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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Friday 10 March 2023
2.00 pm
Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair
Councillor Deacon, Vice Chair
Councillors Finn, Harrison, McDonald, McLay, Murphy, Nicholson, Noble, Partridge, Mrs Pengelly, Reilly and Tuffin.

Members are invited to attend the above meeting to consider the items of business overleaf. For further information on attending Council meetings and how to engage in the democratic process please follow this link - Get Involved

Tracey Lee
Chief Executive

Health and Adult Social Care Overview and Scrutiny Committee

4. West End Hub Programme Delivery (Pages 1 - 12)

NHS
Devon

NHS Devon Integrated Care Board

Plymouth Cavell Centre – Options Report

Date of committee	Date report produced
15 March 2023	1 March 2023

Author(s)		Report approved by	
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Phone:		**Date:**	3 March 2023
Email:			

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary
NHS Devon, and its predecessor NHS Devon Clinical Commissioning Group, has led the system in the Plymouth Cavell Project since its inception. The Board has fully supported the proposal to build the Cavell centre, including approving the Full Business Case, subject to the receipt of Capital from NHS England. NHS Devon has now been told there will be no national capital within this Comprehensive Spending Review. Therefore, this paper identifies the options for the future of the Plymouth Cavell project and addressing the primary care and inequality challenges in the west of the city.

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

The Full Business Case (FBC), which includes full planning permission, was approved by NHS Devon ICB in August 2022 and submitted to South West Region for assessment against the Better Business Cases Fundamental Criteria. The Regional review concluded that the only issue preventing the business case being progressed was the lack of an identified source of capital. While some other points were also identified, these were minor in nature and the FBC has been updated accordingly to reflect these.

The project has a fixed construction price from Kier until 1st September 2023, which is the contract signing deadline. Kier would then have 8 weeks of mobilisation and expect to start on a fully cleared site by 1st November, which means that the required enabling work to divert utilities would need to commence by 1st May at the latest.

Originally the national Cavell team were expecting to receive capital funding for the six pilot sites through the last Comprehensive Spending Review (CSR). Unfortunately, they were unsuccessful and although funding was never promised for the project, NHS Devon was one of the six pioneer sites who were encouraged to develop the business case at pace while national colleagues sought the capital from underspends on other capital projects. We have since been told that no national funding is currently available, and that the Plymouth Cavell will next be considered as part of the CSR in 2024/25. The national team has completed a Cavell Programme Business Case in readiness for the CSR and this is currently progressing through a formal NHS approvals process. On 31st January, Simon Corben, Head of NHS Estates and Chair of the national Cavell Programme, wrote to the other five Cavell Pioneers to state that all work should pause (unless ICB funded) until the national Cavell Programme Business Case is approved.

Alternative sources of capital funding have been explored and the options are detailed in this paper. ICB capital for 2023/24 is fully allocated to critical and high priority projects across the entire NHS estate in Devon, Plymouth and Torbay. Subsequent years allocations will continue to be prioritised for critical and essential maintenance until such time that the New Hospitals Programme can release these pressures. Obtaining a loan from Plymouth City Council via Public Works Loan Board funding and securing private financing have also been considered. However, in both instances the interest charge or required return on capital result in an additional annual revenue cost of over £2 million for which there is no budget. The Devon system is currently in a deficit position and are not able to commit to spend any additional money where there is not an additional funding stream. The Cavell Centre would not be open until April 2025, however it is deemed too high risk to assume that the Devon system will have returned to recurrent financial balance by this time. In addition to this the Devon system are in SOF4, which means we have very little ability to agree any spend outside of existing contracts without approval by South West Region.

On 19th January, Plymouth City Council (CEO and Council Leader) and NHS Devon (CEO and Cavell Project Director) met with the Department of Health Minister of State responsible for the NHS Estate, Lord Markham. Two main options were discussed. First, securing the £45m required to build the Cavell as planned, with a particular focus on accessing some additional capital that is available to systems in

balance (on the grounds that the Plymouth Cavell has always been a national rather than a Devon system initiative). The alternative option related to the potential to combine the proposed Community Diagnostic Centre (CDC) with at least the primary care element of the Cavell care model. Such integration would require national support for some additional capital, confirmation that no capital charges would be applied and the ability to manage a larger and more complicated project within the national CDC reporting framework. Lord Markham agreed to investigate both options and the team is awaiting a response.

The CDC with primary care included would fit within the 6,000m^2 building that has already received planning permission. The alternative would be two separate, but connected facilities, with the primary care element being built when funding was secured. A key challenge with the later approach is securing the approval of the planning authority which has to date been insistent on buildings having a height of at least three stories.

Conversations have also commenced with the three GP practices regarding both the potential for a standalone facility and their ability to remain in their current buildings for at least the short-term. The practices are adamant that retaining the status quo is not a viable or sustainable position. There are significant risks associated with leases and staffing uncertainty due to the timing of partner retirements and nervousness from potential new partners about signing up for a future where there is considerable uncertainty and risk concerning the quality of their estate.

A recent letter from the main party leaders of Plymouth City Council to the NHS Devon Chair demonstrates the strength of local feeling in support of the Plymouth Cavell project.

All of the options are analysed in detail within this paper, but there is no straight-forward low-cost, low-risk route.

It is also important to note that the proposed facility is currently budgeted to have an annual revenue cost of £562,000. Work is ongoing to reduce this to between £200,000-£300,000.

Committees that have previously discussed/agreed the report, and outcomes of that discussion

The project has previously been discussed at an NHS Devon ICB Finance extraordinary meeting on 4th August 2022 and at Devon ICB Board meetings on 20th July, 17th August 2022 and 8th November 2022. The ICB Board agreed to approve the FBC and a letter of support was signed in August 2022 and attached to the business case.

Progress was discussed by the Finance Committee on 28th September, including feedback on the various points made by SW Region as part of the Fundamental Criteria Review.

The options report was discussed at length at the Senior Executive Team meeting on 28th February 2023 to determine the recommendations for the Board.

Key recommendations and actions requested

- The Board commends the work which all partners have undertaken through the Cavell Project Board to achieve the completion of the Full Business Case.
- The Board supports the view of the Executives that, given the change in the national position on capital resources available, at present we cannot support any option that takes the Plymouth scheme forward at this stage. As we are in SOF4, and are facing a £49.5m overspend, our options are severely limited at this stage, unless or until the national position on capital for Cavell schemes changes (Option 6).
- Continue to work with the practices to mitigate risks to the practices in the short-term. We will also work with the practices to identify all risks and opportunities as part of the PCN Estates Toolkit process.

Impact on NHS Devon objectives

Objective	Impact
Improve population health	The impact of this recommendation is that we will not be able to improve the outcomes as originally described in the Full Business Case at this time. However, we will continue to work with the practices on how we achieve the same outcomes without the Cavell building.
Improve services and reduced unwarranted variation	The impact of this recommendation is that we will not be able to improve the service delivery in the way previously described. However, we will continue to work with the practices on how we achieve the same improvements without the Cavell building.
Make more efficient use of our resources	The impact of this recommendation is that we will not deteriorate our financial position.
Develop our culture and how we operate	N/A

Does this report have implications in any of the areas highlighted below?

Area	Yes (summarise implications)	No
Quality of services	Improvement of services for people in one of the most deprived areas of Plymouth and top 1% most deprived wards in England.	
Health inequalities	Reduction in health inequalities by improving access to those in the most deprived part of the city. Life expectancy is 7.7 years lower than other parts of Plymouth. Attendance at ED is 18% higher than the average for the rest of Plymouth.	
Workforce	The integrated model of care and new facility would attract new staff and retain others.	
Resources and finance	The proposed facility is budgeted to have an annual revenue cost of £562,000. Work is ongoing to reduce this to between £200-300,000. The total outstanding capital requirement is £44.1m, excluding the support already committed from Plymouth City Council. There is a fixed price from Kier until 1st September 2023.	
Legal	Legal advice has been sought throughout	
Engagement and consultation	Engagement has been taken in line with the CCG/ICB duties	

NHS Devon has made every effort to ensure this report does not discriminate (directly or indirectly) against employees, patients, contractors, or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

Plymouth Cavell Centre Options Report

Summary of Current Financial Position

The FBC submitted to South West Region in August 2022 was for a 6,000m2 facility that included three GPs practices, Livewell community and mental health services, University Hospitals Plymouth NHS Trust (UHP) outpatients and diagnostics (including X-Ray, Mammography and Phlebotomy), dental, pharmacy and a range of community and voluntary space. The total capital cost was £44.1m which included a commitment from Plymouth City Council (PCC) to provide £2.8m of enabling support. The costs were guaranteed by the contractor, Kier, under the NHS P22 framework, but were conditional on the contract to proceed being signed by 1st January 2023. When it became clear that this deadline was likely to be missed, Kier was asked to provide similar Guaranteed Maximum Prices assuming a 1st March, 1st May and 1st September contract agreement.

In Revenue terms, the FBC forecast an annual net cost increase of £562,000 but recommended some headroom with a cost ceiling of £750,000. In broad terms, the cash saving from vacating leased buildings to move into the Cavell results in a cash release of c£900,000 whereas the estimated cost of operating the new building is c£1m. The major net cost increase is depreciation on the new building and on equipment of £500,000. Some work has been undertaken to try and reduce these costs but with only marginal success due to the impact of much higher utility costs and inflation.

Main Options Identified and Analysed

A significant amount of work has been undertaken to try and identify an affordable way forward. The following six options have been analysed, with the results summarised in Section 3.

Option 1: Maintain the programme and continue to push for full central funding of existing building.

Option 2: Fund with financing from Plymouth City Council via the Public Works Loan Board (PWLB).

Option 3: Fund via private sector financing.

Option 4: Move the UHP Community Diagnostic Centre to the Colin Campbell Court site and combine with at least some, but not all, of the Cavell services.

Option 5: Explore a standalone primary care facility.

Option 6: Formally stand down the Programme Board whilst awaiting the outcome of the next Comprehensive Spending Review and identify opportunities to continue the

project at that time. Meanwhile work with the practices to support their sustainability in both the short-term and in the longer-term through the PCN Estates Toolkit process.

Option Analysis

Option 1 (National Funding). Although highly unlikely, this option is not yet completely closed off. The meeting held with Lord Markham on 19th January discussed whether a £300m pot of unfunded capital reserved for systems in financial balance could be used for the Cavell (given that this is a national pioneer project rather than instigated by NHS Devon). As of 10th February, Lord Markham's office was still following up on matters raised at the meeting and a formal response is still awaited.

In addition, discussions have been held with the Department for Levelling Up, Housing and Communities (DLUHC) to assess whether £10m seed corn capital could be provided given the very significant regeneration benefits that the project would deliver. Feedback is awaited.

Option 2 (PWLB Funding). The project team has worked closely with Plymouth City Council to assess the impact of financing the capital via the PWLB. A series of options have been modelled, but all result in significant additional annual cost increases for NHS Devon. For example:

Capital	Loan Period	Interest Rate	Annual Cost
£45m	50 years	5.35%	£2.60m
£45m	25 years	5.25%	£3.28m
£20m	50 years	5.35%	£1.16m
£20m	25 years	5.25%	£1.46m

The reduced capital amount of £20m assumes that some funding is provided from either national sources or through the Devon systems capital allocation.

Devon receives an annual capital allocation of £83.2m (22/23) which is typically spent on Trust backlog maintenance, equipment purchases, lifecycle costs for existing buildings and upgrades to critical infrastructure. Each year Trusts submit their requirements which the commissioner has to prioritise within this funding envelope with agreement from NHSE.

The annual process is significantly oversubscribed with requirements often quadruple the system affordability. Therefore, once funds for critical and high risk backlog maintenance are allocated along with essential equipment purchases, little funds remain that can be allocated to other areas. Once each of the respective New Hospital Programmes (NHP) progress into later phases, this shall release more funds that can be spent in other areas such as investment in the community estate. However, until NHP sufficiently progresses over the next 5 years, large allocations need to remain prioritised to manage high risk backlog maintenance and critical infrastructure.

The Devon system is currently in a deficit position and are not able to commit to spend any additional money where there is not an additional funding stream. The Cavell

Centre would not be open until April 2025, however it is deemed too high risk to assume that the Devon system will have returned to recurrent financial balance by this time. In addition to this the Devon system are in SOF4, which means we have very little ability to agree any spend outside of existing contracts without approval by South West Region.

Option 3 (Private Finance). Conversations have been held with organisations very familiar with funding health projects, such as PHP and GB Partnerships (partners of the local LIFT Company). PHP stated that its indicative requirement is for a 5.5% return on capital deployed which would result in a similar additional cost for NHS Devon of at least £2.5m per annum. This is higher than the typical new build primary care rentals that are currently being assessed by the District Valuer of around £250/m^2 or an annual rental of £1.5m, but the Cavell has a more complex service mix and third-party developers are in any event pushing the DV for rentals closer to £290/300/m^2.

Option 3 shares the same funding challenges as Option 2.

Option 4 (Combined CDC/Cavell). The same architects, KTA, are designing both buildings and have confirmed that the CDC would fit within the Cavell building that has planning permission, together with sufficient space for all the GP practices and five, possibly ten, dental chairs. There would be no space for Livewell community and mentals health services or for the community/voluntary sector.

This option has the advantage that the building already has planning permission and that UHP has a provisional funding allocation of £24.9m. However, there are four practical challenges:

a) Additional funding of at least £15m would still be required (see funding challenges outlined in Option 2).
b) The national Cavell team stated that the Plymouth Cavell would be exempt from 3.5% capital charges as it would be owned by the ICB rather than UHP. The CDC must be UHP owned and this is likely to result in capital charges on the £15m primary care element creating an additional revenue pressure on NHS Devon. One of the “asks” to Lord Markham was confirmation that capital charges would not apply to a combined building.
c) Delivering a combined CDC/Cavell would be a complex task for UHP, particularly within the tightly defined rules of the national CDC programme. Some relaxation in these rules and timetable would be required to enable the project to be managed effectively as a joint building rather than two silos. This was another “ask” to Lord Markham.
d) Finally, with a capital cost of £24.9m the CDC approval process is via the straight-forward Short-Form Business Case. The combined building spend of £40m+ would normally require a new Full Business Case, without national intervention.

Option 5 (Standalone primary care facility). Although this option completely moves away from the Cavell integrated model of care principles, it does at least address the urgent requirement to stabilise and support primary care in the west end of Plymouth, where there are substantial health inequalities and life expectancy is 7.5 years less than other parts of the city. It is estimated that a standalone primary care facility would need to be around 2,000m^2 and, if funded via a third-party development (e.g. PHP,

Assura), would result in an NHS Devon revenue cost of around £500,000-£600,00 (based on market rents of £250-£300/m^2). VAT would be chargeable on top of these rentals. The current reimbursable cost of the three surgeries is c£180,000, resulting in an additional cost pressure of £320,000-£420,000 per annum + VAT.

Option 5 shares the same funding challenges as Option 2, although to a lesser extent and could be explored as part of Option 6.

Option 6 (Stand down the Programme Board and continue to work with the GP practices on sustainability). Waiting for the next CSR has its attractions, but there are no guarantees that the CSR will result in a successful award of capital. In addition, there are some significant risks to all three GP practices. The practices are adamant that retaining the status quo is not a viable or sustainable position. There are significant risks associated with leases and staffing uncertainty due to the timing of partner retirements and nervousness from potential new partners about signing up for a future where there is considerable uncertainty and risk concerning the quality of their estate.

Conclusion

Unfortunately, none of the options that have been examined result in a low-cost or low-risk way forward. However, one critical matter is clear, which is that the strong relationship between all parties has enabled the project to get to this point, which shows the strength of partnership working.

Recommendations

- The Board commends the work which all partners have undertaken through the Cavell Project Board to achieve the completion of the Full Business Case.
- The Board supports the view of the Executives that, given the change in the national position on capital resources available, at present we cannot support any option that takes the Plymouth scheme forward at this stage. As we are in SOF4, and are facing a £49.5m overspend, our options are severely limited at this stage, unless or until the national position on capital for Cavell schemes changes (Option 6).
- Continue to work with the practices to mitigate risks to the practices in the short-term. We will also work with the practices to identify all risks and opportunities as part of the PCN Estates Toolkit process.

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CITY CENTRE – KEY FACTS AND FIGURES

ODPH January 2023

BACKGROUND OF PLYMOUTH

The City of Plymouth is the largest city in Devon and Cornwall, as well as being one of the largest cities on the south coast and the 15th largest in England. It has a population of approximately 262,100 people, an economic output of £4.99 billion, with 132,300 residents in employment and an overall workday population of 260,913 (2011 Census).

Population increase

There is a projected 34 per cent increase in the number of people aged 75 or over between 2019 and 2035 (an additional 8,000 individuals, and a total in the age-group of around 30,778).

Over the same time period, those aged 85 and over are forecast to increase by 57 per cent (an additional 3,743 individuals in the city and a total in the age-group of around 10,332).

This older cohort of population consumes a disproportionate amount of acute healthcare, for example people aged over 65 make up 18% of the City's population but account for 55% of emergency hospital admissions to the UHPNT.

Wealth

The proportion of residents in Plymouth experiencing deprivation due to low income has increased in recent years, with significant wealth inequalities geographically across the city. The city remains a relatively low wage economy with an average annual wage of £26,364 (90% of the national average) and has over 20% of the city's households earning less than £17,500. The percentage of unemployment is 5.1% in 2020, higher than both the regional and national average (3.4% and 4.1% respectively).

Several areas of the city fall within the top 10% of the most deprived areas in England on the English Indices of Deprivation 2019.

Health

Estimated figures are that healthcare contributes only around 15% towards our health; health-supporting behaviour is around 40% and socio-economic factors around 45%.

The well documented extent of poverty, deprivation and inequality that exists in Plymouth is strongly linked to poor health outcomes across the city that are linked to lifestyle and socio-economic factors. The average life expectancy for men is 79 years (79.6 years national average) and 82.2 years (83.1 years national average). However, there is a significant variance in life expectancy across the city; from 84.8 years in the Plympton / Chaddlewood ward to 77 years in the St. Peter and the Waterfront ward; the ward where the centre is based. The latter ward is the most deprived in the city and in the top 1% of most disadvantaged districts in England.

The Mortality rate (all-age all-cause) in Plymouth is higher than in England; 1,047 per 100,000 population compared to 957 for England.

- For men, the three main causes of death making up the gap are cancer (58 per cent), respiratory (16 per cent), and external causes including deaths from injury, alcohol and substance misuse and suicide (15 per cent).
- For women, the three main causes of death making up the gap are circulatory diseases (25 per cent), cancer (20 per cent) and respiratory (20%).

CITY CENTRE

The city centre population has the highest levels of deprivation and is, within the 1% most deprived in the country. The immediate location of the centre is in a highly deprived area, and it is the area of town which most attracts people from the deprived areas to the east of the city.

- St Peter and Waterfront is Plymouth's most deprived ward. People living here have a life expectancy value of 77 years, which is roughly 7.5 years less than the least deprived area.
- The population has one of the highest rates in Plymouth of residents waiting for an NHS dentist, as well as high rates of smoking, childhood obesity and emergency hospital admissions;
- City Centre has 16.7% of the working age population claiming benefits which is above Plymouth average score of 15% and is ranked 14 / 39 (where 1 is the neighbourhood with the highest %); Stonehouse has 29.1% of the working age population claiming benefits which is above Plymouth average score of 15% and is ranked 2 / 39.
- City Centre has a mortality rate of 62.2 for Cancer, CHD, COPD and Stroke which is above Plymouth average score of 55.1 and is ranked 9 / 39 (where 1 is the neighbourhood with the highest rate); Stonehouse has a mortality rate of 93 for Cancer, CHD, COPD and Stroke which is above Plymouth average score of 55.1 and is ranked 1 / 39.
- City Centre has 23.7 % of families classed as vulnerable which is above Plymouth average score of 18.2% and is ranked 13/39 (where 1 is the neighbourhood with the highest %); Stonehouse has 35.5 % of families classed as vulnerable which is above Plymouth average score of 18.2% and is ranked 2/39;

GP PRACTICES

The City Centre populations is predominantly served by Adelaide, Armada and North Road West surgeries, which are each in separate PCNs (Pathfields, Waterside and Drake respectively).

Each of these practices support areas of considerable deprivation and have practice populations that are becoming ill at an earlier age, likely to suffer from comorbidities while of working age, and die earlier. Many patients also have very complex medical and socioeconomic issues such as homelessness, substance abuse and severe and enduring mental health issues.

There are some 16,000 patients registered with these three practices.

There are various issues with access for patients (including limited DDA compliant spaces), poor quality buildings which are damp and hard to heat, and a lack of staff space which is limited the models of care that can be provided (eg utilising newer models of care with multi-disciplinary working)

The Adelaide and Armada premises are in poor condition, highly constrained and undersized for the patient list – and do not have the space for expanding the workforce to work in different ways. Both practices are occupying premises without an agreed lease with private sector landlords.