.
119. Over the next ten years, the trust's financial position will be affected by a number of factors. Cost impacts will include increases in cost due to higher numbers of patients needing to be treated and new standards that will need to be met, and decreases through greater efficiency. Income will also be affected by increases to the number of patients being treated (likely to increase) and by national policy on how much Trusts are paid for the work they undertake.
120. Whilst there is significant uncertainty about all of these factors over the next ten years, if we continue to work towards our plans, we intend to maintain an improved financial position, which we believe will enable us to deliver a surplus. This will provide the Trust flexibility to finance significant improvements to further enhance the quality of care and experience for its patients.
121. Given the uncertainty about how the future will play out, particularly as demand continues to grow and public resources continue to be constrained, in finding the appropriate solution, affordability will be of paramount importance.

5 Implications of delivering future activity from our current estate

122. Given that we are likely to need approximately the same scale of hospital as currently, it might seem straightforward to simply continue to improve what we currently have. However, the age and limitations of our estate create some significant challenges.
123. To be able to offer the quality of care we aspire to – that is, to the standards prescribed by the current Department of Health best practice guidance – would require a substantial rebuild at both sites. This is far beyond the refurbishments we currently have planned and would come at a substantial cost, with significant implementation challenges. For example, changing our current wards to deliver more single rooms – one of the major priorities – would require stripping wards back to their shell structure (including re-fitting the ventilation, waste, water supply, electricity and medical gas supply) and rebuilding them to provide more single rooms with en suite facilities.
124. Detailed work is required to accurately estimate the total costs of redevelopment, which has not been undertaken at this stage. However, at a high level, **the costs are likely to be in over £500m.**¹⁵
125. This cost is not only driven by the cost of redevelopment. Because we are a busy, working hospital, we would need to move our patients and staff to alternative accommodation while we conduct major redevelopments. **This adds c.40–80% to the cost of upgrading the estate, as we would need to find space for clinical care while we redevelop.**
126. This would be a major investment, which we would need to be confident is the best use of money and is affordable. Because of the potential scale of change and investment needed, we therefore need to consider if there are different ways we can deliver the twenty-first century estate we believe patients deserve.

¹⁵ The cost of this varies *significantly* depending on the degree of re-build undertaken and the degree to which modern standards are complied with or indeed compromises against these standards accepted.

6 Conclusion

127. Whilst we are a safe and effective trust, **patients who attend our trust for treatment are receiving care in inadequate facilities.** Our buildings are currently restricting our ability to deliver high quality care, reducing the patient experience and contributing to infection rates.
128. **Our patients, staff and communities deserve to receive and provide care in buildings that are fit for the provision of modern healthcare.**
129. However, **the age and structure of our buildings limits what we can do** to improve them through maintenance and regular improvement. Our investment over the next five years will create improvements, but these are limited to basic repairs and maintenance. We will still have pre-dominantly pre-war buildings that were designed for a different era, with layouts that make co-locating services difficult and ward shapes that are the wrong size, shape and dimensions to meet modern standards.
130. To be able to offer the quality of care we aspire to, to the standards prescribed by the current Department of Health best practice guidance, **would require a substantial rebuild at both our main sites.** This is far beyond the refurbishments we currently have planned and would come at a substantial cost.
131. Given the scale of the cost, and the complexities involved, **we need to conduct a fuller assessment of our options and the ways we can best meet the expectations of our patients that ensures value for money.**
132. We also need to be able to **show that we can raise the capital required for any estate investment,** and that we can afford the ongoing costs involved. Therefore, we need to look at all our options to consider how affordable they are to the trust.
133. The trust is committed to maintaining services at both Epsom and St Helier hospitals for at least the next five years, and that remains our strategy.

7 Next steps

134. In order to deliver the quality of care our patients deserve, from facilities our staff can be proud of, we need to understand all the options for improving our estate over the next ten years. Therefore, **Epsom and St Helier trust, Surrey Downs CCG and Sutton CCG will be jointly examining the options for how this key issue can be resolved.**
135. This work sits alongside, and will feed into, the wider work we are part of which is exploring a strategy for the South West London health economy, and the programme has been set up to ensure both strands of work can inform each other. We are committed to working in partnership with the other parts of the local NHS. **The options we consider need to not only meet the needs of our local population but they also need to help contribute to resolving issues in the wider NHS.**
136. In the first instance, we will **discuss with our key stakeholders and the public the next steps** following agreement by the Board for us to explore our estate options. This will include our local authorities (Merton Council, Sutton Council, Epsom & Ewell Borough Council, Mole Valley District Council, Reigate & Banstead Borough Council and Surrey County Council), local Healthwatch organisations, and patients and the public.
137. We would like to discuss whether our local communities support us in our desire to see our services be delivered from modern buildings and to begin a dialogue on what **people believe we should consider when we look at the options.**
138. Following this, **we will develop options and appraise them** against the things the public have told us are important, based on a thorough analysis of the implications of changing the estate. This will ensure we can deliver what people need from the estate. The Board will agree these options before the work progresses.
139. At this stage, we have not set a detailed time frame. We would like to have the conversations on this document over the summer and be in a position to come back in the autumn with some options for the future.