

The Shrewsbury and Telford Hospital



NHS Trust



The Future Configuration of Hospital Services

**Securing High Quality, Safe and
Sustainable Hospital Services in
Shrewsbury and Telford**

Full Business Case Summary

16 April 2012

LOOKING TO THE FUTURE

1. Introduction

This paper summarises the Full Business Case for the Future Configuration of Hospital Services. It sets out the plans and investment required to support changes to some services in Shrewsbury and Telford which will enable essential hospital care to remain in the county.

Aims, objectives, and purpose of the FBC

The Full Business Case (FBC) sets out the clinical case for change for the delivery of the Future Configuration of Hospital Services programme. It is supported by a clear and robust case for the required capital investment to enable change to be implemented.

Fundamentally, the proposed solution for the reconfiguration of services is the same scheme as that put forward within the Outline Business Case (OBC). The FBC therefore confirms that this is still the optimum solution for the Trust, and details how the Trust has developed the clinical, technical, financial, and management aspects of the scheme to its current stage.

The FBC is applying for £34.873m to implement the scheme through a Public Dividend Capital investment. It demonstrates that the proposed reconfiguration is affordable, and that this investment offers value for money. It shows that the proposed works are deliverable, and there is a robust management procedure in place to achieve this by the summer of 2014.

FBC structure and compliance

The FBC is compliant with the Department of Health and Treasury best practice, and follows the “5-case format”. Each case is summarised below:

- The **strategic case** sets out the Trust’s case for change, explains why a reconfiguration of hospital services is required, and how these plans fit in with local and national strategy
- The **economic case** confirms that the Trust’s preferred option continues to meet future service requirements and provides the best value for money; and then provides details of the proposed reconfiguration solution
- The **commercial case** details the contracts that the Trust will enter into and confirms that these offer value for money and do not expose the Trust to undue risk; and explores possibilities for commercial opportunities
- The **financial case** confirms that the investment is affordable in revenue terms, and confirms funding arrangements and cashflow
- The **management case** details how the Trust will plan, manage, control, and assess the delivery of the proposed solution

Setting the Scene

The Trust, and local NHS, has to do something to ensure the range of hospital services provided in the county continue and have the opportunities to develop further. The agreed clinical strategy detailed within the FBC provides the most pragmatic and sustainable solution to address the challenges currently faced: meeting clinical need within an affordable and future-proofed plan for change.

Keeping safe, sustainable and high quality services in the county is the primary goal for the reconfiguration of hospital services. The clinical issues and challenges have been debated for many years. There is unanimous clinical agreement that the Trust cannot maintain the status quo long into the future. The clinical strategy has been developed by Trust and Primary Care clinicians, shared with patients and the public during the Keeping It In The County consultation and was formally agreed by the local NHS on 24 March 2011. The Outline Business Case developed this clinical strategy and its delivery further. The Outline Business Case was submitted to the Trust Board on 25 August 2011 and was subsequently approved by NHS Telford and Wrekin and Shropshire County PCT on 13 September and NHS Midlands and East on 27 September 2011. The OBC was supported by the Joint Health Overview and Scrutiny Committee on 23 August 2011.

The 'do nothing' option was discounted by local clinicians in August 2010. Maintaining inpatient and acute surgery across two sites carries high levels of clinical risk. Supporting two inpatient paediatric wards with the right levels of medical cover is increasingly difficult: a national issue recognised by the Royal College of Paediatrics and Child Health. And continuing to provide maternity and neonatology care in a building built for 2,000 births in the 1960s is no longer acceptable for patients, their families and staff with around 5,000 births each year.

Doing nothing means that the Trust would risk losing its Vascular Service as a safe rota could not be maintained, which if it occurred would mean Abdominal Aortic Aneurysm (AAA) Screening not being provided locally, as without a Vascular Team, AAA Screening cannot take place. Without robust plans to ensure the ongoing sustainability of surgical services, the Royal Shrewsbury Hospital would not have been designated a Trauma Unit and patients with serious trauma would be taken directly to Birmingham or Stoke. Mothers, newborn babies and children, including those with the most serious of needs, would continue to be cared for in sub-standard accommodation with small cramped clinical areas and a lack of privacy and dignity. Millions of pounds would have to be spent just maintaining the Maternity Block at RSH without any real benefit to patients and their families. The Trust would continue to struggle to recruit medical and nursing staff and the pressures on existing clinical teams would increase over time.

Doing nothing would also prevent the Trust moving forward with new pathways and ways of delivering patient care. Reconfiguring services is one of the Trust's key foundation priorities in Putting Patients First– it will enable ambulatory care to be appropriately provided; facilitate the shift to day case care; and provide a much needed cultural and physical shift to the use of new technologies to support care closer to and at home. These developments will be much more difficult if the Trust does nothing.

The communities served by the Trust want, and expect, two balanced sustainable hospitals in the county now and in the future. This formed the foundation of the plans discussed by clinical leaders some 18 months ago where the solution became clear. Services have to be reconfigured across the two hospital sites to provide a better standard of accommodation and support high quality and safe clinical care and delivery

Delivery of this solution however is not easy given the financial forecasts for the NHS, the public sector and the economy as a whole. The Trust and local NHS have to meet demanding year on year savings, putting increased pressure on running costs. The options for delivering Keeping It In The County were assessed with a need to be pragmatic: the solution has to make the most of existing space; minimise capital spend; enable sustainable workforce

models; and enable an appropriate level of investment to meet the clinical needs of the population without compromising the future viability of the organisation.

The outcome of the Keeping It In The County public consultation and assurance phase of the programme is described in the Trust and PCT's Board and Joint Health Overview and Scrutiny Committee papers and the of 24 March 2012. All organisations supported the Trust's proposal to progress and develop the plans to reconfigure services that would see,

At the Princess Royal Hospital (PRH):

- A consultant-led maternity and neonatology unit, co-located with gynaecology and paediatric inpatient services and a Paediatric Assessment Unit
- Enhancing the current antenatal service
- Establishing a Women's Service to include inpatient gynaecology and breast surgery, gynaecology assessment and treatment, Colposcopy and the Early Pregnancy Assessment Service (EPAS) on one ward
- Adult inpatient head and neck services being located near theatres and critical care
- New accommodation for paediatric outpatients, paediatric cancer and haematology unit and parts of the children's ward alongside refurbishment of the existing children's ward

At the Royal Shrewsbury Hospital (RSH):

- All inpatient general surgery, both planned and emergency, for vascular, colorectal, bariatric, urology and upper gastro-intestinal co-located near theatres and critical care
- Developing a Surgical Assessment Unit (SAU) adjacent to A&E
- Relocating and improving accommodation for the antenatal services, Pre Antenatal Day Assessment unit (PANDA) and the Midwifery-Led Unit (MLU)
- Relocating and improving accommodation for paediatric outpatients and a PAU adjacent to A&E

Re-providing a new Women and Children's Unit at the PRH responds to the changing demographic of the population served by the Trust. It acknowledges that whilst the journey for some patients will be longer, more patients will access these services within twenty minutes than they do now. In addition, building at the PRH offers robust clinical adjacencies with these vital services at the heart of the hospital and enables development and connection to existing services (access; water; electric etc) that is more cost efficient and easier to implement – something that is not possible at RSH.

Since the approval of the OBC, the Trust has made significant improvements and efficiencies in the quality and delivery of care provided through improved patient flow. This has resulted in additional clinical space being available at both sites and enabling improved clinical adjacencies and locations than described within the OBC. These efficiencies have been integral to the Trust's achievement of the conditions for approval of a FBC by NHS Midlands and East. The following targets have been achieved:

- Reduce medical locum costs
- Reduce nursing agency costs
- Reduce the inpatient bed base by 100
- Reach and maintain financial balance

On the strength of clinical strategy and the case for change, the achievement of the conditions described above and the timeline for delivery of change, the Strategic Health Authority put forward the Future Configuration of Hospital Services programme to the Department of Health to access recently announced Public Dividend Capital funding. This will

have a positive effect on the revenue cost associated with this scheme. This provides a far better solution than as described in the OBC enabling the Trust to reduce the impact on its revenue costs and help negate the long term impact of future QIPP plans.

Activities since the OBC

The pace for the delivery of the Future Configuration of Hospital Services (FCHS) programme since August 2010 has been maintained from the approval of the OBC to the development and submission of the FBC.

As before, this has focussed on four key workstreams:

1. Models of care (clinical pathways and processes, workforce, benefits, impact and implementation)
2. Estates and facilities (design and layout of the new Women and Children's Unit at PRH and the required refurbishments at both sites)
3. Communication and engagement (robust internal and external activities that have supported widespread opportunities and routes for involvement and comment)
4. Assurance and governance (an ongoing process of informal and formal review of progress and delivery of recommendations)

Since the approval of the OBC a number of key deliverables have been achieved. In summary this includes:

- a. Ongoing clinical leadership in the programme and clinical and staff involvement at all stages of development
- b. Continued acknowledgment and responses to the concerns raised by patients and the public
- c. Review, agreement and sign-off of clinical pathways and plans for new ways of working
- d. Designation of the RSH as a Trauma Unit and a Centre for AAA Screening (enabled through the plans to consolidate surgery on one site)
- e. Review and development of detailed workforce plans
- f. Detailed design and layout development for the new build at PRH and refurbishments at both sites
- g. Appointment of Balfour Beatty as the Trust's ProCure21+ partner
- h. Planning approval for the Women and Children's Unit at PRH
- i. Planning application for the extension at RSH
- j. Engagement and involvement of patients, parents, carers and the public in the design and development of facilities and services
- k. Ongoing and widespread communication and engagement with the individuals, groups and communities
- l. Delivery of ongoing assurance activities and support from the Joint Health Overview and Scrutiny Committee, the Clinical Assurance Group and completion of a Gateway 3 Review
- m. Securing funding investment from the DH for Public Dividend Capital subject to the approval of the FBC

Trust Board approval of changes from OBC

The Trust Board reviewed and approved the critical changes since the OBC at the Board Meeting on 1 March 2012, with particular emphasis on the plans for the refurbishment at RSH, including:

- The need to reconsider and therefore delay the original aspirations for the development of an Integrated Assessment Zone alongside A&E. This is in recognition of the amount of service developments and redesign underway in the unscheduled care pathways such that the exact requirements for integrated assessment are not yet known. In addition, the current estate at RSH would restrict this from happening without major reorganisation
- The need to provide a 30-bedded Surgical Assessment Unit (SAU) resulting in the need for both Adult and Children's Head and Neck to be utilised as the new SAU. This has meant that the original plan to use Children's Head and Neck as the new PAU cannot be progressed
- The proposal for the Paediatric Assessment Unit (PAU) to be provided in refurbished and extended Trauma and Orthopaedic (T&O) offices thereby providing the essential clinical adjacency to A&E. The area occupied by the current Shropdoc demountable building will also be utilised for the PAU and Shropdoc out of hours service will be relocated to alternative accommodation. The T&O office function will be relocated to the main administration corridor above Main Outpatients. This is permitted by the relocation of the offices from the main administration corridor to the refurbished Maternity building (as described in the OBC)
- The plan for Paediatric Outpatients to utilise the current Ophthalmology Outpatients which will be relocated to refurbished space on the main administration corridor
- The Midwifery Led Unit, Antenatal Day Assessment (PANDA) and Maternity Outpatients will be relocated in refurbished Wards 31 and 32 alongside the Early Pregnancy Assessment Service (EPAS) and Fertility

All of these changes do not materially affect, and in most cases actively improve, the Trust's preferred option; and have all been incorporated into the proposed solution set out within the FBC.

The Trust Board also reviewed and approved the revised funding plan:

- Following DH confirmation on 5 March 2012 that the Trust would receive up to £35m as Public Dividend Capital (PDC) funding, to fully fund the proposed reconfiguration works, following a recommendation to the Treasury from NHS Midlands and East. Whilst this route of funding would be cheaper than the original planned loan, the upper limit of £35m remains in terms of affordability and the ability to access these funds

Engagement

Following on from the 'Keeping It In The County' consultation, at OBC stage, a number of concerns were raised, which required ongoing discussion and resolution (see below). This has required continued engagement and involvement of staff, key stakeholders and partners and patients, parents, carers and members of the public. Much of the detailed work and discussion has been held within Focus Groups and specific 'task and finish' groups which have been instrumental in taking this work forward. The areas of concern raised by PCTs at their meeting on 13 September 2011 are shown below along with an update on progress:

Concern	Response
Travel and Transport	
Concerns about increased travel time for some patients raised during the consultation period continued to be expressed at the OBC stage. Whilst the work the Trust had undertaken in partnership with the PCTs and West Midlands Ambulance Service (WMAS) and the Welsh Ambulance Service (WAS) was welcomed and noted, the delivery of plans for reducing the impact additional travel time may have on patients and their families is still an issue for members of the public and the organisations involved on their behalf.	<p>The Trust continues to work to address the travel and transport concerns and issues. This work will come together in the Travel and Transport Plan in the summer of 2012. The areas of focus since the approval of the OBC have been:</p> <ul style="list-style-type: none">• Cross border working between WMAS and WAS so that the nearest ambulance responds• Reduction of 'door to needle' time within paediatric oncology• Paediatric triage and transfer processes• Review of the safe transfer for women in labour• Travel and transport analysis including impact and patient/public survey• Car parking at PRH
Engagement	
The Joint HOSC and both the PCTs were keen to see the extensive communication and engagement undertaken prior to the submission of the OBC continue and that this should include all staff, not just clinical leaders.	<p>The Communication and Engagement activities have been maintained. Activities have included:</p> <ul style="list-style-type: none">• Chief Executive staff and public briefings• Q&A sessions with the CEO and clinical leads• Looking To The Future – quarterly reconfiguration newsletter plus special editions• Dedicated website (www.sath.nhs.uk/future)• Public Focus Groups• Staff Focus Groups• Health Information Events
Workforce	
Concerns on workforce include two main areas: the involvement of those clinicians who had expressed concerns about the changes as part of the consultation; and the future workforce requirements	<p>The engagement of all clinicians in the development of the FBC has been encouraged and welcomed. This has included dedicated meetings within each specialty, involvement in the Clinical Working Groups; discussions at team meetings; Centre Board and Centre meetings; and the circulation of a weekly internal bulletin - The Future This Week.</p> <p>The OBC workforce plan has been developed further. The Trust's Negotiation and Consulting Committee (the Trust's meeting with the Unions) has also been involved.</p>

Assurance

The Trust has continued to seek all appropriate assurances for the proposed reconfiguration in the development of this FBC. This has included four key elements. These were:

Joint Health Overview and Scrutiny Committee – The committee have indicated that they remain supportive of the plans for Women and Children's Services; Surgery; and Head and Neck. Regular formal and informal meetings have been held and the Trust continues to provide updates for the JHOSC work programme to support their own monitoring and response to concerns raised

Gateway Review – Gateway 3 Review took place from 14-16 March 2012. They reported significant progress of the reconfiguration programme and the Trust received a delivery confidence rating of AMBER/GREEN – 'successful delivery appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery'

Clinical Assurance Group – The Clinical Assurance Group met on 8 March 2012 and received a progress update from the Clinical Centres and the Executive Team. There remains a high level of clinical support across all organisations for the reconfiguration programme

Equality and Quality Impact Assessment – The recommendations within the Equality Impact Assessment undertaken during the consultation and assurance phase of the programme have been and will continue to be implemented. In addition, the Trust has established a system for undertaking Quality Impact Assessments (QIA) for all service changes and improvements. A QIA has been undertaken by the Centres for Women and Children's; Surgery; and Head and Neck.

Confirmation of Board and Commissioning support for the FBC

The proposed hospital reconfiguration programme has been actively supported by the Trust Board and Commissioners throughout its development.

All of these approval bodies have been actively engaged throughout the process, including the production of this FBC. The Trust Board and Commissioners have all confirmed their support for this FBC in principle, with the formal approval process shown below:

- The Trust Board will approve the FBC on 16 April 2012, and for onward submission to NHS Midlands and East for approval
- West Mercia PCT Cluster have confirmed their ongoing support and are due to formally approve the FBC on 29 May 2012
- Shropshire Clinical Commissioning Group (CCG) affirmed their ongoing support on 4 April 2012 and are due to approve the FBC on 2 May 2012
- Telford & Wrekin CCG are due to approve the FBC on 17 April 2012
- The Joint Health Overview and Scrutiny Committee reaffirmed their support at their meeting on 15 March 2012 and are due to review and support the FBC on 12 April 2012

2. The Strategic Case

Trust background

The Shrewsbury and Telford Hospital NHS Trust (SaTH) is the main provider of district general hospital services for half a million people living in Shropshire, Telford and Wrekin and mid Wales. Services are delivered from two main acute sites: The Royal Shrewsbury Hospital in Shrewsbury and the Princess Royal Hospital in Telford. The Trust also provides outreach services at the Robert Jones and Agnes Hunt Hospital in Oswestry and the community hospitals in Whitchurch, Bridgnorth, Ludlow, Bishops Castle and Welshpool.

In 2011, the Trust re-organised its leadership structure to reflect the drive to become a clinically-led organisation. Eleven Clinical Centres were formally established on 1 October 2011. Each Centre has devolved responsibility for the services they provide. The Centre Chiefs (all senior clinicians) work alongside their Centre Managers and the Clinical Champions (Clinical leaders who focus on Cancer Care; Scheduled Care; Unscheduled Care; and Telehealthcare) to ensure the day-to-day operational delivery of care and also plan and improve services for the future.

Strategic context

The Strategic Context as set out within the OBC is largely unchanged. Plans for widespread organisational reform within the NHS in England continue to be progressed and proposals for ongoing change will be implemented as a result of the approval in the House of Lords of the Government's Health and Social Care Bill. The Trust therefore operates within a challenging environment that includes:

- Putting Patients and the Public First and demonstrating achievement of the Department of Health's four tests for reconfigurations, also known as the Nicholson or Lansley Tests
- Delivering outcomes that are amongst the best in the world
- Establishment of Clinical Commissioning Groups and the National Commissioning Board and the end of PCTs and SHAs
- Increasing efficiency within a financially challenged health and social care economy and the delivery of year on year savings in the context of an aging and rural population
- An increasing birth rate
- Achievement of Foundation Trust status
- A mixed estate with different needs and challenges. The RSH has a range of accommodation from the Maternity building built in 1967 to the new Cancer and Haematology Centre that is currently being constructed. Services are provided in a range of buildings inter-connected by corridors pathways. In comparison, the PRH was opened in 1988 and was extended in 1999 and was built using a nucleus template thus providing a much more uniform structure with a central hospital street

The Case for Change

The case for change is based on three drivers:

- Safety and viability of clinical services
- Workforce challenges
- Poor facilities for Women and Children

Safety and viability of clinical services – there are currently a number of challenges in delivering safe and timely hospital care. The main risks associated with the future delivery and viability of clinical services are:

- **Sustaining acute surgery on two sites** with prompt access to senior clinical input to ensure the best possible outcomes of care. Across the country vascular surgery is being consolidated into bigger centres as part of a nationwide drive to improve survival rates for major surgery. Keeping services in Shropshire is only achievable if the teams who provide these services are brought together onto a single site. Similarly, the Trust is only able to offer Abdominal Aortic Aneurysm (AAA) screening because there are plans to bring vascular services onto one site
- **Sustaining inpatient paediatric services on two sites**, providing senior paediatric input and maintaining accreditation for doctors in training. The challenge of maintaining smaller inpatient paediatric units within 30 minutes of each other is now well documented by the Royal College of Paediatrics and Child Health (RCPCH) who are recommending the consolidation of services into larger single site centres

Workforce challenges – in order to provide high quality and effective patient care, the Trust has to ensure that the right people with the right skills are always in the right place at the right time to meet the needs of patients. This is a real challenge to the Trust as the workforce has seen a number of changes which impact on the organisations ability to provide this requirement at both sites:

- **Changes to the training of medical staff** resulting in the training programme for doctors now being significantly different to training in previous years. In the past, a general surgeon would have carried out large volumes of abdominal, breast and vascular surgery during their training. Now, consultants specialise in one of these surgical sub-specialties much sooner meaning they will not have the necessary skills to perform techniques that they have not been trained to deliver. This results in a situation where a surgeon is required to operate on the abdomen for example at night, when they do not perform this surgery in the day
- **Reduction in ‘middle grade’ doctors** – due to the changes in training described above, traditional ‘middle grades’ are disappearing. The Trust will have to increasingly move towards a consultant delivered services to fill this gap.
- **Changes to staff working hours** – the European Working Time Directive continues to challenge the Trust in that more doctors have to be recruited than in the past to maintain a 24 hour rota across two sites
- **Challenges in recruiting medical staff** means that on occasions there are not enough medical staff to cover all departments. This is because doctors can choose where to work and some are deciding not to come to the Trust and also because the Trust has experienced a reduction in the availability of some doctors from overseas

Facilities for Women and Children's Services – the current maternity building is over forty years old and is the Trust's oldest building. It does not provide an appropriate environment for patients and their families. There is inadequate and substandard space that is no longer fit for purpose. The condition report of 2007 emphasised the need for the Trust to address high and significant risk items as a priority. It is estimated that extensive work would need to be undertaken just to resolve the building deficiencies in the order of approximately £14million.

The table below summarises how the plans set out in the FBC will mitigate these risks and issues.

Current issue	Expected benefit and impact
Sustainability of acute surgery	
Sustainability of acute surgery on two sites including: delays of transfer into appropriate units/beds; delays in access to specialised senior clinical input; a lack of confidence to manage patients out of own surgical expertise	A single inpatient site for emergency and elective surgery will enable patients to be managed in the right subspecialty by appropriately trained and experienced medical staff via separate rotas for vascular and general surgery. Training places for junior doctors will be more attractive and locum dependency is reduced
Sustainability of inpatient paediatrics	
Sustainability of inpatient paediatrics on two sites including: challenge of providing 24-hour senior paediatric input; maintaining accreditation for doctors in training; a reliance on staff/middle grades; and an inability to develop services such as high dependency care	A single inpatient site for paediatrics will enable a sustainable medical rota to be implemented. The unit will be run at optimum efficiency with space allocated for high dependency care. The majority of children will continue to be seen in-hours and in the PAUs at both sites (as now). Children requiring inpatient care who attend RSH in the future will be stabilised if required and transferred to the inpatient unit PRH
Poor facilities for Women and Children	
Poor physical environment in the Women and Children's departments at RSH, as well as the need to provide additional obstetric theatre capacity to support the number of births in the county	A new, fit for purpose Women and Children's Unit is created which includes two obstetric theatres that mitigate the current risks associated with single theatre provision. Low risk, midwifery led care will continue to be provided at both sites along with antenatal and outpatient clinics. Relocated and improved accommodation for the Women and Children's services at RSH will be provided.
Changing training programme for doctors	
Changing training programme for doctors resulting in earlier specialisation, a lack of skills in techniques doctors have not been trained to deliver and a disappearing middle grade workforce	The consolidation of services onto a single site will enable single speciality rotas and enhanced senior clinician cover
Medical staff recruitment	
Medical staff recruitment challenges and the implications of EWTD are exacerbated through difficult working environments, on-call commitments and numbers of patients to be managed	Single site provision is more attractive than split site services for training, working and development

Benefits

The OBC described seven high level benefits which remain the same:

1. Patients continue to have access to 24 hour acute surgery in county
2. Children and families have access to inpatient paediatric services that are in line with services delivered within a district general hospital
3. Women and families have access to a fit for purpose, modern obstetrics, gynaecology and neonatology facility
4. Robust and sustainable medical and nursing rotas are in place
5. Patients have access to day case assessment, treatment and care and their stay in hospital is as short as clinically appropriate
6. The impact of additional travel time for some patients is minimised
7. Services are efficient with good clinical outcomes and high level of patient satisfaction

In addition, service specific benefits have also been identified and agreed by each Centre and are included within the main FBC.

Risks

There are a number of risks associated with the delivery of the FCHS programme. These are identified by clinical and the project leads and team. Risks, their mitigation and supporting actions are reviewed and monitored by the FCHS Project Board. In addition, risks are also reported through the Trust's Programme Management Office.

Construction and development risks have also been identified in partnership with Balfour Beatty and a joint risk register has also been developed (also see Management Case).

3. The Economic Case

A detailed and rigorous options appraisal exercise was undertaken within the OBC which generated a long list of possible options, shortlisted these to a smaller number of potential options, and then assessed them to determine a preferred OBC solution. This options appraisal exercise undertaken as part of the OBC continues to be valid now and confirms that the OBC preferred option is still the preferred option for FBC and to be taken forward for implementation.

The conclusions at OBC were that:

- For PRH the preferred option was Option P4
- For RSH the preferred option was Option R6

Developments and changes from OBC to FBC

Although there have been a number of changes and developments since the OBC, these do not have a material effect on the options appraisal nor the choice or viability of the preferred solution; and indeed in most cases, these actively improve the OBC options. The key changes which have occurred since the OBC (all of which were approved by the Trust Board on 1 March 2012) are:

- The removal of an Integrated Assessment Unit (IAU) from the plans. This will be reconsidered in the next five years to allow sufficient time for the health economy to develop necessary changes to unscheduled care pathways
- More existing space in clinical areas has been made available at both PRH and RSH
- There is a need for Paediatrics Outpatients at RSH to be adjacent to A&E, which was not defined at OBC stage
- Bed reduction project has been developed (which validates the future proof adjustment index applied at OBC stage).
- The preferred options have generally developed and been worked up in more detail since the OBC.
- The Trust has pursued a different source of funding for the scheme following the announcement by the Department of Health to release Public Dividend Capital funding for capital schemes across the NHS in England.

Revalidation of the options

Option P4 was the preferred option at OBC for the developments at PRH. Option P4 remains materially the same as at OBC stage with the following changes and general development of the option:

Option P4

(Minimises new build capital investment, co-locating Postnatal Ward with Obstetrics and Neonatology) (This option continues to minimise new build capital investment, but is now able to co-locate Post-natal with Ante-natal).

Provides the majority of the Obstetrics and Neonatology in new build accommodation, next to the existing Paediatric services and retains the existing MLU and Clinic services to the east of the site. (This is still correct).

Utilises converted accommodation (vacant HSDU) for overnight stay and non clinical support. (This is still correct, but overnight stay is now able to be accommodated within the Ward as part of neo-natal, paediatrics, and paediatric oncology- which represents an improvement from OBC).

Respiratory Medicine is re-located from ward 8 to ward 15. (Respiratory Medicine is not now required as a stand-alone service, so ward 8 is now vacant).

Postnatal ward is adjacent to the Obstetric Unit in the vacated surgical ward 12. (Post-natal is still provided, but is now able to be accommodated as part of the new build and co-locates with ante-natal on the ground floor; and gynaecology is relocated to Ward 12- which represents an improvement from OBC).

General rehabilitation (ward 15) is re-provided in the community. (This is still correct).

Consolidates Children's services around their existing accommodation providing new build accommodation for Outpatients, Oncology and Paediatric Assessment, retaining the existing inpatient accommodation. Services within close proximity to A&E and Imaging. (This is still correct).

Consolidates Women's services (breast, gynaecology and EPAU) into existing ward 14, with close proximity to theatres. (This still correct and the services are still being consolidated, but is improved as we are now able to include Ward 12, which brings all of the services together).

Locates Head and Neck Inpatient services on existing ward 8 with close proximity to theatres and critical care. (This is still correct).

Option R6

Option R6 was the preferred option at OBC stage for the RSH. Option R6 remains materially the same as at OBC stage, although some changes have occurred as a result of the changes listed above and general development of the option:

MLU, Antenatal, PANDA, and existing EPAS consolidated in converted Ward 22 and front-of-house areas of main Ward Block. (This is still correct, although are now located in Ward 31 and 32- which represents an improvement from OBC).

Paediatric Outpatients forms part of the existing outpatient facilities, additional clinic space is created by reinstating part of level 2 for consulting / examination (This is improved from the OBC, as Paediatrics does not now need to be split, as it can be incorporated into the refurbished ophthalmology)

Paediatric Assessment is provided within existing Paediatric Head and Neck facility with light touch refurbishment (Paediatric Assessment is still provided, but this is now located within the refurbished and extended T&O offices and Shropdoc in order to support the need for Paediatrics Outpatients to be adjacent to A&E- which represents an improvement from OBC)

Transferred surgical inpatients from PRH to be accommodated largely on Level 4, final bed configuration assumes a more robust and developed DTOC strategy and reduced medical bed quantum. (This is still correct).

Creation of an Integrated Assessment Unit including engineering links to facilitate existing MAU and existing Head and Neck facility, major refurbishment of current Head and Neck facility for provision of SAU. Medical office suite converted to 2 four bed bays with en-suites and clinical support to enhance the IAU. (IAU not now required. The SAU is being provided in the existing Adult Head & Neck and the Paediatrics Head and Neck- which wasn't available at OBC stage).

Safeguarding of Wards 31 and 32 for future DTOC. (This is now a consolidated MLU - which represents an improvement from OBC)

Existing maternity building available throughout to assist with temporary decanting of non-clinical functions. (This is still correct).

Capital Costs and Value for Money

Capital costs have been produced for the programme of work in accordance with the NHS Capital Investment Manual by the Trust's Cost Advisor. In addition, the ProCure21+ Principal Supply Chain Partner (Balfour Beatty) have undertaken a detailed cost verification exercise, including benchmarking, and a programme of detailed market testing.

The total out-turn project capital cost for the FCHS reconfiguration programme of works is £34.873m. At OBC stage this figure was £34.957m

These capital costs are:

- In line with the capital costs previously calculated at OBC stage (previously £34.956m)
- Commensurate with a scheme of this size and complexity
- Value for money for the Trust
- Within the level of PDC funding available

Capital Costs

Capital costs have been produced for the schemes at Princess Royal Hospital and Royal Shrewsbury Hospital in accordance with the NHS Capital Investment Manual.

The total out-turn project capital cost for the FCHS reconfiguration programme of works is **£34,872,580**, summarised as follows:

	Princess Royal Hospital	Royal Shrewsbury Hospital	Total
Works cost (at Reporting level BIS Pubsec 173)	£18,793,092	£4,525,655	£23,318,747
Fees	£2,818,964	£724,105	£3,543,069
Non Works Costs (excluding Land)	£554,493	£162,298	£716,791
Land	£374,000	£0	£374,000
Equipment Costs	£502,592	£0	£502,592
Planning Contingencies	£283,364	£108,241	£391,605
Optimism Bias	£213,458	£110,406	£323,864
Sub - Total	£23,539,964	£5,630,705	£29,170,669
VAT	£3,766,394	£844,606	£4,611,000
Total (at Reporting level BIS Pubsec 173)	£27,306,358	£6,475,311	£33,781,669
Inflation to start on site 3rd Quarter 2012	£941,194	£149,717	£1,090,911
Total (3rd Quarter 2012)	£28,247,552	£6,625,028	£34,872,580

Summary of Proposed Solution

The proposed solution involves:

- Construction of a new two storey building and reconfiguration of part of the existing hospital buildings at PRH to create a new dedicated Women and Children's Centre
- Phased refurbishment and extension of the existing clinical facilities at RSH to facilitate the creation of a new specialist surgical centre, and upgrade local maternity services, paediatric facilities, and other supporting space.

The overall aim of the proposed solution is to reconfigure the provision of hospital services across the two hospital sites, in order to ensure safe and high quality care for patients and to keep services in the county, and address the three key drivers for change of:

- Safety and viability of clinical services
- Workforce challenges
- The condition of the current Maternity Building at RSH

All as set out in the table below:

Driver	Outcome	Means of delivery
Safety and viability of clinical services		
Sustainability of acute surgery	Single specialty rotas Enhanced senior clinician cover Improved perception of training and working practices	Single inpatient site for emergency and elective surgery (excluding breast and gynaecology)
Sustainability of inpatient paediatrics	Sustainable medical rota Provision of fit for purpose paediatric assessment and high dependency care Improved cancer and haematology care provision	Single inpatient site for paediatrics PAUs and children's outpatients at both sites. HDU capacity within inpatient ward Dedicated day case provision, ability to maintain separate outpatients, appropriate room filtration for immunocompromised patients
Workforce challenges		
Medical staff recruitment	Single speciality rotas Single site provision	Consolidation of Surgery at RSH and Women and Children's at PRH
Changing medical training programme	Single speciality rotas Enhanced senior clinician cover	Consolidation of Surgery at RSH and Paediatrics at PRH
Condition of current Maternity Building		
Poor physical environment for Women and Children's Services	New, fit for purpose Women and Children's Unit at PRH and relocated and improved services at RSH Appropriate clinical adjacencies and connectivity with other clinical services	New build and refurbishment at PRH Relocation and refurbishment at RSH

Proposed Works at Princess Royal Hospital, Telford

The proposed works at the PRH site comprise:

- Initial enabling works, including the relocation of the existing paediatric outpatients department, medical records, and patientline modular buildings; re-routing the existing access road; and moving the helipad
- Refurbishment of the existing Ward 8 to accommodate Head and Neck
- Construction of a new 2-storey building to accommodate obstetric and neonatal services, part of children's services, and new clinical support offices
- Refurbishment of the existing Wards 2 and 3 (paediatric), and construction of a ground floor extension and single storey new build within the courtyard, to accommodate paediatrics inpatients, outpatients, and oncology
- Refurbishment of the existing Wards 12 and 14 (Surgery) on the first floor to accommodate women's services
- Refurbishment of existing Midwife Led Unit, Antenatal Day Assessment, and Antenatal clinic
- Associated external works and car parking

Obstetric and Neonatal Services

Antenatal and postnatal services are now co-located and provided within the ground floor of the new build accommodation, creating clinical adjacencies with the existing paediatric department, imaging and A&E. A new co-located delivery suite, neonatal unit, and maternity theatres are provided on the first floor of the new build accommodation, creating adjacencies with the existing theatres, and refurbished support accommodation including on-call and relative's overnight stay.

Midwife Led Unit, WANDA and Antenatal Clinic

The Midwife Led Unit, WANDA (Antenatal Day Assessment), and Antenatal Clinic all remain in their current locations with a refresh of the appearance, lighting and finishes.

Children's Services

Paediatric Inpatients and the Paediatric Assessment Unit (PAU) are provided in the fully refurbished existing ground floor accommodation and two new build extensions.

Paediatric outpatients is provided in new build single-storey accommodation on the ground floor which makes specific provision for discreet scheduling of immuno-compromised patients and provides a paediatric audiology facility. The new design enhances elements of the existing Day Case Unit to create a 'child friendly' patient pathway.

Paediatric Oncology is provided in a state-of-the-art new build accommodation on the ground floor with a dedicated large external courtyard; both of which are significantly larger than the existing Rainbow Unit facility at RSH.

All of the new paediatric facilities are within close proximity to theatres, imaging and A&E.

Women's Services

Gynaecology, breast inpatient beds, EPAS, colposcopy, and the new gynaecology assessment and treatment unit are all accommodated in the fully refurbished accommodation on the first floor, which provides a fully integrated assessment/ treatment unit for women's services, with close proximity to theatres. Gynaecology outpatients will transfer to Main Outpatients.

Head and Neck Services

The transferred adult head and neck inpatients are located within Ward 8, with close proximity to theatres and critical care.

Parking and External Works

A section of the existing site access road and part of the car park to the north of the site requires reconfiguring to suit the new layout. A number of existing car parking spaces are displaced as a result of the works, which are re-provided as part of a new car park on the adjacent land, subject to final ratification of the travel and traffic impact assessment commissioned by the Trust in connection with this project and the conditions imposed by the planning consent. The allocation of the additional spaces between staff and patient visitor parking remains to be finalised and agreed with the local planning authority but is conditioned to be dealt with prior to start on site.

Proposed Works at Royal Shrewsbury Hospital

The proposed works at the RSH site comprise:

- Refurbishment of the existing Ward 29 to accommodate new Surgical Assessment Unit (SAU)
- Refurbishment of the existing Wards 31 and 32 (Head & Neck and Gynaecology) to accommodate a new consolidated women's centre, incorporating MLU, Antenatal, and EPAS
- Refurbishment of the existing Maternity block to form new offices
- Refurbishment of the existing first floor offices to accommodate relocated Ophthalmology clinic and Trauma and Orthopaedics offices
- Refurbishment of the existing Trauma offices, and construction of a new build extension to become new Paediatric Assessment Unit (PAU) and Paediatric Outpatients

All of the works are phased and will be completed sequentially to maintain the existing hospital services at all times.

Obstetrics, Midwife-led Unit, Antenatal, and Early Pregnancy Assessment Service (EPAS)

The existing Midwife-led Unit, Antenatal Clinic, and PANDA (Antenatal Day Assessment) will be relocated from the maternity block into the refurbished Wards 31 and 32, and will co-locate with the Early Pregnancy Assessment Service (EPAS) and Fertility Service. This will create an integrated Obstetrics unit at RSH, which has a discrete and separate identity, but is centrally located with other clinical services.

Children's Services

The Paediatric Assessment Unit (PAU) is developed at RSH after the inpatient service transfers to PRH, and requires a new location with immediate adjacencies with A&E. Paediatric Outpatients also needs to be retained, and again needs to be adjacent to A&E (which is a change in clinical requirements from the OBC).

These services will therefore be co-located in a combined PAU and Paediatrics Outpatients area in refurbished and extended core clinical space (currently occupied by Ophthalmology, Shropdoc and T&O offices). The PAU is adjacent to A&E and supports a robust staffing model. Paediatric Outpatients does not rely upon a relationship with Main Outpatients and the services and facilities within, and is now clearly identifiable as an area for children. It is envisaged that paediatric audiology will be delivered in the same way as currently at RSH via existing facilities and booked children's clinic sessions.

Surgical Assessment Unit (SAU)

The new 30-bedded Surgical Assessment Unit (SAU) is provided within refurbished space, (currently Ward 29), and is adjacent to A&E, Theatres and Imaging, the Medical Assessment Unit (MAU), the Paediatric Assessment Unit (PAU), and the Surgical Wards.

Ophthalmology

The Ophthalmology Clinic will relocate to the first floor, and will be provided in refurbished accommodation above the Main Outpatients (currently occupied by the Trust offices).

Trauma and Orthopaedics Offices

The Trauma and Orthopaedics office function will relocate to the first floor, and will be provided in refurbished accommodation above the Main Outpatients (currently occupied by the Trust offices).

Shropdoc Out of Hours Service and DAART

The Shropdoc out of hours service and DAART will be relocated to alternative accommodation. Reprovision of these services are part of the health economy- wide discussions regarding unscheduled care pathways; and discussions are underway to find suitable alternative accommodation within the Trust's existing building stock.

Non-Clinical Support Offices

A new centralised suite of management offices will be created in refurbished accommodation within the vacated Maternity Building, including Trust Management, Finance and Human Resources. This will consolidate and integrate the existing management functions at RSH that are vacating offices at Level 3 above Main Outpatients, and 'repatriate' divisions that are currently located off-site. This allows better use of core clinical space within the main building to be used for clinical functions, integrates the management functions, and allows the external leases to be terminated.

Consistent with the estates strategy the resolution and consolidation of non clinical spaces, particularly office spaces will offer significant opportunities to relocate supporting services and non direct patient activities from areas within prime clinical space and subsequently offer the Trust an opportunity to resolve clinical service priorities.

Land Transfer Requirements

The proposed building solution at PRH developed with clinical colleagues provides them with the optimum space shapes and layouts to meet the demands of the various services being provided. This solution was developed in part in response to feedback about previous designs but also as a result of an opportunity to acquire land to the west of the site from NHS Telford & Wrekin. This opportunity came about as the PCT's development plans emerged for this parcel of land. Driven by the requirement for limited future development the PCT has agreed the sale/transfer of a portion of this land to provide mutually beneficial regularisation of the present situation.

In order to facilitate the transfer, Heads of Terms have been agreed and valuations undertaken in accordance with NHS Estate Code i.e. at existing book price.

The PCT currently hosts a GP provision on this land adjacent to the PRH site and wishes to develop this in the near future. The remainder of the land in their ownership will then become surplus.

Design Solution

The new scheme at PRH will provide a flagship Women and Children's Unit for the Trust which will transform the patients experience and the delivery of these services. The new women and children's facilities cluster around a central double height circulation space, providing support facilities and providing access to the new departments. The maternity facilities are contained within a new two storey block of accommodation to the north of the 'atrium', while the single storey Paediatric accommodation combines a refurbishment of the existing nucleus template with a significant area of new build, formed around two new external courtyard areas.

- New facility with its own distinct identity which is still an integral part of the hospital as a whole
- Enhanced amenity spaces for patients, visitors and staff
- Clear and simple organisation around a spacious, daylit, double height space
- Modern facilities to support the Trust's clinical agenda
- Bespoke paediatric facilities enabling two distinct clinics to be undertaken simultaneously
- Interior design features to childrens outpatients department to make the spaces more 'friendly' and less institutionalised
- Planning and layout take consideration of out of hours and emergency access
- Separate routes for patients, visitors and support services enabling an 'on stage'- 'off stage' concept which enhances efficient operation of the building, and improves the overall patient experience
- Maximising natural daylight in patient and staff areas
- A range of external courtyards combining playspace, private areas, landscape features and artwork

The new scheme at RSH will provide greatly improved service delivery by optimising clinical adjacencies, taking opportunities to co-locate services, and making better use of core clinical space. The Trust is making best use of the existing building and all affected areas will benefit from refurbishment and upgrade works bringing a refreshed and more modern feel. In addition, services will benefit from being located in the centre of the hospital, and the PAU/ Paediatrics Outpatients will benefit from an extended and completely revamped space. The Trust are also optimising the use of the existing Maternity building at RSH by utilising this for non-clinical functions.

Design Requirements

Compliance with Standards

The proposed solution generally complies with all applicable standards, however there are a number of areas where the Trust has been required to deviate from these. These deviations, which are not unusual for a project of this size and complexity, have been agreed with Trust clinical and non-clinical staff and recorded on a formal derogations schedule (which is included as an appendix to the FBC). The design has been approved by the Fire Officer and Control of Infection.

AEDET

The design has undergone and passed an NHS Achieving Excellence Design Evaluation Toolkit (AEDET) review to assess the building's impact, build quality and functionality.

BREEAM, Energy, and Carbon

The scheme has been assessed using the BRE Environmental Assessment Method (BREEAM), and preliminary assessments have been carried out to predict the anticipated score. To date these anticipate the agreed target of achieving at least 'Very Good' for the refurbishment areas and 'Excellent' for the new build element.

The design has been developed to reduce annual energy consumption, whilst providing energy in the most environmentally friendly way to reduce annual CO2 emissions.

Town and Country Planning

The proposed development at PRH has been the subject of a planning application made to Telford and Wrekin Council. Conditional planning permission was granted on 28 March 2012, which is subject to a number of expected and usual conditions, including resolving issues relating to traffic and car parking, ecology and trees.

The proposed development at RSH has been subject to a pre-application submission to Shropshire Council, to confirm the principle of development which constitutes a single storey extension largely within the footprint of existing development. The Council have not raised any objection to the development.

Transport and Travel

Travel and transport has been the focus of much discussion and debate which started during the Keeping It In The County public consultation. The Trust and its partners have worked hard to mitigate the future impact of additional travel time and distance for patients accessing its services in the future in an emergency or with an urgent care need.

The non-urgent, or routine access issues have also been widely discussed. The planning conditions from Telford and Wrekin Council require a reduction in single occupancy car use and on-site parking. All the work on travel and transport will be developed into a single Travel and Transport plan due to be published in summer 2012.

Equipment

The Trust will need to directly procure items of loose furniture, fittings, and equipment (clinical and non-clinical) for the new facilities (the main contractor, Balfour Beatty, will provide all fixed furniture and fittings as part of their works).

The Trust is anticipating that a large proportion of the existing equipment can be re-used within the new facilities, with the remainder being procured specifically for this project. An appropriate cost allowance has been included within the FBC to cover the purchase of this new equipment, as well as a provision for temporary equipment hire.

IM&T

All of the new facilities will be serviced by the Trust's IM&T system, and the existing hospital informatics infrastructure will be accessed by and extended into the new build areas. The Trust's IM&T team are working with the designers to ensure provision for physical infrastructure to accommodate network distribution, access and management and ensuring that the timing of such activities are scheduled into the wider build programme; and subsequently on the future introduction of healthcare informatics applications and patient management systems and services in line with the implementation of the wider hospital informatics strategy.

The new build will have, as a default, access to all hospital clinical and administrative systems currently in operation. The cost of the Trust's IM&T installations have been included in the FBC.

FM and Support Services

The Trust's FM services (including catering, portering, telecommunications, logistics, maintenance, medical engineering services, accommodation etc) are currently delivered across the two hospital sites entirely by in house teams. Therefore for the purposes of the FBC there is no reliance upon external providers or requirement for complicated amendments to contracts, and the activity associated with the new facilities will be assimilated into the present arrangements and shift patterns. The resources associated with the provision of these services will therefore be broadly balanced across the hospital sites with staff, associated costs and budgets transferring appropriately to provide an overall and containable neutral resource impact.

Key dates, and requirements for phasing & decanting

The works at PRH and RSH will take place simultaneously. The works at PRH will be carried out in a single phase, preceded by some early enabling works, and followed by Trust direct fit-out works. The works to the RSH site are phased and will be carried out in 5 distinct phases. All of the works will be complete to allow service commencement in July 2014.

Work Package	Commencement Date	Completion Date
<u>Pre-Construction</u>		
Submit FBC to SHA		17 April 2012
SHA Approve FBC		24 May 2012
Stage 4 Contract and agreed GMP		27 July 2012
<u>PRH Works</u>		
PRH Enabling Works	18 June 2012	10 August 2012
PRH Main Works	13 August 2012	21 February 2014
PRH Trust-fit out and decant	February 2014	June 2014
PRH Service Operational		July 2014
<u>RSH Works</u>		
RSH Main Works (Phased)	3 September 2012	6 June 2014
RSH Trust-fit out and decant	9 June 2014	July 2014
RSH Service Operational		Phased, with all complete by July 2014

A Full Construction Programme and a detailed Phasing Plan are included within the FBC.

Workforce

The workforce challenges detailed in the Strategic Case are addressed through the consolidation of services onto the RSH or PRH site, the improvement of clinical adjacencies and robust workforce planning to reduce the reliance on middle grades over time and ensure the safe delivery of new care pathways and models of care.

Focussed and detailed workforce planning since the OBC has enabled each Centre to identify their future workforce needs. This largely remains consistent with the plans within the OBC in that there is a reduced head count in both Surgery and Head and Neck and a minimal investment required in paediatrics.

The workforce changes as a result of the reconfiguration are shown below:

Reference To	OBC				FBC			
	2012/13		2013/14		2012/13		2013/14	
	WTE	£000	WTE	£000	WTE	£000	WTE	£000
Paediatrics								
Consultants			0.4	45			0.4	59
Junior Doctor Banding Supplement		(25)		(25)		(25)	(2.0)	(233)
Associate Specialist PA requirements			(0.6)	(45)				(45)
SHOs			(2.0)	(88)				
APNP	4.0	258			4.0	258 ¹		
Qualified Nurses			4.19	263			10.1	310
Unqualified Staff			1.8	15			3.87	16
Neonatal			0	0			0	0
Women's Services			0	0			0	0
Surgery								
Qualified Nurses			(4.12)	(160)			(10.11)	(341)
Unqualified Staff			(1.14)	(24)			(3.15)	(72)
Head and Neck								
Qualified Nurses			(0.88)	(36)			(3.7)	(125)
Unqualified Staff			0.5	9			0.32	6
TOTAL	4.0	233	(1.85)	(46)	4.0	233¹	(4.27)	(425)

1- WTE APNPs have now been appointed by the Trust and are therefore included in the baseline data for the financial model, as set out in the Financial Case.

Women's Services

Given the current number of births a year, work carried out within the Centre has demonstrated that there is no requirement to make changes to the numbers of medical staff providing women's services. Other than the location of the services, there is also no need to make significant changes to consultant job plans or junior doctor rotas. Similarly, there is no requirement to make changes to the numbers of staff employed within the nursing and midwifery, healthcare scientist, additional clinical services, administrative and clerical or estates and ancillary workforce as a direct result of the FCHS programme. As with medical staff, other than the location of the services there is no need to make significant changes to the job descriptions or roles of staff.

Paediatrics and Neonatology

Although the Paediatrics and Neonatology services operate independently with their own specialist workforces, they do provide cover for each other, especially out of hours.

Paediatrics – Medical Workforce

During the development of the OBC it became clear that detailed work on medical staff deployment, Consultant job plans and new ways of working would be required as the FCHS Programme progresses. The context of the medical workforce model is to ensure the provision of high quality patient care on the PRH site as well as at the stand-alone and geographically separate PAU on the RSH site. Additionally, account has been taken of the recommendations of the Royal College of Paediatrics and Child Health (RCPCH) regarding consultant presence on the inpatient ward at times of peak activity.

The assumption at OBC stage was that when the FCHS programme is implemented, training places will be easier to fill. This is based on the fact that the unit will be relatively large with a consolidated paediatrician workforce, able to provide robust and wide-spread training opportunities.

All medical workforce plans, job plans and rosters are scheduled for review again at the end of April 2012 in the light of recent changes in the availability of middle grades from the Deanery.

Advanced Paediatric Nurse Practitioners

Advanced Paediatric Nurse Practitioners (APNPs) which will ultimately (once competent) form part of the middle grade medical rota were introduced within the OBC. These posts are intended to address the risks around the sustainability of middle grade rotas and also provide an additional career step for the paediatric nursing team. They provide longer-term workforce flexibilities in enabling the RSH PAU to be a completely nurse-led service, should this be an acceptable model of care in the future.

Nursing and the Ward-based Workforce

The workforce establishment for the service model in existence at the time of the OBC has been used as the baseline from which to develop the nursing workforce numbers for the FCHS programme, in order to ensure consistency. However it is important to clarify that the staff associated with the Head & Neck Children's service were omitted from the OBC. This position has now been clarified and the staff are included in the workforce plans for paediatric nursing.

Neonatology

The Neonatology Service is transferring to PRH in its current configuration, so it continues to be anticipated that there will be no change in workforce numbers within the service as a direct result of the FCHS programme.

Delivery of Outpatient services

The Centre's outpatient services will continue to be delivered on both sites as currently.

Surgical Centre

The make-up of this Centre has changed significantly since the development of the OBC. However, other than a change to the range of services falling under the auspices of the Centre, the issues affecting the workforce remain the same as the OBC.

In order to relocate services to the RSH site, the Centre will be combining the current configuration of four inpatient wards and two surgical assessment units on two sites into two inpatient wards and one surgical assessment unit on one site. This change, along with new ways of working, brings a reduction in beds.

Medical Workforce

The Centre is anticipating no changes to medical numbers, although there will be significant changes to medical ways of working. These changes will affect all grades of medical staff in all surgical and anaesthetic specialties. Work continues with the Centre to identify the detailed service model upon which the medical workforce changes can be built.

Nursing and the Ward-based Workforce

The reduction in bed numbers brings associated changes in the nursing and additional clinical services workforce for the Centre. These changes include reductions in nursing posts, health care assistant (Bands 2 and 3) and ward clerk posts at Band 2 – as well as slight increases in health care assistant posts at Band 1.

Theatre Workforce

The efficient and effective operation of theatres underpins service delivery for all of the reconfigured services. The Centre's plan continues to be that theatre staff will remain in their present locations and, following a training needs analysis, be provided with any relevant additional skills required. There are no anticipated changes in workforce numbers as a direct result of the FCHS programme.

Sterile Services

The Trust's Sterile Services department work closely with the Theatres team. The changes to specialty and case mix between the RSH and PRH sites will affect the department in terms of logistics and planning. However, it is not anticipated that there will be any changes in workforce numbers as a direct result of the FCHS programme.

Other Service Developments

The Centre is currently working through its theatre utilisation model, and developing business cases and change programmes to enable it to make the most effective use of its physical and human resources.

Delivery of Outpatient services

The Centre's outpatient services will continue to be delivered on both sites. It is not anticipated that there will be any changes to workforce numbers within the outpatients service as a direct result of the FCHS programme.

Head and Neck Centre

At OBC stage, the Head & Neck service came under the auspices of Surgical services in Division 2 of the Trust. It now exists as a clinical Centre in its own right.

The reconfiguration of Head & Neck services means a reduction in the number of inpatient beds and the transfer of the inpatient ward to the PRH site, along with the delivery of major head and neck surgery.

Medical Workforce

The Centre's management team and medical staff have been working with Kendall Bluck Associates to identify the issues associated with the FCHS programme. They have highlighted potential challenges such as theatre and clinic capacity and job planning inefficiencies linked to potential travel between sites. Kendall Bluck Associates are continuing to work with the Head & Neck team to establish an agreed way forward and develop a medical team job plan that makes best use of the medical workforce. Despite the identified challenges and the need to change established ways of working, the Centre is anticipating no changes to medical workforce numbers as a direct result of the FCHS programme.

Nursing and the Ward-based Workforce

The reduction in bed numbers brings associated change in the nursing and additional clinical services workforce for the Centre. These changes include reductions in nursing posts at Band 6 & 5 and health care assistant posts at Band 2, as well as slight increases in nursing posts at Band 7, health care assistant posts at Band 1 and ward clerk posts at Band 2.

Delivery of Outpatient services

The Centre's outpatient services will continue to be delivered on both sites. Like the other Centres, patient booking services, outpatient locations and the workforce associated with outpatient clinics are provided through the Ophthalmology & Patient Access Centre. However, the split in workload is expected to change. Currently approximately 90% of the Centre's outpatient workload is delivered at RSH, with the remaining 10% at PRH. Following reconfiguration, it is expected that the split will be more like 70% delivered at PRH and 30% remaining at RSH. This will have a consequence for the deployment of the outpatients workforce, although it is not anticipated that any changes to workforce numbers will be required as a direct result of the FCHS programme.

Ophthalmology and Patient Access Centre

This Centre is responsible for the provision of outpatient patient scheduling and booking for all other Centres. All nursing and additional clinical services staff associated with outpatient clinics rotate through every speciality clinic, meaning that all have generic clinical skills. It is anticipated that there will be no change in workforce numbers as a direct result of the FCHS programme. However, the proposed changes to the balance of Head & Neck outpatient clinics between sites will have an effect on the numbers of clinic staff on each site. The Centre plans to manage this through natural turnover and the careful management of vacancies.

Emergency and Critical Care

The provision of safe, high quality surgical services relies upon the provision of safe, high quality anaesthetic and intensive care services. The changes to configuration of general and head and neck surgery between the Trust's two main sites will impact upon both services, provided through the Emergency & Critical Care Centre.

At OBC stage the assumption was (and still remains) that relocating the Surgical Centre to RSH and the Head & Neck Centre to PRH would require the rebalancing of ITU/HDU workload and staff between the sites, reducing the dependency at PRH and increasing it proportionately at RSH. On this basis, it is anticipated that there will be no change in workforce numbers as a direct result of the FCHS programme. The Trust is developing a strategy for the long term provision of future Critical Care services in the County outside the FCHS programme.

4. The Commercial Case

This section of the FBC provides details of how the design, construction, and associated works are being procured, including details of how the Trust is achieving value for money, and managing its commercial risk.

Procurement Strategy (Design, Construction, and Management)

The Trust has devised a carefully considered strategy for the procurement of the construction, design, and other associated works for the Future Configuration of Hospital Services programme of works; which were agreed and ratified at Trust Board on 30 June 2011, and were set out in the OBC. The procurement route remains as shown in the OBC.

The vast majority of the reconfiguration work is being procured using the Department of Health (DH) ProCure21+ Framework, with some limited amounts of minor refurbishment works being undertaken through direct contracts let by the Trust, where there is a genuine benefit in doing this.

The Trust is continuing to use some external professional advisors, including a Cost Consultant and a Town Planning consultant, which are being let as direct appointments by the Trust. Equipment and Trust direct fit-outs (e.g. IM&T) is being procured directly by the Trust, through the normal routes.

Work Package	Procurement Route
Construction of PRH new build and associated works	ProCure21+ Framework
Construction of most refurbishment works at PRH	
Construction of most refurbishment works at RSH	
All associated design, cost, programming, and planning work	
Some minor refurbishment works at both PRH and RSH	Traditional tender- let directly by the Trust
Some early fit-out and refurbishment works at both PRH and RSH	
Some Trust direct enabling works	
Trust Advisors (Cost Consultant, Planning Consultants etc)	Trust direct appointments
Equipment and Trust-direct fit-out (IM&T etc)	Trust direct appointments and extensions to existing agreements

Selection of P21+ Design and Construction Partner

The Trust has followed the prescribed ProCure21+ procedures for the selection of the P21+ Design and Construction Partner ("Principal Supply Chain Partner, or "PSCP"). The Trust issued a High Level Information Pack (HLIP) inviting all six framework PSCPs to submit a written Expression of Interest response (EoI). The Trust then evaluated these EoI responses and shortlisted four PSCPs, who were invited to an Open Day, and then to two formal interviews, where they were evaluated and the preferred PSCP was selected in November 2011, which was Balfour Beatty.

Proposed Contract Arrangements for Design & Construction

ProCure21+ Stage 3 contract

The Trust have entered into a ProCure21+ Stage 3 Form of Agreement with Balfour Beatty which covers the period from their appointment in November through to agreement of a Guaranteed Maximum Price (GMP) and approval of the FBC. All design responsibility passed to Balfour Beatty at the point of their appointment in November 2011. Balfour Beatty and their supply chain are therefore fully responsible for carrying out all design to meet the Trust brief, including taking on responsibility for any design work carried out by the Trust prior to their appointment. The form of contract for all ProCure21+ schemes is an amended version of the NEC3 Option C: Target Contract with Activity Schedule. The Trust has therefore used this standard form of contract for the agreement with Balfour Beatty, supported by project-specific information (works information, site information, Priced Activity Schedule, target programme etc).

Under the Stage 3 contract, the Trust pays Balfour Beatty for actual work done, against the agreed Priced Activity Schedule, using pre-agreed rates. These rates have been market tested by the DH as part of Balfour's tender return for the ProCure21+ framework, and reflect the very competitive market conditions at the time of tender. It is important to note that the Trust is not committed to the design, construction, or cost of the works until after the FBC has been approved and the Stage 4 agreement has been signed.

ProCure21+ Stage 4 contract and Guaranteed Maximum Price (GMP)

Once the GMP has been agreed, and the FBC has been approved, the Trust will enter into the Stage 4 Agreement with Balfour Beatty for final design and for construction of all the works being completed under the P21+ contract. This contract is programmed to be completed and executed in July 2012.

The GMP or 'target price' in the NEC3 Contract, is the agreed maximum outturn cost between The Trust and Balfour Beatty for all Balfour's costs, including Stage 4 construction works and all design work, based on the defined scope of work at the time the GMP is agreed. The GMP is the most accurate forecast of outturn cost based on the information available to the team, together with joint assessment and agreed allocation of risk. The Trust acknowledges that the GMP is only 'guaranteed' and 'maximum' for the defined scope of work at the time of the GMP agreement and includes no client direct costs or risks (these reside above the GMP agreement and are managed by the Trust). If the scope of work is subsequently altered or a client risk comes to fruition then the GMP will be changed accordingly.

The Stage 4 Agreement will again use the standard ProCure21+ Form of Agreement, complemented by a full set of project specific information and the agreed GMP.

The ProCure21+ form of agreement specifies that the Trust reimburses Balfour Beatty on an actual cost basis for all of their works completed on the project. This cost is calculated based on actual cost incurred by Balfour Beatty, work done against the pre-agreed Bid Return Document (BRD) rates (as provided when Balfour Beatty tendered for the framework), and staff rates. These rates have been market tested by the DH as part of Balfour Beatty's tender return for the ProCure21+ framework, and reflect the very competitive market conditions at the time of tender. The final outturn cost (i.e. total actual cost paid by the Trust to Balfour Beatty) cannot ever exceed the agreed GMP.

The framework agreement also incentivises the PSCP to make ongoing efficiencies through the later design and construction phases, by providing them with a "gainshare" of any savings achieved on a 50/50 basis up to a maximum of 5%, with any additional benefit going 100% to the Trust.

Contract Terms for Risk Management and Apportionment

The allocation of risk is a key area within the ProCure21+ contract agreement. The project risks are currently being managed by The Trust and Balfour Beatty jointly and on an open book basis. The Trust and Balfour Beatty are using the standard ProCure21+ risk register as a basis for risk identification and management, which becomes a contractual document within the Stage 4 contract.

Value for Money from the ProCure21+ Contract

The ProCure21+ contract being let between the Trust and Balfour Beatty will deliver value for money for the Trust's investment. Whilst in the current tendering climate, the agreed contract price (GMP) could be higher than the lump sum tender price if the scheme were tendered to the open market, ProCure21+ is likely to deliver a much closer final outturn cost, with far less risk to the Trust. Value for money is achieved through the ProCure21+ contract by:

- Market testing/ competitive tendering of contract works packages
- Using pre-tendered rates, which were obtained at the bottom of the market
- Allocation of risk on a best value basis
- One point of responsibility for design and construction
- Reduced pre-contract time period, and the benefit of early contractor involvement
- Fully open book and partnering approach, which reduces the risk of dispute and litigation
- Agreement of a GMP prior to the Trust committing to commencing construction
- An agreed post-contract process for change

5. The Financial Case

Capital Funding Requirement

The capital costs for the financial analysis are based on (BIS) PUBSEC for a projected start date of second quarter 2012. The capital costs include an element of non-recoverable VAT based on an estimated level of recoverable VAT (assumed to be 20% at PRH and 25% at RSH).

Option P4 also includes the proposed purchase of land from NHS Telford and Wrekin at a value of £374,000. The Trust employed the services of the District Valuer (DV) to value this parcel of land and the £374,000 has been derived from the DV's report.

	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	Total £000
Option -OBC					
P4		11,785	11,380	5,534	28,699
R6		2,633	2,454	1,174	6,261
Total	0	14,418	13,834	6,708	34,960
Option - FBC					
P4	2,074	12,314	13,342	518	28,248
R6	501	3,371	2,584	169	6,625
Total	2,575	15,685	15,926	687	34,873

Option P4 minimises new build elements and relies on a co-ordinated programme of ward refurbishment. A summary position is described within the Economic Case.

Option R6 relies entirely on co-ordinated programmes of ward refurbishment and allows re-provisioning Corporate functions into the vacated and refurbished maternity building. A summary position is described within the Economic Case.

The Trust has pursued a different source of funding for the scheme following the announcement by the Department of Health to release Public Dividend Capital funding for capital schemes across the NHS in England.

Supported in the application by NHS Midlands and East, the Trust received confirmation on 5 March 2012 that the Trust would receive up to £35m as PDC funding, to fully fund the proposed reconfiguration works.

	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	Total £000
Option					
P4	2,074	12,314	13,342	518	28,248
R6	501	3,371	2,584	169	6,625
Total	2,575	15,685	15,926	687	34,873
Funded by:					
PDC	2,000	32,873	0	0	34,873
Total	2,000	32,873	0	0	34,873

Impact on the Organisation's I&E Account

The initial incremental revenue and expenditure impacts associated with the preferred options are presented over the first 7 years of the project only and are based on the following:

Income

- The preferred options allow the Trust to retain vascular surgery and as such the Trust is aiming to become an 'AAA' screening site. A recurrent income stream of £186,000 has been included from 2012/13 onwards.
- The preferred options allow the Trust to perform certain paediatric elective work that currently goes out of the county to other providers. An estimated income stream of £100,000 has been included to recognise this activity from 2014/15 onwards.

Pay

- Staff cost reductions are being planned within the Surgical centre and are driven by the consolidation of services onto the RSH site. The impact is based on the more efficient usage of ward staff and equates to a reduction in 2013/14 of 13.26 whole time equivalents (wte) with a cost saving of £413,000.
- Staff cost increases are being planned within the Women and Children's centre over the first two years of the project and are driven by changes in the mix of type of staff within the Paediatric team. The increase in 2013/14 is 12.37 wte with a cost increase of £107,000.
- Staff cost reductions are being planned within the head and Neck centre and are driven by the consolidation of services onto the PRH site. The impact is based on the more efficient usage of nursing staff and equates to a reduction in 2013/14 of 3.38 whole time equivalents (wte) with a cost saving of £119,000.

Non Pay

- There is a net increase in the size of the Estate by 7,287 sqm that will generate additional running costs- heat and light and cleaning. The additional running costs have been costed from the Trust's ERIC data at rates of £19.95sqm for cleaning and £21.83sqm for heat and light. This total number is £305,000 and when comparing the net effect of running costs is offset against the equivalent type of costs that will be saved as part of the repatriation of the Finance function from the current offsite facilities. This saving is estimated to be £85,000 and is shown within the repatriation saving detailed below.
- The Finance and HR functions are to be repatriated and relocated from their current locations. The rent saving and the opportunity to rent the current HR offices as staff accommodation have been included as a saving of £329,000 and £70,000 respectively.
- 'One-off' revenue expenditure relating to decanting costs of £500,000 has been included within 2013/14. Capital related decanting costs have been included within the FB forms.

Capital Charges

- The depreciation of the developments has been set to replicate asset lives of 40 years and is consistent with the Trust's accounting policy. The proposed purchase of land of £374,000 has been treated as a non-depreciating asset.
- The Public Dividend Capital (PDC) dividend effect has been calculated at 3.5% of the relevant changes within net assets.
- The potential 'brought into use' revaluation impairment has not been included within the income statement as this price impairment is excluded from NHS performance metrics.

- The Trust has assumed that any potential economic impairment relating to the maternity block at RSH will be absorbed within the revaluation reserve for this asset. As such, no impairment has been recognised in the income statement.

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000	£000	£000
Income								
AAA Screening	186	186	186	186	186	186	186	186
Paediatric elective	-		100	100	100	100	100	100
Total Income	186	186	286	286	286	286	286	286
Pay								
Surgical	0	413	413	413	413	413	413	413
Women and Children	0	-107	-107	-107	-107	-107	-107	-107
Head and Neck	0	120	120	120	120	120	120	120
Total Pay	0	426	426	426	426	426	426	426
Non Pay								
Running costs	-	-	-305	-305	-305	-305	-305	-305
Repatriation savings	-	-	399	399	399	399	399	399
Decanting costs	-	-500	-	-	-	-	-	-
Total Non Pay	0	-500	94	94	94	94	94	94
Capital Charges								
Depreciation	-	-962	-962	-962	-962	-962	-962	-962
PDC	-368	-903	-1,172	-1,150	-1,117	-1,083	-1,049	-1,016
Total Capital Charges	-368	-1,865	-2,134	-2,112	-2,079	-2,045	-2,011	-1,978
Total Charge	-182	-1,753	-1,328	-1,306	-1,273	-1,239	-1,205	-1,172

Impact on the Statement of Financial Position

The proposed options will have the following impact on the long term assets and liabilities of the Trust's Statement of Financial Position over the first 8 years of the scheme. The timing and the drawdown of the £32.873m in 2012/13 has to be agreed with the Department of Health.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
	£000	£000	£000	£000	£000	£000	£000	£000
WIP	2,575	17,886						
Land		374	374	374	374	374	374	374
New Buildings			32,850	32,574	31,613	30,651	29,689	28,727
Total Assets Employed	2,575	18,260	33,224	32,948	31,987	31,025	30,063	29,101
Tax Payers' Equity - Public Dividend Capital	2,000	34,873	34,873	34,873	34,873	34,873	34,873	34,873
Total Tax Payers' Equity	2,000	34,873	34,873	34,873	34,873	34,873	34,873	34,873

Impact on the Statement of Cashflow

The proposed options will have the following impact on the cashflow of the Trust:

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000	£000	£000
Income	186	186	286	286	286	286	286	286
Pay	0	426	426	426	426	426	426	426
Non Pay	0	-500	94	94	94	94	94	94
PDC Dividend	-368	-903	-1,172	-1,150	-1,117	-1,083	-1,049	-1,016
Total cash outflow	-182	-791	-366	-344	-311	-277	-243	-210

Revenue Impact and Affordability

The Trust's current Long Term Financial Plan (LTFP) details the income statement for the period 2012/13 to 2016/17. The assumptions within this model are:

- The changes within income are as a result of the following elements:
 - a reduction in clinical income inflation (tariff) by 1.1% in the year to 2012/13 followed by a 1.8% reduction in all years to 2016/17
 - an increase in income representing demographic growth of 1.3% in all years to 2016/17
 - a reduction in other clinical income inflation (non-tariff) by 1.8% in all years to 2016/17
 - a nil movement in other non-clinical income that includes education and research and development in all years to 2016/17
- In addition to the income items detailed above the following adjustments have been recognised in respect of 2012/13 income only:
 - a reduction in income of 0.8% representing the estimated loss of income due to readmissions activity for elective and non-elective readmissions
 - A reduction in income of 2.1% representing the reduced income given to the Trust by local QIPP schemes and initiatives delivered by local commissioners
- The changes within expenditure are as a result of the following elements:
 - Increases in pay inflation of 2% per annum to 2016/17
 - Increases in non-pay inflation of 4.5% per annum to 2016/17
- Nil inflation in finance costs to 2016/17

The table below shows that the Trust is forecasting sufficient cash generated surpluses to absorb the additional costs of the developments

	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000
Income	302.5	288.4	287.6	286.4	285.2
Pay	-206.7	-202.6	-204.5	-206.8	-209.1
Non Pay	-94.8	-99.6	-104.4	-109.5	-114.7
Finance Costs	-14.2	-14.4	-14.4	-14.4	-14.4
Result before CIP	-13.2	-28.2	-35.7	-44.3	-53.0
CIP					
Trust Schemes – see section below	3.1	7.7	14.5	22.0	29.6
PWC Schemes - see section below	10.5	24.3	25.3	26.3	27.3
Surplus after CIP	0.4	3.8	4.1	4.0	3.9
Revenue effect of reconfiguration	-0.2	-1.8	-1.3	-1.3	-1.3
Surplus after service improvements	0.2	2.0	2.8	2.7	2.6

6. The Management Case

This section of the FBC sets out the Trust's 'comprehensive delivery plan' to ensure the Trust plans and manages the successful delivery of the reconfiguration programme, including setting out arrangements for governance; management of programme, design, cost, and quality; risk and benefits management; workforce; assurance and engagement; and arrangements for handover and post-project evaluation.

Programme Management Arrangements

The Trust recognises that the successful delivery of the FCHS programme of works is a significant task, which will require robust project management and a real commitment from everyone involved to ensure its success.

The proposed reconfiguration works are being managed by the Trust as a single overall programme of works. The Trust is managing most of the project internally, complemented by external advisors where appropriate and the ProCure21+ Partner, Balfour Beatty, for the technical delivery aspects. One of the key reasons for the Trust selecting the ProCure21+ procurement route was to obtain the expertise and experience of a specialist healthcare contractor to fully manage the design and construction of the scheme from FBC stage onwards. The Trust does however fully understand that a P21+ scheme does not run itself, and the Trust still need to provide management time and expertise to the project.

The Trust has put in place robust procedures to manage risk, ensure benefits are realised, seek appropriate assurance, provide engagement, and ensure a smooth transition of services.

The Trust has successfully managed the project to date, and has delivered an OBC approval and an FBC within a robust management and governance structure. This management structure was documented within three separate Delivery Plans and a Project Initiation Document (PID), all of which were approved by the Trust Board.

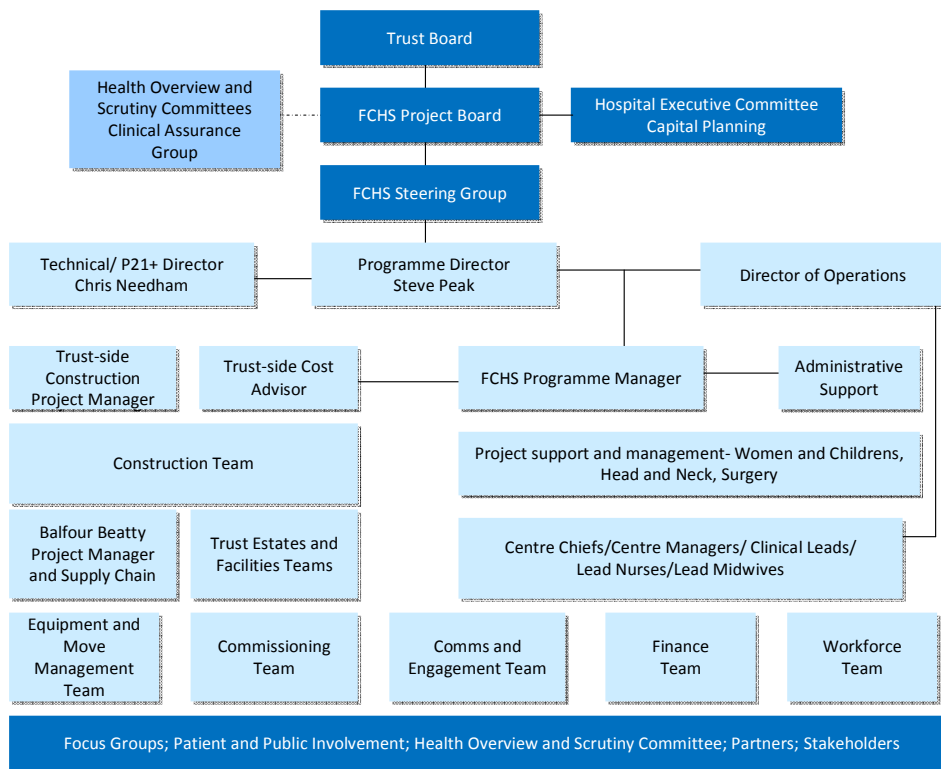
The post-FBC arrangements therefore build on these arrangements which have worked well to date, making suitable provision for the shift in emphasis from planning to delivery, as well as the introduction of the P21+ partner.

Project Governance

The project is resourced from within the Trust, complemented by external specialist consultants. The governance of the project is carefully structured with clearly defined roles for individuals; and the establishment of a series of groups, teams and boards. This ensures all team members understand their role and responsibilities, and provides a clear and auditable route for decision making and the escalation of risks and issues.

In order to achieve the successful delivery of an FBC, there has been considerable work undertaken by a number of groups and individuals to date, and there are therefore already a robust set of programme structure and governance arrangements in place. These have been developed in discussion with the relevant Centre Chiefs and Business Managers, and reflect the need to support and maintain the clinical leadership of the programme. These arrangements have all been agreed and signed off by the Trust Board.

These previous governance arrangements have now been reviewed and updated where required to ensure the challenges of entering the delivery phase of the project are met. The updated FCHS Programme and Governance Structure for the Implementation Stage is shown in the diagram below:



This structure reflects the need to ensure the construction of the new build at PRH and the refurbishment of the existing estate at both sites alongside the operational implementation of the new models of care; new ways of working; management of change; and continued communications and engagement, internally and externally. It also responds to the requirements of the Clinical Centres to be at the heart of the implementation yet supported by dedicated project and corporate teams.

From FBC stage onwards, a significant amount of the Trust-side management will be undertaken by:

- the **FCHS Programme Manager**, reporting to the Project Director, who will manage the overall Trust programme, including risks, issues, benefits, engagement, and assurance
- the **Trust-side Project Manager**, reporting to the Associate Director of Estates & Facilities, who will manage the technical aspects and provide the day to day management and liaison with the ProCure21+ Partner (and will be the named party within the P21+ contract).

Both of these people will sit within a **Project Team**, who will meet/communicate weekly. The programme will also report progress into the Trust's Programme Management Office function (PMO) where delivery and performance against plans is tracked. Progress will be reviewed, risks identified and reassessed and issues and challenges with the deliverables shared at each Project team meeting.

The roles and responsibilities of each of the various project groups are shown in detail within the FBC.

Management of Programme, Cost, Design, Change, and Contract Administration

The Trust has robust arrangements in place for the ongoing management of the programme, cost, design, change, and contract administration- which are set out in detail within the main FBC document.

Risk Management

The Trust has robust risk management processes in place for the delivery of the FCHS programme. The Trust needs to be confident that the project's aims and objectives are able to be delivered within the defined constraints. There is therefore a need to closely manage the financial, strategic, clinical, and technical risks associated with the project, to ensure that these do not jeopardise its successful delivery. The risk management within the project has to align completely with the operational risk management within each Clinical Centre.

Risk management will be carried out throughout the course of the project. This will include risk workshops to suit the project stage, enabling identification, management and mitigation of the risks; and establishment of a contingency fund within the cost plan. Risk identification will commence at an early stage, and risk reduction analysis will be encouraged as part of normal design and construction. Risk Management occurs at two interlinked levels:

1. The FCHS Programme Manager manages the overall programme-level risks using the agreed Trust risk management process for the FCHS programme; and
2. The Trust-side Project Manager manages the delivery level risks, in conjunction with the ProCure21+ Partner, using the ProCure21+ and NEC3 risk management process.

Level 1 manages the interdependency with the Centre's clinical risk management processes. Detailed project risk registers are included as an Appendix to the FBC..

Benefits Management

The Economic Case sets out the desired benefits which the Trust aims to realise, and then shows how the chosen proposed solution will optimise these benefits. In summary the benefits the reconfiguration programme aims to realise are:

- Improve quality of services
- Develop existing services and enable provision of new services
- Improve environment and patient experience
- Improve safety of patients, visitors and staff
- Ensure viability of and sustainability of clinical services
- Create flexibility for the future
- Practicality and ease of implementation

The management of ensuring these benefits are achieved are captured in a detailed benefit management plan, which is an Appendix to the main FBC.

Workforce - Implementation

Detailed workforce implementation plans are being developed for each Centre to ensure applicable employment law is being followed, appropriate consultation is carried out with staff, and a programme of familiarisation and training is implemented. Monthly updates will be provided to the TNCC.

Following a review of contractual entitlements, it is clear that the majority both of Agenda for Change and Medical staff have a contractual mobility clause. This means that the relocation of services between sites is not a redundancy situation, but rather a management of change to be handled with local consultation under Trust policy HR38: Management of Organisational Change.

However there is the potential to reduce workforce numbers in certain staff groups –albeit very small numbers. But, due to the fact that fewer than 20 staff are being affected, this is not a collective redundancy situation. This means that there is no legal requirement to consult for a statutory minimum period or report these numbers to the Department of Business, Innovation and Skills. The Trust will follow good practice and consult internally under Trust policy HR38: Management of Organisational Change. There is also a local requirement to seek the approval of Remuneration Committee and the SHA.

In order to mitigate the risk of compulsory redundancy the Trust's aim would be to make these reductions through normal turnover; the Trust average turnover for the period February 2011 – January 2012 is 8.48%. Additionally, statistics gathered as at January 2012 indicate that the Trust is established at 91.9% of budgeted establishment. Clearly, although this is a snapshot at a point in time, it indicates that there are vacancies within the Trust's budgeted establishment that can be used to mitigate the required reductions in the directly affected Centres. Hence even without turnover, the risk of actual redundancies is very slight. Should it still remain impossible to mitigate the risk of actual redundancy, the Trust will consider all available avenues including the possible termination at expiry of temporary and fixed term contracts; voluntary early retirement and voluntary redundancy before implementing compulsory redundancy as a final measure.

Consultation and Communication

Given the nature of this change and the number of affected employees, although the formal consultation process will be relatively short it will need to be comprehensive. As overall there is no requirement for a consultation period greater than 30 days, much of the work traditionally carried out within such a consultation period may take place outside that formal time provision.

Consultation

Within the three directly affected Centres, there are nine different staff groups working in up to nine different services. The aim would be to try to deliver at least one group meeting for each staff group within each service, as well as a Centre specific meeting. The facility for individual consultation meetings will be offered and the Trust will guarantee this for any individual requesting a meeting. There will be individual discussion as part of the implementation phase, to take account of the information contained in the employee's personal file (including their personal circumstances, preferences for site or specialty and any relevant issues they wish to make the Trust aware of in relation to equality and diversity). They may also be used as part of the training needs analysis.

Attendance at monthly TNCC and bi-monthly LNC meetings will form a key part of the formal consultation programme. Additionally, under Trust policy HR38: Management of Organisational Change the Trust would create a joint management and staff side formal consultation group within each of the directly and indirectly affected Centres..

For the Ophthalmology & Patient Access and Emergency & Critical Care Centres, a similar consultation structure is required. In these Centres there are four different staff groups working in up to two different services. Again, the aim will be to deliver at least one group meeting for each staff group within each service, as well as a Centre specific meeting. Individual consultation meetings will also be offered.

Communication

Regular communication is essential, both for the directly and indirectly affected staff. During consultation and implementation briefings will be given weekly in the form of a written update. This will be made available on the Trust intranet for all employees and will also be used as the base for discussion in all relevant Trust corporate and Centre specific meetings.

Updates targeted at particular stakeholder groups will be used, identifying the issues relevant to this particular stakeholder group. Examples of key internal stakeholder groups are:

- Staff side
- Directly affected staff
- Indirectly affected staff
- Line managers
- Individual professional groups
- Key Trust corporate meetings

Timescales

Although there is no legislative requirement to consult for a specified minimum time period, good practice would suggest a minimum consultation period of no less than 30 days for these changes. The Trust may choose to run a single consultation period for the entire change, or several service-specific consultation periods as necessary. The timescales for local consultation, discussion and approval surrounding the small number of potential redundancies, as well as the implementation, appeal and possible notice periods all lead to the proposed timescales set out below:

Action	Length	Proposed Date
Formal consultation on FCHS with stakeholders (staff side, affected staff, all staff) begins		March 2012 until implementation
Communication programme to begin		March 2012 until implementation
Transformational change programme		March 2012 until implementation
Line manager briefings and preparation for formal consultation	1 month	February 2013
Local discussion at Remuneration Committee; relevant regional approval processes	3 months	March to May 2013
Implementation process	4 months	June to September 2013
Appeal period, notice period (if necessary) and	3 months	October to December 2013
Shadow operation/recruitment to gaps & Trial periods if required	3 months	January to March 2014
Go Live		April 2014

Transition Management

The reconfiguration will be implemented in a staged and systematic way that causes the least amount of disruption to services. The implementation phase will formerly start from May 2012.

The Clinical Working Groups (Surgery; Head and Neck; and Women and Children's) will oversee the transition required within each Clinical Centre. Within Women and Children's a number of Clinical Implementation Teams will progress change within each clinical specialty.

Implementation will be driven within each Clinical Centre, led by the Centre Chief and Centre Manager but with support from the FCHS Project Team and corporate Operational Leads. Implementation plans with a detailed critical path have been developed for each service, which are included as an appendix to the main FBC. These are based on the phasing and decanting plans identified by the construction times. Each Implementation Plan will be used as the basis for the formal management of change process and the communication and engagement activities within each service area.

Quality Impact Assessments have also been undertaken within each Centre and will continue to be updated and used as the basis for measuring impact and supporting the management of risk. The latest version of the plans are included as an appendix to the main FBC.

Commissioning and Post-Project Activity

The Trust has a managed process in place for the commissioning of the completed facilities from completion of construction through to commencing operation, which will be developed further as we progress through the project. This includes a process for the handover and commissioning of the built works, the successful implementation of Trust-direct fit-out items, a managed process for defects, a managed Trust commissioning process, and finally post-project management and evaluation.