

APPENDIX 2a – Health economy’s health service need against TDA health service need criteria

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Criteria	Relevant Measure	Identified/Addressed
1) Need for improved strategic fit	Meets the strategic needs of locality	Strategic case for change and models of care developed with partners, the public and stakeholders
	Improves the quality of service relationships and departmental links	Integrated partnership working is key to the future emergency/urgent care service model
	Realises the benefits of interdependence	Co-location of specialties promotes efficiencies and smooth pathways Co-location of specialties promotes efficiencies and smooth pathways
	Introduces flexibility to cope with changes in demand	Capacity designed to respond to growth and demographic change, including shifts from acute to community provision
2) Need to meet national, regional and local policy imperatives	Promotes new models of care	New models of care proposed within: Acute and episodic care Long term conditions/frailty Planned Care Partnership working integral to patient pathways
	Enables a shift to primary care (where appropriate)	
	Is sufficiently flexible/robust to cope with future changes in patterns of service delivery	
	Enables better integration of services	
	Delivers long term service commitments, including maximum waiting times	Split of unscheduled and scheduled care supports delivery of national waiting time targets
3) Need for better access to services	Reduces travelling time by public and private transport for patients, staff and visitors	Provision of Urgent Care Centres for non-life threatening urgent care Services delivered in rural and urban locations Planned care services delivered locally
	Improves equality of access	
	Has a greater responsiveness to patients’ health needs, including patient choice	
4) Need for improved clinical quality of services	Prevents quality of services deteriorating	Addresses challenges with split site provision for emergency and critical care Clinical teams have required numbers of staff Outcomes are improved out of co-location of consolidated emergency services Partnership approach supports knowledge and skills transfer between acute and community staff
	Addresses clinical problems in the service	
	Provides better health outcomes for patients	
	Facilitates improvements in clinical practice	
	Facilitates better configurations of service extending to whole health economy	Whole system approach to addressing current challenges with proposed improvements in acute and community services

Criteria	Relevant Measure	Identified/Addressed
5) Need for development of existing services and/or provision of new services	Develops or provides services as required by commissioners	Addresses challenges with split site provision for emergency and critical care Clinical teams have required numbers of staff Outcomes are improved out of co-location of consolidated emergency services Supports the provision of care closer to home where clinically appropriate
	Protects the provision of existing services	
6) To meet training, teaching and research needs	Makes it easier to recruit and retain staff	Addresses challenges with split site provision for emergency and critical care Clinical teams have required numbers of staff Morale is improved within existing teams as service challenges are resolved
	Contributes to clinical advance	
7) For improved environmental quality of services	To address backlog maintenance requirements and improve the quality of the estate	Backlog maintenance will continue to be an issue in some options as the use of existing estate is required however New/refurbished facilities in all options will improve functional suitability
	To improve functional suitability and site lay-out	
8) To make more effective use of resources	To improve productivity and make better use of cash, human and estate resources	Clinical teams have required numbers of staff
9) Other To address acute service workforce challenges	Consolidates teams around patient and service needs	Addresses challenges with split site provision for emergency and critical care Clinical teams have required numbers of staff Outcomes are improved out of co-location of consolidated emergency services
	Makes it easier to recruit and retain staff	
	Promotes partnership working across organisations and clinical 'boundaries'	

APPENDIX 2b – Urban Urgent Care Centre draft service outline

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The Shrewsbury and Telford Hospital NHS Trust

Urban Urgent Care (UCC) - Service Outline DRAFT

What is an Urban Urgent Care Centre?

In 2014/15 over 115,000 patients arrived at the Shrewsbury and Telford Hospital A&E departments believing they needed immediate access to health care. The majority of these patients (about 75,000) were not in need of life saving intervention and therefore could be more appropriately seen in an Urgent Care Centre.

The Urban Urgent Care Centres within the local health system would provide safe and effective care for patients requiring urgent but not life or limb threatening emergency care. The Urban UCC's would provide assessment, monitoring and treatment for patients and ensure that patients are cared for by the right person, in the right care setting and in a timely manner. This is based on national and local guidance and in particular:

- Transferring Urgent and Emergency Care Services in England, NHS England, August 2015
- Commissioning Standards Integrated Urgent Care, NHS England, September 2015

How many Urban UCC's would there be?

There would be two Urban Urgent Care Centres (UCC); one at the Royal Shrewsbury Hospital and one at the Princess Royal Hospital in Telford. They would be easy to access and visible to patients, with drop off points outside, similar to the current A&Es.

How would the Urban UCC's link to other services?

The UCCs provided at the Royal Shrewsbury Hospital (RSH) and the Princess Royal Hospital (PRH) would work in partnership with the Emergency Department (ED), Rural Urgent Care Centres, Primary Care Providers and the Ambulance Service to ensure that patients are seen and treated in the right place and by the right people. Teams and individuals working within these services would follow agreed processes and pathways and work to common standards and protocols.

For patients accessing the Urban UCC, their care and ongoing treatment (if required) would appear seamless in terms of 'who does what' i.e. if they walk-in to the Urban UCC but require care within the Emergency Department, they would be transferred without delay.

When would the Urban UCC's be open?

The Urban UCCs would be open 24 hours a day, 7 days a week, 365 days a year.

What sorts of patients could go to the Urban UCC's?

The Urban UCC's would treat patients of all ages that require an urgent healthcare intervention that is not life or limb threatening and cannot be treated within a primary care setting (by a GP or Pharmacist). The sorts of things that the Urban UCC's would expect patients to arrive with would be (this is not an exhaustive list) :

- Simple fractures
- Cuts and bruises
- Moderate respiratory complaints
- Some abdominal and chest pain
- Other minor injuries
- Simple eye complaints

How would patients know where to go?

Where the UCC and ED are on the same site:

From the public's perspective, patients would walk into the department through a single door and be triaged by a clinician promptly upon their arrival. If the patient can be seen in the UCC they would be asked to register and begin their pathway of care. Should the triaging clinician believe that the patient requires emergency care the patient would be escorted directly to the Emergency Department without delay.

Where the UCC is not on the same site as the ED:

Patients would walk into the department and be triaged by a clinician promptly upon their arrival. If the patient can be seen in the UCC they would be asked to register and begin their pathway of care. Should the triaging clinician believe that the patient requires emergency care an ambulance would be arranged for the prompt transfer of patients. Experienced clinicians would care for the patient until the ambulance arrives.

How would patients get to the UCC ?

Patients cannot contact the UCC by telephone or make appointments to see the Clinicians. Patients can arrive at the UCC as a 'walk-in' or via Ambulance.

What would happen to those patients that couldn't be seen in the Urban UCC?

For some patients the Urban UCC would not be the most appropriate place for them to be treated as their condition/injury is not severe enough for the UCC. In these cases the patient would be advised to speak to the Navigator within the UCC who could sign post the patient to a more appropriate professional such as a Pharmacist, GP or Practice Nurse. If the patient was not registered with a GP practice or is unable to make an appointment the Navigator could support them with this/ make an appointment directly. The UCC would ensure that all patients leaving the department have been directed to the most appropriate service to meet their needs.

Who would look after the patients?

The workforce within the UCCs would be made up of the following:

- Advanced Clinical Practitioner
- Emergency Nurse Practitioner
- GP
- Clinical Triager/Streamer
- Navigator
- Support staff
- Administrator/receptionist
- Therapists

The team would also have access to specialist clinicians within the hospital for advice and support.

What would the Urban Urgent Care Centre look like?

The UCC would provide a number of clinical assessment and treatment areas, including consultation and quiet rooms. Rooms would be sound proofed to ensure patient confidentiality and dignity is maintained. The environment would be designed to meet the needs of all patients including children and patients with mental health needs.

How would patients be treated? *Please refer to appendix a*

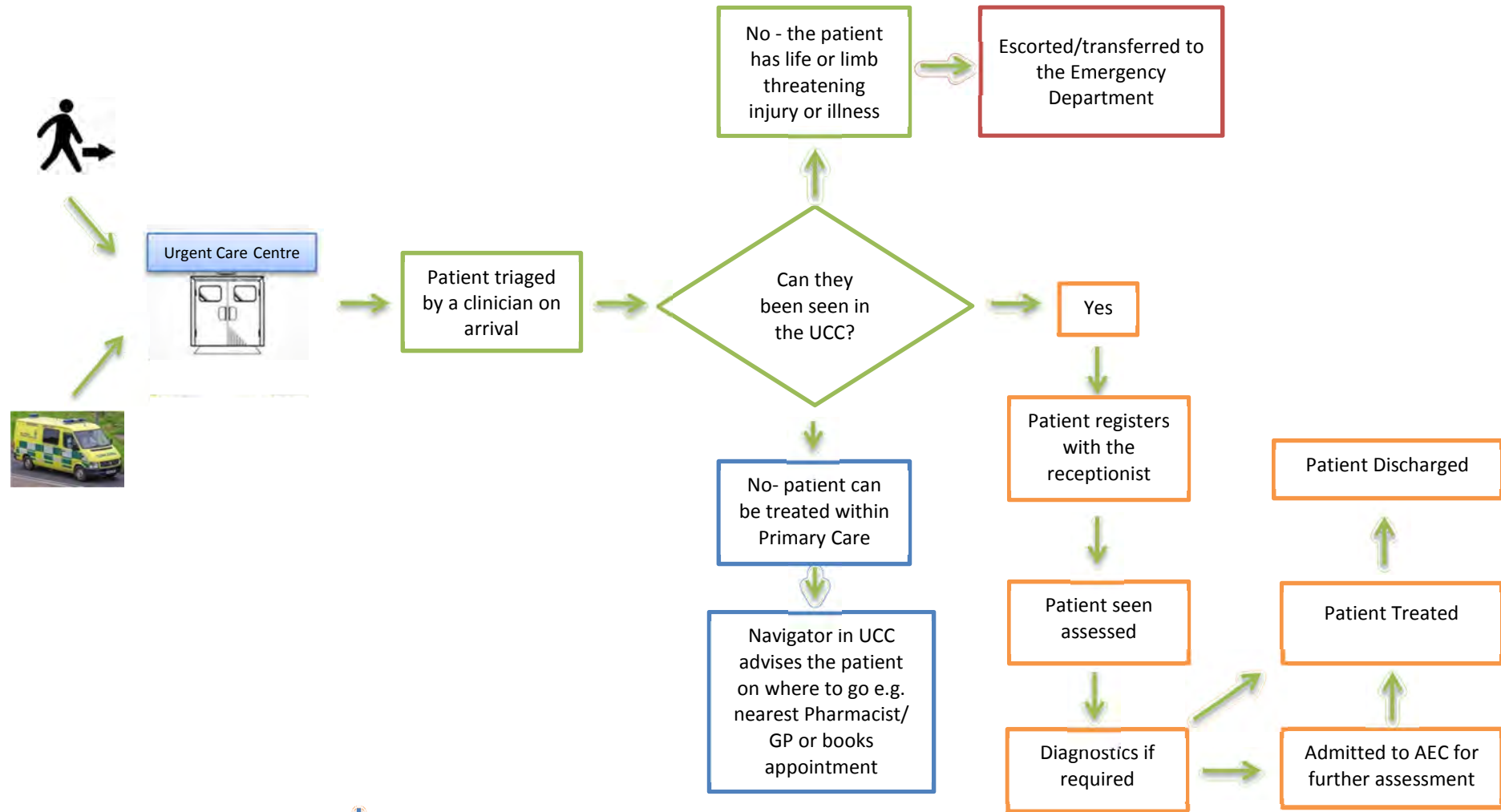
Patients would be assessed and/or treated by a member of staff with the skills to care for their condition/injury. Based on the outcome patients would be discharged

home with advice and/or follow-up care or referred for further assessment and/or treatment to the Ambulatory Emergency Care (AEC) Unit or the Children's Assessment Unit (CAU). The clinical team within the UCC, may call on the ED team or other teams within the Trust for advice/support at any time.

The UCC would be able to access a full range of diagnostics, such as x-ray, blood tests and ultra-sound within the hospital. This would help the clinicians decide what treatment is best for the patient.

Pharmacy can be accessed by patients on site in hours (9am-5pm Monday - Friday). Out of hours, stock within the UCC would be issued for patients requiring immediate medication.

Appendix a – proposed patient pathway



95% on patients to be discharged from the UCC/ED within 4 hours of their arrival

APPENDIX 2c – CSU Activity Modelling Process

Appendix 2c – CSU Activity Modelling Process

2.4 Activity and Capacity Modelling

The Central Midlands Commissioning Support Unit (CSU) was commissioned to support the health economy in Shropshire and Telford to develop a range of models to estimate future activity levels in the local health economy as part of the Future Fit Programme. The activity modelling was planned in sequential stages as follows:

Future Fit Phase 1b: Initial Acute and Community Hospital Activity Models – To estimate the impact of demographic change, traditional commissioner activity avoidance and provider efficiency strategies on acute and community hospital activity;

Future Fit Phase 2: Effects of new models of care – Building on the initial models, to estimate the consequences of more radical redesign proposals generated by the three clinical redesign workstreams: acute and episodic, planned care and long term conditions and frailty;

Future Fit Phase 3: Option appraisals – Building on the models above, to estimate the likely activity levels at various sites under consideration.

To date, Phases 1 and 2 of the activity modelling have been completed, and are reflected within this SOC.

The **Phase 1 modelling**, undertaken between November 2013 and May 2014, estimated the levels of activity that Shropshire and Telford acute hospitals and the Shropshire community hospitals might be expected to manage in 2018/19 taking into account demographic change (two scenarios were considered and are explored further later in the SOC), a range of commissioner activity avoidance schemes and provider efficiency schemes.

The phase 1 activity models were produced by the CSU's Strategy Unit, supported by a reference group of clinical and managerial representatives from the local CCGs and provider trusts. The reference group – the Activity and Capacity subgroup of the Future Fit Programme Board – met on 7 occasions between November 2013 and February 2014 to define the scope of the model, agree the model components and set the model's change parameters. The Phase 1 modelling approach is summarised in Figure 1:

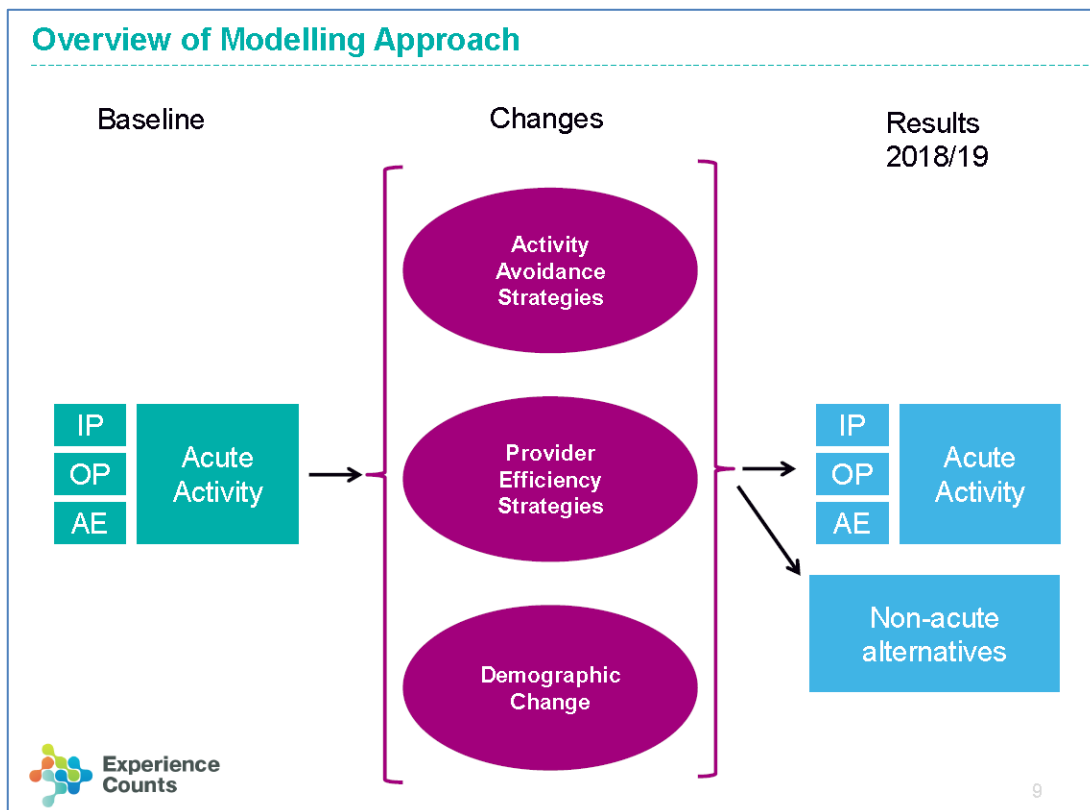


Figure 1: Phase 1 Modelling Approach

Three aspects of **demographic change** were considered;

Changes in population size were derived from the Office for National Statistics (ONS) sub-national population projections;

Changes in population age profile were also be derived from ONS sub-national population projections;

Changes in age-specific population health status may offset some of the aging population effect as the population's age-specific health status improves. The reference group considered trends in life-expectancy and disability free life expectancy as a means of making judgments about whether there will be an expansion or compression of morbidity at the end of life. The reference group requested that two scenarios were modelled:

1. No change in disability free life expectancy over the 5 year period covered by the model. In this scenario no changes are applied to age specific utilisation rates;
2. An increase in disability free life expectancy, but at half the rate than has been experienced nationally over the past decade or so. In this scenario, age specific utilisation rates are altered by 1 year over the 5 year period, such that an average 91 year old in 2018 has the health status, and associated utilisation rates of a 90 year old in the baseline year.

A range of commissioner activity avoidance strategies was analysed and considered.

These subsets of acute activity commonly form the basis of commissioner Quality,

Innovation, Productivity and Prevention (QIPP) plans. The reference group reviewed materials comparing activity of these types at Shrewsbury and Telford Hospital NHS Trust with other trusts in the West Midlands, encompassing activity trends, comparative rates of change and detailed diagnostic breakdowns. Based on this contextual information and knowledge of planned or potential QIPP schemes, the group set their expectation for activity of this type to change over the next 5 years across the following activity categories:

- Conditions amenable to ambulatory care;
- Medicines-related admissions;
- Self-harm related admissions;
- Falls related admissions;
- Vaccine-preventable admissions;
- Alcohol-related admissions;
- Smoking-related admissions;
- Obesity-related admissions;
- End of life care;
- Medically unexplained symptoms;
- Zero day stays with no procedure;
- Cancelled operations;
- Procedures of limited clinical value;
- Frail elderly – step-up admissions;
- Psychiatric liaison in A&E;
- Readmissions;
- GP referral management;
- New to follow-up outpatient ratios;
- Consultant-to-consultant outpatient referrals;
- Outpatient procedures;
- Patients who left A&E without being treated;
- Low-cost A&E attendances referred to GP or discharged;
- Frequent A&E attenders.

The **provider efficiency strategies** considered are commonly the focus of provider Cost Improvement Plans (CIPs) and in both elective care and urgent care and aim to reduce the bed usage for admitted patients or the resource impact of outpatient and A&E activity. The reference group set out their expectations for changes in the following areas in the next 5 years:

Increased use of day surgery;
 Enhanced recovery;
 Excess bed days;
 Ambulatory emergency care;
 Stroke early supported discharge;
 Psychiatric liaison for inpatients;
 Pre-operative length of stay;
 Frail elderly stepdown care;
 A&E attendance duration;
 A&E number of investigations.

The outputs of the first phase of activity modelling were summarised in two documents;

Modelling Future Activity Levels Shrewsbury & Telford Hospital NHS Trust, published in May 2014;

Modelling Future Community Hospital Provision in Shropshire and Telford, published in February 2014.

Figure 2: Headline changes in acute activity, resource and costs between 2012/13 and 2018/19 shows the headline changes in acute activity, resource use and costs between the baseline year 2012/13 and 2018/19, under the two demographic scenarios.

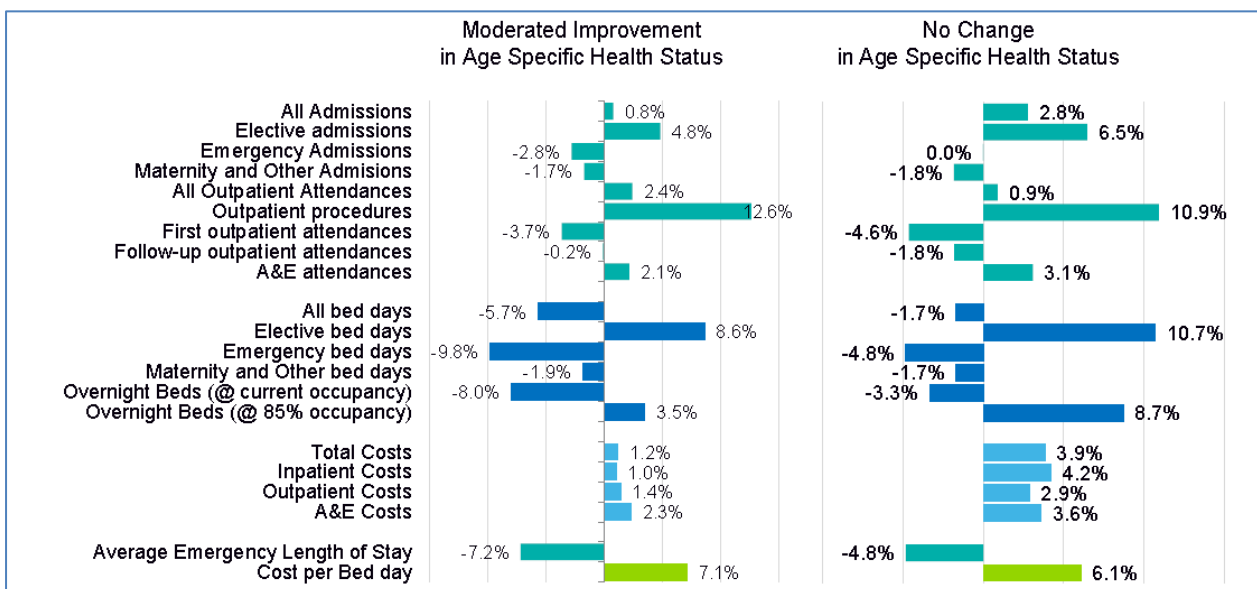


Figure 2: Headline changes in acute activity, resource and costs between 2012/13 and 2018/19

The **Phase 2 modelling** was undertaken between June and December 2014 to assess the activity consequences of the Future Fit Clinical Model. The outputs were summarised in the document:

Modelling the Activity Implications of the Future Fit Clinical Model, published in December 2014.

This Phase 2 modelling built on the initial models to estimate the consequences of more radical redesign proposals generated by the three clinical redesign workstreams: acute and episodic, planned care and long term conditions and frailty.

The **acute and episodic care model** suggests that 69% of front door urgent care activity incorporating activity current managed in ED, direct GP admissions community hospital step-up admissions, MIU and WIC attendances, Diagnostics, Assessment and Access to Rehabilitation and Treatment (DAART) assessments and GP Out of Hours (OoH) Primary Care Commissioning (PCC) contacts) could be managed at an urgent care centre, with the remaining 31% (circa 68,000 attendances) requiring the emergency centre. 75% of the activity being managed by the urgent care centres will take the form of minor injuries or ailments, 12% as ambulatory emergency care, 8% as frailty management with 5% taking other forms.

The **planned care model** suggests that 67% of the planned care activity in 2018/19 would take place in Local Planned Care Centres, 29% at a Diagnostic and Treatment Centre and 4% in an Emergency Centre. Approximately 35,000 follow-up outpatient attendances managed by the local planned care centres could take place virtually.

Long Term Conditions and Frailty: there were approximately 10,000 emergency admissions associated with either frailty or long term conditions in 2012/13. The phase 1 models suggested these admissions could fall by 8% by 2018/19 largely as a consequence of improvements in primary care management and through better use of community hospitals. The Phase 2 models suggest that a further 24% could be avoided by reducing the prevalence of the key risk factors that give rise to LTCs (e.g. smoking, cholesterol, blood pressure) and through greater integration of community and primary care.

Activity Modelling Results

The results of the activity modelling are summarised in 1. This shows the baseline and projected future activity for each activity type.

Please note that the below activity represents the activity held in the Secondary Uses Service (SUS) and does not directly represent how activity is commissioned.

Activity Type	Activity Baseline 2012/13	Projected 2018/19 Activity
Daycase admissions	46,043	47,640
Elective Inpatient admissions	6,959	7,867
Non-elective Inpatient admissions	40,942	40,111
Maternity admissions	6,666	6,613
Regular Day attenders	26,532	28,337
Outpatient attendances	266,310	258,789
Outpatient procedures	98,878	109,656
A&E / Urgent Care attendances	131,607	134,380
Walk-in Centre attendances	38,611	39,068
DAART attendances	3,525	3,719
Community Hospital Step-up assessments	476	1,588
Direct GP MAU attendances	19,044	18,631
GP Out of Hours contacts	27,314	27,754

Table 1: Activity: Baseline 2012/13 and Projected 2018/19 by activity type

A more detailed breakdown of acute inpatient activity for adults and children by bed group is shown in Table 2.

Bed Group	Activity Baseline 2012/13: Adults	Activity Baseline 2012/13: Children & Adolescents	Projected 2018/19 Activity: Adults	Projected 2018/19 Activity: Children & Adolescents
Short Stay Frailty	1,377		1,494	
Short Stay Medicine	9,774		10,303	
Short Stay Surgery	3,297		3,370	
Acute Medicine	9,227		9,853	
Oncology	496		567	
Acute Surgery	3,782		4,514	
Trauma	2,304		2,392	
Children	4	4,719	4	4,748
Maternity	5,808	181	5,779	168
Neonatology		1,987		1,888
DTC (Elective) Inpatients	2,562		2,998	

Table 2: Acute Inpatient Activity: Baseline and projected 2018/19 by bed group

Note: this table includes overnight stay activity only

The activity modelling process mapped the projected future activity into the main functional units proposed in the Future Fit clinical model. The results of this are summarised in 3.

Functional Unit	EC	DTC	Maternity	UCCs	Local Planned Care Direct	Local Planned Care Virtual	Avoided Long Term Conditions activity
Daycase admissions	2,727	36,483			8,430		
Elective Inpatient admissions	3,999	3,868					
Non-elective Inpatient admissions	40,111						
Maternity admissions			6,613				
Regular Day attenders					28,337		
Outpatient attendances		70,288			153,681	34,821	
Outpatient procedures	12,205	19,127			78,325		
A&E / Urgent Care attendances	53,744			79,346			1,291
Walk-in Centre attendances				39,068			
DAART attendances				3,719			
Community Hospital Step-up assessments				1,588			
Direct GP MAU attendances	14,711			3,919			
GP Out of Hours contacts				27,754			

Table 3: Activity: Projected 2018/19 by activity type and main functional unit

Setting	EC	DTC	LPC/UCC
CT scans	12,330	11,343	
MRI scans	2,164	8,118	
Diagnostic ultrasound	7,688	8,099	26,385
Plain film x-ray	48,857	9,255	60,669

Table 4: Diagnostic Imaging Activity: projected activity 2018/19 by setting

Capacity Projections

The detailed activity modelling was used to calculate the capacity requirements for the future. In doing this, the following throughput and utilisation assumptions have been made as shown in Table.

Category	Capacity Modelling Assumption
Inpatient % occupancy*	90%
Daycase turnover rate	1.5
Theatre weeks per year	52
Theatre sessions per week	10
Theatre minutes per session	210
Theatre end utilisation**	80%
Outpatient attendances per room per year: 1 st attendances	2,500
Outpatient attendances per room per year: follow-up attendances	3,500
Outpatient attendances per room per year: outpatient procedures	2,500

Table 5: Throughput and Utilisation assumptions

* 90% inpatient occupancy rate relates to the main medicine and surgery bed pools, with remaining beds calculated at 85% occupancy.

** Theatre end utilisation takes account of multiple factors, including cancelled sessions as well as non-operating time within sessions (due to gaps between patients etc), and logistical scheduling issues

The resulting capacity requirements for the future are summarised in Table 6.

Bed Group	Projected Inpatient Bed Requirements
Short Stay Acute Frailty	9
Short Stay Acute Medicine	33
Short Stay Acute Surgery	18
Acute Medicine	304
Oncology	8
Acute Surgery	79
Trauma	57
Critical Care	30
Children	41
Maternity	51
Neonatology	20
DTC Inpatients	20
Sub-Total Inpatient Beds	670
PAU (Paediatric Assessment Unit)	16
DAART	8
Stepdown sub-acute care to be re-provided in other ways	55
Total Inpatient Beds	749

Table 6: Projected Inpatient Bed Requirements 2018/19

Work has been undertaken to quantify and plan for inpatients that no longer require acute hospital care. This cohort of patients equates to those who are classified by the acute trust as “Fit to Transfer” and it has been agreed that their subsequent care does not need to take place within the Emergency Centre. The EC inpatient bed requirement in Table has accordingly been reduced by 55 beds to reflect this.

Acute bed numbers have been adjusted to reflect an expectation that the models of care developed by the programme would improve assessment and discharge processes and would substantially reduce unnecessary delays in a hospital setting. Typically there will be around 65 patients across the hospital who are deemed “fit for transfer”. These plans assume that this figure would be reduced to 10 patients, recognising it is will not be possible entirely to eliminate delays in this group of patients but setting a challenging standard for delayed transfers of care.

Area	EC	DTC	Maternity	Local Planned Care
Cath Lab	2			
Endoscopy Room	1	5		
Maternity Theatre*			2	
Procedure Room	3	5		5
Theatre*	8	9		4
Cath Lab Stage 1 Recovery	2			
Cath Lab Stage 2/3 Recovery	8			
Endoscopy Stage 1 Recovery	1	5		
Endoscopy Stage 2/3 Recovery	2	10		
Daycase Theatre Stage 1 Recovery		18		8
Daycase Theatre Stage 2 Recovery		36		16
Daycase Theatre / Procedure Room Stage 3 Recovery		30		16

Table 7: Projected Theatre and Procedure Room Requirements 2018/19

* Allowance made for NCEPOD and emergency maternity theatres

Area	EC		DTC		LPC		UCCs
	Adult	Child	Adult	Child	Adult	Child	
General OPD		2	10	3	51	7	
ENT		1			6	1	
Dental		4	5		3	1	
Eyes			11		2		
Dermatology					5		
Oncology			4		2		
Maternity					9		
GP Out of Hours							8

Table 8 Projected Outpatient Consult / Exam Room Requirements 2018/19

APPENDIX 2d – Commissioner activity avoidance strategies



Central Midlands
Commissioning Support Unit

Modelling Future Activity Levels **Shrewsbury & Telford Hospital NHS Trust**

v3

Background

Central Midlands Commissioning Support Unit were commissioned to support the health economy in Shropshire and Telford to develop a range of models to estimate future activity levels in the local health economy as part of the Future Fit Programme.

This document provides the results of the first stage of the activity modelling process in relation to acute hospital services in Shropshire and Telford.

This document should be read in conjunction with the output of a parallel piece of work to estimate future activity levels in community hospitals - *Modelling Future Community Hospital Provision in Shropshire and Telford.*

Future Fit Programme

The objectives of the FutureFit programme are;

- to agree the best model of care for excellent and sustainable acute and community hospital services that meet the needs of the urban and rural communities in Shropshire, Telford and Wrekin, and Mid Wales;
- to prepare all business cases required to support any proposed service and capital infrastructure changes;
- to secure all necessary approvals for any proposed changes; and
- to implement all agreed changes.

Stages of Activity Modelling

Modelling Stage	Scope	Future Fit Phase
Initial Acute and Community Hospital Activity Models	To estimate the impact of demographic change, traditional commissioner activity avoidance and provider efficiency strategies on acute and community hospital activity.	Phase 1b
Effects of new models of care	Building on the initial models, to estimate the consequences of more radical redesign proposals generated by the three clinical redesign workstreams; acute and episodic, planned care and long term conditions and frailty.	Phase 2
Option appraisals	Building on the models above, to estimate the likely activity levels at various sites under consideration.	Phase 3

Initial Acute Activity Modelling – Objectives

To estimate the level of in-patient, out-patient and A&E activity that Shrewsbury and Telford Hospitals Trust might be expected to conduct in 2018/19 and the number of beds that would be required to deliver this.

These inputs, methods and results of the modelling exercise should be understood and agreed by representatives of Shrewsbury and Telford Hospitals Trust and the CCGs that are responsible for commissioning the majority of the activity from the trust.

Process

The Activity and Capacity subgroup of the Future Fit Programme Board acted as the reference group for the modelling exercise.

The group met on 7 occasions between November 2013 and February 2014 to define the scope of the model, agree the model component and set the models change parameters.

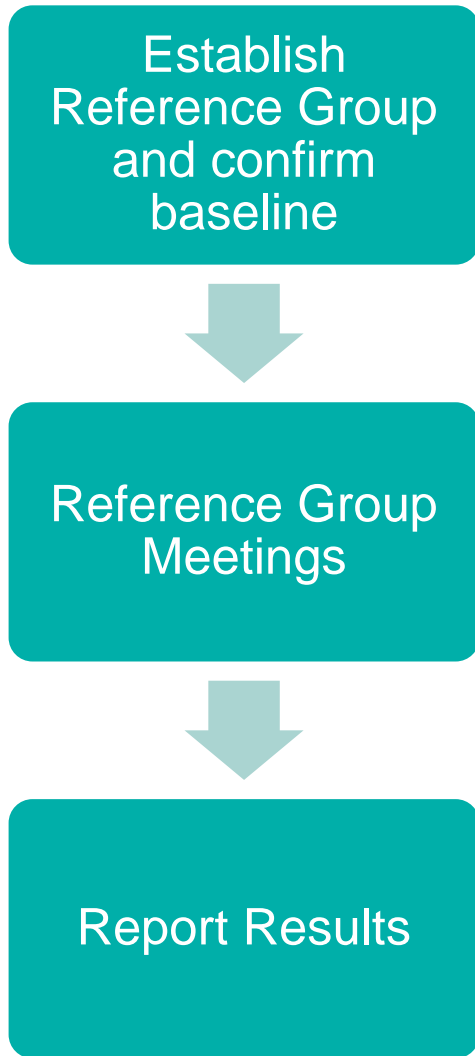
Meeting Dates

- 12th November 2013
- 26th November 2013
- 17th December 2013
- 21st January 2014
- 4th February 2014
- 25th February 2014

Reference Group Members

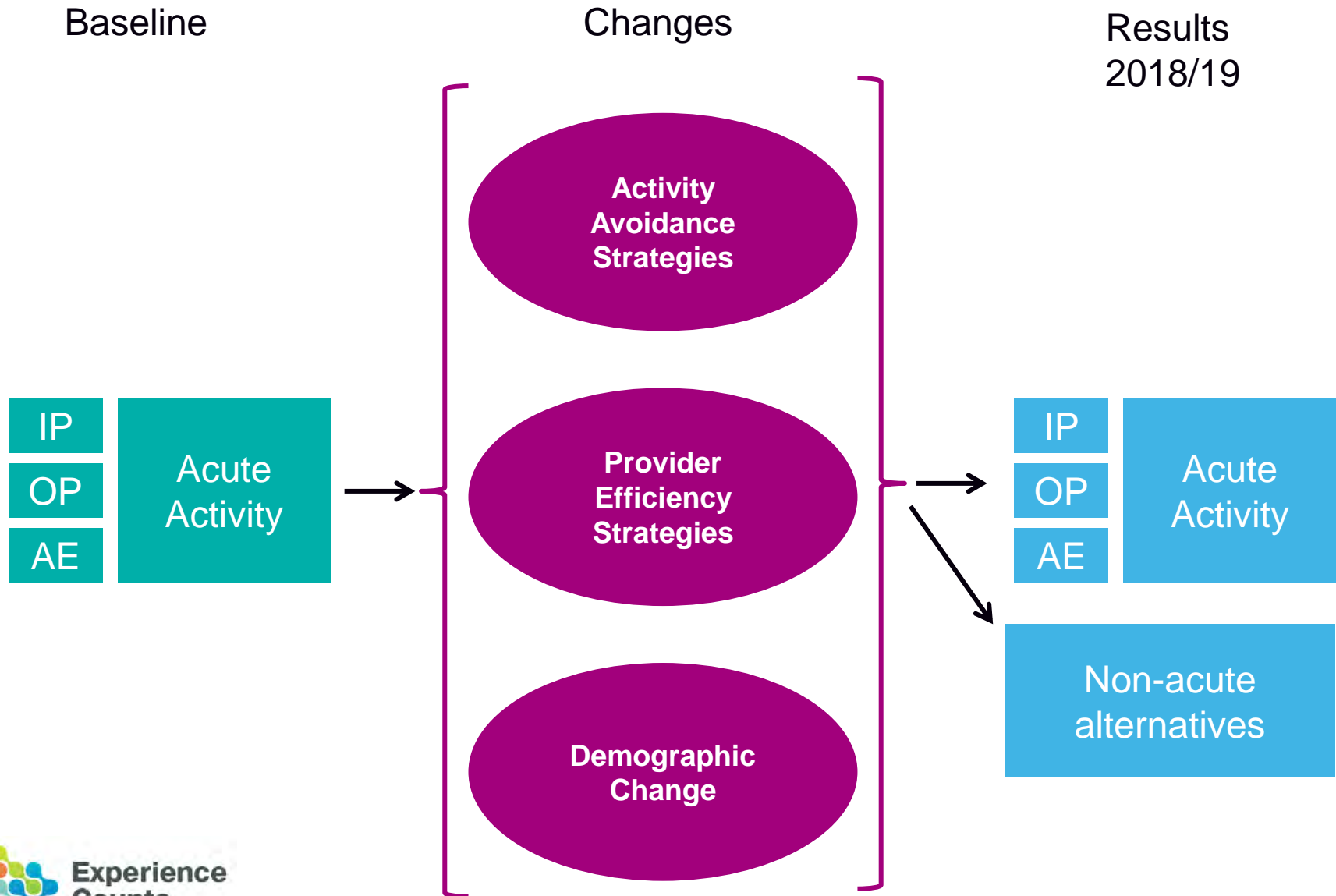
Name	Role	Organisation
Dr James Hudson*	GP Lead	Telford & Wrekin CCG
Mr Mark Cheetham*	Scheduled Care Group Medical Director	Shrewsbury & Telford Hospital NHS Trust
Julie Davies	Director of Strategy & Redesign	Shropshire CCG
Dr Bill Gowans	Vice Chair	Shropshire CCG
Donna McGrath	Chief Finance Officer	Shropshire CCG
Andrew Nash	Chief Finance Officer	Telford & Wrekin CCG
Fran Beck	Executive Lead, Commissioning	Telford & Wrekin CCG
Teresa Smith	Ward Manager, Ludlow Community Hospital	Shropshire Community Health NHS Trust
Julie Thornby	Director of Governance & Strategy	Shropshire Community Health NHS Trust
Dr Emily Peer	Associate Medical Director	Shropshire Community Health NHS Trust
Dr Subramanian Kumaran	Clinical Director	Shrewsbury & Telford Hospital NHS Trust
Dr Kevin Eardley	Unscheduled Care Group Medical Director	Shrewsbury & Telford Hospital NHS Trust
Debbie Vogler	Director of Business & Enterprise	Shrewsbury & Telford Hospital NHS Trust
Mr Andrew Tapp	Women's & Children's Care Group Medical Director	Shrewsbury & Telford Hospital NHS Trust
Jon Cook	Head of Strategic Transformation	Central Midlands CSU
Steven Wyatt	Head of Strategic Analytics	Central Midlands CSU
Jake Parsons	Strategic Analytics Senior Manager	Central Midlands CSU

Process



Workshop	Content
1	Review and confirm objectives and scope Agree conceptual model & model components
2 - 4	Set inpatient parameters
5	Set demographics parameters
6	Set outpatient parameters Set A&E parameters
7	Review initial results Adjust parameters

Overview of Modelling Approach



Demographic Change

Three aspects of demographic were considered;

- **Changes in population size** were derived from ONS sub-national population projections.
- **Changes in population age profile will also be derived from** ONS sub-national population projections. Given that age is a strong predictor of healthcare utilisation, the model will estimate the change in demand attributable to the changing population age profile.
- **Changes in age-specific population health status** may offset some of the aging population effect as the population's age-specific health status improves. The reference group considered trends in life-expectancy and disability free life expectancy as a means of making judgements about whether there will be an expansion or compression of morbidity at the end of life. The reference group requested that two scenarios were modelled;
 1. No change in disability free life expectancy over the 5 year period covered by the model. In this scenario no changes are applied to age specific utilisation rates.
 2. An increase in disability free life expectancy, but at half the rate than has been experienced nationally over the past decade or so. In this scenario, age specific utilisation rates are altered by 1 year over the 5 year period, such that an average 91 year old in 2018 has the health status, and associated utilisation rates of a 90 year old in the baseline year.

Further details can be found in appendix A.

Commissioner activity Avoidance Strategies

These subsets of acute activity commonly form the basis of commissioner QIPP plans. The reference group reviewed materials comparing activity of this types at Shropshire and Telford Hospitals NHS Trust with other trusts in the West Midlands, activity trends, comparative rates of change and detailed diagnostic breakdowns. Based on this contextual information and knowledge of planned or potential QIPP schemes, the group set their expectation for activity of this type to change over the next 5 years.

Inpatients

Ambulatory care sensitive

- Chronic
- Acute

Medicines related

Self Harm related

Falls related

Vaccine preventable

Alcohol related

- Wholly attributable
- Largely attributable
- Somewhat attributable

Smoking related

- Largely attributable
- Somewhat attributable

Obesity related

- Largely attributable
- Somewhat attributable
- Marginally attributable

End of Life Care

Medically unexplained symptoms

Zero Day LoS, no procedure, discharged alive

- Children
- Adults

Cancelled operations

Procedures of limited clinical value

- Relatively ineffective
- Close benefit / harm ratio
- Probably aesthetic
- Cost effective alternative

Frail Elderly – step up

Psychiatric liaison in A&E

Readmissions

Out-patients

GP Referral Management

New to follow-up ratios (LTC)

Consultant to Consultant referrals

OP procedures

A&E

Patient left A&E before being treated

Low cost attendances – referred to GP or discharged

Frequent Attenders

Provider Efficiency Strategies

These subsets of acute activity are commonly the focus of provider CIPs and in both elective care and urgent care and aim to reduce the bed usage for admitted patients or the resource impact of outpatient and A&E activity. The reference group set out their expectations for changes in these areas in the next 5 years.

Inpatients

Increased use of Day Surgery

- Day cases
- Outpatient procedures

Enhanced Recovery

- Colectomy
- Excision of Rectum
- Hip surgery
- Knee surgery
- Bladder surgery
- Prostate surgery
- Hysterectomy

Excess bed days

- Elective
- Emergency

Ambulatory emergency care

- Low potential
- Moderate potential
- High potential
- Greatest potential

Stroke early support discharge

Psychiatric Liaison – In-patients

Pre-Op Length of Stay

Frail elderly – Step Down

Out-patients

A&E

Attendance duration

Number of Investigation

Links between the Inpatient, Outpatient, A&E and Community Hospital Models

Four activity models were created for Future Fit Phase 1b;

- Inpatients
- Outpatients
- A&E
- Community Hospitals

Although these models were constructed separately, the following transfers of activity between the domains covered by the models have been incorporated.

1. Ordinary elective and day case admissions >> outpatient procedures
2. Where certain emergency admissions avoided then associated A&E attendances also removed
3. Emergency admissions of frail older people to acute hospitals >> step-up admissions in community hospitals
4. Reducing length of stay of frail older people in acute hospitals >> step-down admissions to community hospitals

Setting Parameters

The reference group were given the following guidance when setting change parameters in the model:

The parameters should represent the consensus view of the reference group about the extent to which activity of this type could be avoided by 2018 in comparison to the baseline year.

The parameters should be informed by the contextual information supplied at the workshop session, but also their local knowledge of current, planned or potential QIPP or CIP schemes.

Each activity subset should be considered individually.

The agreed parameters should be both challenging and realistic.

Strategy parameters should be independent of demographic change and of each other.

The reference group were asked to consider the effect of traditional commissioner and provider plans and should not consider the potential effect or more radical service changes or site changes.

Agreed Inpatient Strategy Parameters (1)

Admission Avoidance	Agreed parameter
Ambulatory care sensitive acute	Reduce 0 and 1 day LOS admissions for J03 and J06 at Telford by 20%
Ambulatory care sensitive Chronic	No change
Medicines related - Diuretics	No change
Medicines related - benzodiazepine	No change
Medicines related - Anti diabetics	No change
Medicines related - NSAIDS	No change
Self Harm related	No change
Falls related	20% reduction
Vaccine preventable	Remove 15% of total including all 0 LOS episodes
Alcohol related wholly	Switch proportions of day cases and inpatients for F10 and K70
Alcohol related somewhat	Remove 20% of 65+ non elective spells. Convert 50% of these to elective spells
Alcohol related marginal	Apply long term trend
Smoking related largely	Reduce to 0.5% across both sites
Smoking related somewhat	15-20% reduction of short stay R07 episodes
Obesity related -wholly	15% increase
Obesity related somewhat	Base parameter on age specific increases in obesity from foresight report
Obesity related marginal	Base parameter on age specific increases in obesity from foresight report
End of Life Care <2days	20% reduction
End of Life Care 3-14 days	20% reduction
End of Life Care 14+	No change
Medically unexplained symptoms	No change
Zero Day LoS, no procedure, discharged alive - Adults	Defer
Zero Day LoS, no procedure, discharged alive - Children	Defer
Cancelled operations	Maintain at 2.2% until 18/19 when 1% achieved
Procedures of limited clinical value – relatively ineffective	Reduce to 0.6%
Procedures of limited clinical value - potentially Cosmetic	No change
Procedures of limited clinical value close benefit-harm	No change
Procedures of limited clinical value cost effective alternatives	No change

Agreed Inpatient Strategy Parameters (1)

Admission Avoidance	Agreed parameter
Community Hospital Step-Up (frail elderly group 1)	80% reduction at Royal Shrewsbury
Community Hospital Step-Up (frail elderly group 1)	45.5% reduction at Royal Shrewsbury
Psychiatric Liaison - A&E	No change
Readmissions	No change
Length of Stay Reduction	Agreed parameter
BADS mainly Day Case	Move 50% of Q17 DCs at Shrewsbury to OP
BADS mainly OP procedure	No change
BADS mainly Day Case or OP procedure	Move 60 Q18 cases at Shrewsbury from DC to OP
BADS Occasionally Day Case	Increase J18 cases to achieve 80% DC Increase B27 cases to achieve 15% DC Increase M65 cases to achieve 20% DC Increase P23 cases to achieve 12.5% DC
Enhanced recovery - Hips	Down to 5.5 days
Enhanced recovery - Colectomy	Down to 5 days
Enhanced recovery - Excision of rectum	Down to 6.7 days
Enhanced recovery - Knees	Down to 5.2 days
Enhanced recovery - Bladder	No change
Enhanced recovery - Prostate	Down to 2.3 days
Enhanced recovery - Hysterectomy	Down to 2.5 days
Elective Excess bed days	No change
Emergency Excess bed days	No change
Psychiatric Liaison - Inpatient	No change
Stroke Early Supported Discharge	Down to 7 days
Ambulatory emergency care - Low	Achieve Mid Staffs levels 9% 0LOS
Ambulatory emergency care - Moderate	Achieve WAH level 39% 0LOS
Ambulatory emergency care - High	40% 0LOS
Ambulatory emergency care - Very High	Achieve mid staffs levels 27% 0LOS
Pre op LOS	Bring down Telford to 0.9
Community Hospital Step-down	63.8% reduction for 16.9% of cases

Agreed Outpatient and A&E Parameters

A&E	Agreed parameter
Patient attending lives close to A&E	No change
Patient left A&E before being treated	No change
Low cost attendances – referred to GP or discharged	Defer
Frequent Attendees	Not set (additional information required)
Number of Investigations	Remove investigations of the following types to achieve waiting time ambition – haematology, clotting studies, biochemistry, x-ray (plain film)
Length of time from being seen to departure	Achieve 97% < 4 hrs
Emergency ambulance conveyances	Not set

outpatients	Agreed parameter
GP Referred 1st Attendances – Trauma & Orthopaedics	Achieve average
GP Referred 1st Attendances – Cardiology	Telford down to regional average, RSH down to 0.5
GP Referred 1st Attendances – Ophthalmology	Defer
GP Referred 1st Attendances – All Other Specialties (children)	Achieve average
GP Referred 1st Attendances – All Other Medical Specialties	Achieve average plus rate of change
GP Referred 1st Attendances – All Other Surgical Specialties	Not set (additional information required)
New to Follow-Up Ratio – Medical Specialties	Move to 2.5
New to Follow-Up Ratio – Surgical Specialties (General)	No change
New to Follow-Up Ratio – Surgical Specialties (Ophthalmology)	No change
New to Follow-Up Ratio – Surgical Specialties (T&O)	Telford down to regional average
Consultant to Consultant Referrals	Achieve regional average

Links between the Inpatient and A&E Models

The reference group considered a wide range of opportunities to reduce emergency admissions and set parameters to reflect extent to which these opportunities could be realised by 2018/19.

In some cases reductions in emergency admissions could be delivered by changes in decision criteria in A&E, in others cases, admissions could be avoided through upstream interventions or by community based pathway redesign. In these latter cases A&E attendances associated with emergency admission were removed from the A&E model in 2018/19.

Avoided emergency admissions where the associated A&E attendance also assumed to be avoided;

- Ambulatory Care Sensitive (Acute)
- End of Life Care
- Smoking (Wholly and somewhat attributable)
- Alcohol (All those marginally attributable and all aged 65+ in somewhat attributable)
- Vaccine related
- Falls related

Links between the Inpatient and Outpatient Models

The reference group reviewed elective activity which was delivered as ordinary or day case admissions in the baseline year and agreed parameters to reflect the opportunity to manage some of these cases as outpatient procedures.

The cases affected by these assumptions were removed from the inpatient activity model in 2018/19.

HRG specific multipliers were applied to the outpatient activity model to uplift the outpatient procedure activity accordingly.

Links between the Acute and Community Hospital Models

In 2013, the health economy in Shropshire and Telford commissioned the Oak Group to conduct a utilisation audit of a sample of patients in the 2 acute and 4 community hospitals in Shropshire and Telford. The results of this audit were used by the reference group to estimate the level of activity that might be transferred from the acute hospitals to community hospitals. Two activity transfers were considered.

These changes were incorporated into both the acute and community hospital models.

Step-up - avoiding acute admissions of frail older people by admitted these patients instead to community hospitals, where bedded intermediate care, rather than acute care, was required at the point of admission.

Step-down – reducing the length of stay of frail older people in acute hospitals by discharging these patients promptly to community hospitals where the acute phase of their care is complete but the patient required a bedded intermediate care service.

RTT Adjustments

The reference group requested elective and outpatient activity in the baseline year be adjusted to reflect that fact that activity levels in the baseline year were not those that were regarded as appropriate to keep pace recurrently with new referrals into RTT pathways.

In some specialties, activity in the baseline year was thought to be inadequate to keep pace with new referrals, leading to an increase in waiting lists and times.

In other specialties, waiting list initiatives in the baseline year meant that elective and outpatient activity was higher than would be required to keep pace with new referrals.

Specialty level adjustments were made to reset elective and outpatient activity levels in the baseline year to those delivered in 2013/14. Activity levels in 2013/14 were thought to reflect recurrent level of demand. (See appendix B for more information).

Non-recurrent activity increases may be required to achieve RTT targets in the next few years, but these are unlikely to persist until 2018/19.

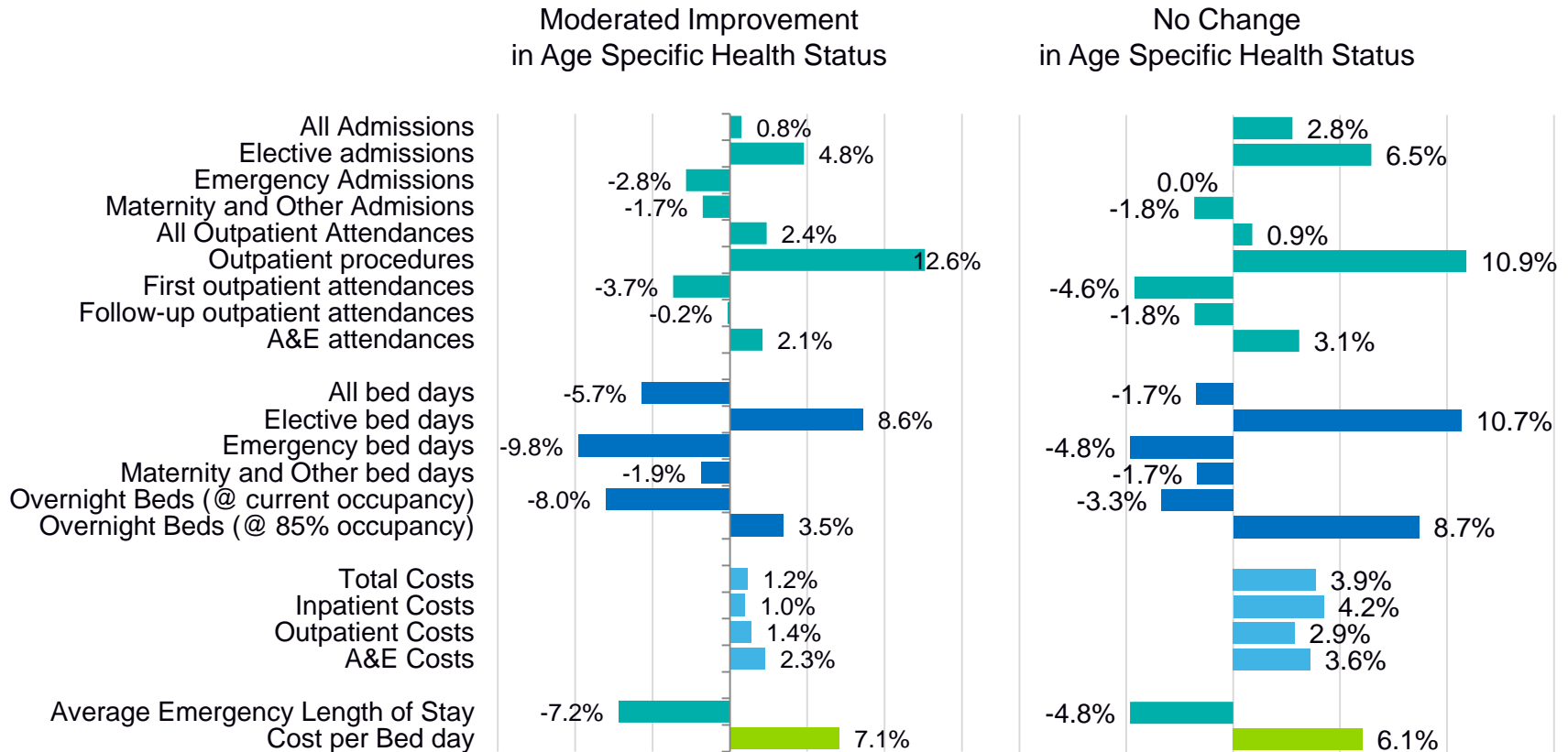


Central Midlands
Commissioning Support Unit

Summary Model Results

Summary Model Results

The following chart shows the headline changes in activity, resource use and costs between the baseline year 2012/13 and 2018/19, under the two demographic scenarios.



Detailed analysis of these model results for these two scenarios are provided in the following sections.

Unless otherwise stated, the following conventions have been followed when compiling the model results,

- activity in 2018/19 has been costed at 2012/13 prices
- bed days include both full and partial beds days – not just overnight stays

APPENDIX 2e – Schedules of Accommodation

SaTH Sustainable Services: Indicative Space Standards

Critical Care Unit - 30 beds

Activity space	HBN size	Quantity	Area	Subtotals	Notes
Entrance & reception					
Reception, 2 positions	9.50	1	9.50		
Waiting Area: 30 places	46.00	1	46.00		
Beverage Bay - without HRB	5.00	1	5.00		
Toilet - Accessible	4.50	2	9.00		
	<i>Sub Total</i>			<i>69.50</i>	
Clinical Spaces					
Bedroom & sanitary facilities					
Staff Base (8) with Clean Supplies	30.00	1	30.00		
Isolation Room	26.00	6	156.00		ensuites to be included in OBC planning
Gowning Lobby	6.00	6	36.00		
4 Bed Bay	143.00	6	858.00		
Interview Counselling	9.00	3	27.00		
Assisted Shower / WC / WHB	8.00	2	16.00		
	<i>Sub Total</i>			<i>1,123.00</i>	
Support facilities					
Clean Utility with controlled drugs	14.00	3	42.00		
Ice Making Machine Bay	1.50	1	1.50		
Near Patient Testing Room	8.00	2	16.00		
Dirty Utility with macerator	12.00	2	24.00		
Beverage Room / Pantry	12.00	1	12.00		
Store	32.00	4	128.00		bulky consumables, medical gas cylinders, linen, furniture
Store - clinical equipment	24.00	2	48.00		
Decontamination Room - clinical equipment	16.00	1	16.00		
Blood Refrigerator Bay	2.00	1	2.00		
Equipment Bay	2.00	4	8.00		imaging equipment
Equipment Bay	2.00	4	8.00		resus trolley
Domestic Services Room	7.00	2	14.00		
Disposal hold	12.00	2	24.00		
	<i>Sub Total</i>			<i>343.50</i>	
Relatives Accommodation					
Relatives Overnight Stay	17.00	1	17.00		
Ensuite - Shower/WC/WHB	4.50	1	4.50		
Sitting Room (7 places)	12.00	1	12.00		

SaTH Sustainable Services: Indicative Space Standards

<i>Sub Total</i>			33.50
Staff Spaces			
Office - Single person	8.00	3	24.00
Office - open plan - Allocated	6.00	29	174.00
Meeting Room (7 places)	16.00	1	16.00
Seminar room 32 place	45.00	1	45.00
Staff Rest (30 place)	30.00	1	30.00
Staff Changing / uniform issue (100 Lockers)	36.50	2	73.00
Staff - Shower	2.50	2	5.00
Staff WC	2.00	8	16.00
			0.00
<i>Sub Total</i>			383.00
Net internal area (NIA)			1,952.50

Note: Circulation & Engineering Allowance to be added.

SaTH Sustainable Services: Indicative Space Standards

Inpatient Ward - 32 Beds, 50% Single Rooms

Activity space	HBN size	Quantity	Area	Subtotals	Notes
Entrance & reception					
Reception (size based on number of places)	5.5	2	11		
Waiting area (size based upon number of places)	1.7	8	13.6		
WC: semi-ambulant	2.5	2	5		
WC: independent wheelchair	4.5	1	4.5		
				<i>Sub Total</i>	<i>34.1</i>
Clinical Spaces					
Bedroom & sanitary facilities					
Single-bed room: adult	19	16	304		P21+ = 23.3 - 24.9m2 (including ensuite)
Shower room: en-suite: chamfered	4.5	16	72		
Multi-bed room: adult: 4 beds	64	4	256		Includes clinical support areas. Could be reduced to 61m2. P21+ = 58.4 - 61.3m2
WC: semi-ambulant	2	3	6		P21+ = 1.9m2
Shower room: assisted	6.5	3	19.5		P21+ = 6.3m2
Bathroom: assisted	15	1	15		
				<i>Sub Total</i>	<i>672.5</i>
Support facilities					
Office/meeting room: 10 places (including 2 workstations)	16	1	16		
Touchdown base	2	8	16		
Treatment room: double sided couch access	16	1	16		
Interview room: 4 places (including 1 wheelchair place)	8	1	8		
Breakout space: patients	6	4	24		
Pantry: ward	12	1	12		option to use regen kitchen
Parking bay: resuscitation equipment	2	1	2		
Parking bay: food trolley	2	1	2		
Parking bay: mobile hoist	2	1	2		
Ward storage allowance	0.75	32	24		0.75 sqm per bed, includes clinical equipment, general store, and linen
Medicine store/preparation room	8	1	8		Alternatively provide 16m2 clean utility in lieu of medicine store & clean supply
Clean supply room allowance (0.34m2 per bed)	0.34	32	10.88		
Dirty utility room: bed pan processing	12	2	24		
Disposal hold allowance (.25m2 per bed)	0.25	32	8		
Cleaners' room	8	1	8		
				<i>Sub Total</i>	<i>180.88</i>

SaTH Sustainable Services: Indicative Space Standards

Staff Spaces				
Staff support				
Locker bay: 12 small lockers	1.5	3	4.5	
WC: ambulant	2	2	4	
Staff rest & mini-kitchen (size based on number of seats)	1.8	3	5.4	
Seminar room: 24 places (including 1 wheelchair place)	32	1	32	to be shared between 2 wards
Communal changing area (size based on number of lockers)	1.4	18	25.2	
	<i>Sub Total</i>		<i>71.1</i>	
Net internal area (NIA)			958.58	

Note: Circulation & Engineering Allowance to be added.

SaTH Sustainable Services: Indicative Space Standards

Emergency & Urgent Care (Emergency & Acute Site)

Activity space	HBN size	Quantity	Area	Subtotals	Notes
Emergency Department					
Ambulance Entrance Facilities					
					Based on SHP work with COI
Main entrance draught lobby	11.0	1	11		
Store: ambulance equipment	6.0	1	6		
Decontamination room	20.0	1	20		
Store: major incident equipment	6.0	1	6		
Parking bay: 4 accident trolleys & 4 wheelchairs	16.0	1	16		
Ambulance Cleaning Bay	8.0	1	8		
	<i>Sub Total</i>			67	
Clinical Zone					
Resuscitation: 8 place	26	8	208		Based on HBN Critical Care room
Staff Base: 4 place (within resus room)	22	1	22		5.5m2 per member of staff
Rapid Assessment & Treatment	10	3	30		cubicles. No HBN equivalent
Majors	16	16	256		allowed for rooms based on HBN treatment room. Could be cubicles instead. Capacity to be reviewed as part of OBC.
Paediatric Majors	16	2	32		
Staff Base: 8 place	44	2	88		5.5m2 per member of staff
	<i>Sub Total</i>			636	
Support facilities					
Near patient testing room	8.5	2	17		
Parking bay: mobile X-ray unit	2.0	2	4		
Parking bay: ultrasound unit	1.0	2	2		
Clean Utility	16	3	48		
Dirty Utility	12	2	24		
Linen Store	16	1	16		
Storage Allowance	78	1	78		Assumes 3m2 per patient room
Disposal Hold: 1700 litres	8	1	8		
Cleaners' room	8	2	16		
Store: ready to use medical gas cylinders	9.0	1	9		
Service room: equipment	21.0	1	21		
WC: Assisted	7.5	1	7.5		Assumes most patients supplied with bed pan
	<i>Sub Total</i>			250.5	

SaTH Sustainable Services: Indicative Space Standards

Distressed & Bereaved Facilities				
Sitting room with beverage bay: 8 persons	16.0	2	32	
WC & handwash: accessible, wheelchair	4.5	2	9	
Body viewing/bier room	10.0	2	20	need to be assessed as part of OBC as may not be required
<i>Sub Total</i>			<i>61</i>	
Staff Spaces				
Staff support				
Office: 1 person	8	1	8	
Locker bay: 12 small lockers	1.5	5	7.5	
WC: ambulant	2	8	16	
Staff rest & mini-kitchen (size based on number of seats)	1.9	50	95	
Communal changing area (size based on number of lockers)	1.4	60	84	
<i>Sub Total</i>			<i>210.5</i>	
Net internal area (NIA)			1225	

Note: Circulation & Engineering Allowance to be added.

Activity space	HBN size	Quantity	Area	Subtotals	Notes
Urgent Care Department (Emergency & Acute Site)					
Entrance & Public Facilities					
Main entrance draught lobby	11.0	1	11		
Parking bay: 8 wheelchairs	6.0	1	6		
Reception: 3 staff	5.5	3	16.5		
Waiting area (size based on number of places)	2.25	25	56.25		
Waiting play area: 15 children	25.0	1	25		
Refreshment: drinking water dispenser	0.5	1	0.5		
Refreshment: vending machine	3.0	1	3		
WC: semi-ambulant	2.5	4	10		
WC & handwash: accessible, wheelchair	4.5	2	9		
Nappy changing room	5.0	1	5		
Infant feeding room	6.0	1	6		
<i>Sub Total</i>			<i>148.25</i>		
Clinical Zone					
Triage Room	12	2	24		Based on HBN Consulting Room

SaTH Sustainable Services: Indicative Space Standards

Minors: See & Treat	12	6	72	Based on HBN single sided consult/exam room. Could be cubicles
Paeds Minors	12	2	24	Based on HBN single sided consult/exam room. Could be cubicles
Staff Base: 3 place	16.5	2	33	5.5m2 per member of staff
Eye Room	12	1	12	Based on HBN Outpatients ophthalmology room
Plaster Room	16	1	16	
Plaster Store	3	1	3	
Isolation Room	16	1	16	Based on HBN double sided consult/exam room.
Isolation Lobby	5	1	5	
Therapy Assessment Room	16	1	16	Based on HBN double sided consult/exam room.
Equipment Store	12	1	12	
<i>Sub Total</i>				233
Support facilities				
WC & handwash: accessible, wheelchair	4.5	1	4.5	
Near patient testing room	8.5	1	8.5	
Parking bay: mobile X-ray unit	2.0	1	2	
Parking bay: ultrasound unit	1.0	1	1	
Clean Utility	16	1	16	
Dirty Utility	12	1	12	
Linen Store	6	1	6	
Storage Allowance	39	1	39	Assumes 3m2 per patient room
Disposal Hold: 1700 litres	8	1	8	
Cleaners' room	8	1	8	
Store: ready to use medical gas cylinders	9.0	1	9	
<i>Sub Total</i>				114
Social care & distressed/disturbed persons				
Interview room: 7 places (including 1 wheelchair place)	12.0	1	12	
WC & handwash: assisted	5.5	1	5.5	
De-escalation room	18.0	1	18	
<i>Sub Total</i>				35.5
Staff Spaces				
Staff support				
Office: 1 person	8	1	8	
Locker bay: 12 small lockers	1.5	1	1.5	
WC: ambulant	2	2	4	
Staff rest & mini-kitchen (size based on number of seats)	1.9	10	19	

SaTH Sustainable Services: Indicative Space Standards

Communal changing area (size based on number of lockers)	1.4	12	16.8	
				<i>Sub Total</i>
				49.3
Net internal area (NIA)				580.05

Note: Circulation & Engineering Allowance to be added.

Activity space	HBN size	Quantity	Area	Subtotals	Notes
Emergency & Urgent Care (Emergency & Acute Site): Shared					
Staff Support					
Admin, Training & Education					
Office: 1 person	8	1	8		
Office: Open Plan	6	18	108		
Seminar room: 24 places (including 1 wheelchair place)	32	1	32		
Library & Study Room: 5 Persons	20	1	20		
				<i>Sub Total</i>	
				168	
Net internal area (NIA)				168	

SaTH Sustainable Services: Indicative Space Standards

Acute Emergency Care Unit (Emergency & Acute Site)

Activity space	HBN size	Quantity	Area	Subtotals	Notes
Acute Emergency Care Unit (Emergency & Acute Site): Option 4, 17 trolleys					
Entrance & Public Facilities					
Reception: 2 staff	5.5	2	11		
Waiting area (size based on number of places)	2.25	5	11.25		
WC: semi-ambulant	2.5	2	5		
WC & handwash: accessible, wheelchair	4.5	1	4.5		
	<i>Sub Total</i>			31.75	
Clinical Zone					
Trollyed Area	12	17	204		No HBN Equivalent
Staff Base: 3 place	16.5	3	49.5		5.5m2 per member of staff
	<i>Sub Total</i>			253.5	
Support facilities					
WC & handwash: accessible, wheelchair	4.5	2	9		
Parking bay: mobile X-ray unit	2.0	1	2		
Parking bay: ultrasound unit	1.0	1	1		
Clean Utility	16	1	16		
Dirty Utility	12	1	12		
Linen Store	6	1	6		
Disposal Hold: 1700 litres	8	1	8		
Cleaners' room	8	1	8		
	<i>Sub Total</i>			62	
Staff Spaces					
Staff support					
Office: 1 person	8	1	8		
Locker bay: 12 small lockers	1.5	1	1.5		
WC: ambulant	2	2	4		
Staff rest & mini-kitchen (size based on number of seats)	1.9	10	19		
Communal changing area (size based on number of lockers)	1.4	12	16.8		
	<i>Sub Total</i>			49.3	
Net internal area (NIA)				396.55	

SaTH Sustainable Services: Indicative Space Standards

Urgent Care (Acute & Planned Site)

Activity space	HBN size	Quantity	Area	Subtotals	Notes
Urgent Care Department (Acute & Planned Site)					
Entrance & Public Facilities					
Main entrance draught lobby	11.0	1	11		
Parking bay: 8 wheelchairs	6.0	1	6		
Reception: 3 staff	5.5	3	16.5		
Waiting area (size based on number of places)	2.25	25	56.25		
Waiting play area: 15 children	25.0	1	25		
Refreshment: drinking water dispenser	0.5	1	0.5		
Refreshment: vending machine	3.0	1	3		
WC: semi-ambulant	2.5	4	10		
WC & handwash: accessible, wheelchair	4.5	2	9		
Nappy changing room	5.0	1	5		
Infant feeding room	6.0	1	6		
				<i>Sub Total</i>	
					<i>148.25</i>
Clinical Zone					
Triage Room	12	1	12		Based on HBN Consulting Room. Capacity to be reviewed as part of OBC as there may be a need for 2 triage rooms.
Minors: See & Treat	12	6	72		Based on HBN single sided consult/exam room. Could be cubicles
Paeds Minors	12	2	24		Based on HBN single sided consult/exam room. Could be cubicles
Staff Base: 3 place	16.5	2	33		5.5m2 per member of staff
Eye Room	12	1	12		Based on HBN Outpatients ophthalmology room
Plaster Room	16	1	16		
Plaster Store	3	1	3		
Isolation Room	16	1	16		Based on HBN double sided consult/exam room.
Isolation Lobby	5	1	5		
Therapy Assessment Room	16	1	16		Based on HBN double sided consult/exam room.
Equipment Store	12	1	12		
				<i>Sub Total</i>	
					<i>221</i>
Support facilities					
WC & handwash: accessible, wheelchair	4.5	1	4.5		

SaTH Sustainable Services: Indicative Space Standards

Near patient testing room	8.5	1	8.5	
Parking bay: mobile X-ray unit	2.0	1	2	
Parking bay: ultrasound unit	1.0	1	1	
Clean Utility	16	1	16	
Dirty Utility	12	1	12	
Linen Store	6	1	6	
Storage Allowance	39	1	39	Assumes 3m2 per patient room
Disposal Hold: 1700 litres	8	1	8	
Cleaners' room	8	1	8	
Store: ready to use medical gas cylinders	9.0	1	9	
<i>Sub Total</i>				<i>114</i>
Social care & distressed/disturbed persons				
Interview room: 7 places (including 1 wheelchair place)	12.0	1	12	
WC & handwash: assisted	5.5	1	5.5	
De-escalation room	18.0	1	18	
<i>Sub Total</i>				<i>35.5</i>
Staff Spaces				
Staff support				
Office: 1 person	8	1	8	
Locker bay: 12 small lockers	1.5	1	1.5	
WC: ambulant	2	2	4	
Staff rest & mini-kitchen (size based on number of seats)	1.9	10	19	
Communal changing area (size based on number of lockers)	1.4	12	16.8	
<i>Sub Total</i>				<i>49.3</i>
Net internal area (NIA)			568.05	

Note: Circulation & Engineering Allowance to be added.

Activity space	HBN size	Quantity	Area	Subtotals	Notes
Urgent Care (Acute & Planned Site): Shared Staff Support					
Admin, Training & Education					
Office: 1 person	8	1	8		
Office: Open Plan	6	18	108		
Seminar room: 24 places (including 1 wheelchair place)	32	1	32		
Library & Study Room: 5 Persons	20	1	20		
<i>Sub Total</i>				<i>168</i>	

SaTH Sustainable Services: Indicative Space Standards

Net internal area (NIA)	168
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Note: Circulation & Engineering Allowance to be added.

SaTH Sustainable Services: Indicative Space Standards

Acute Emergency Care Unit (Acute & Planned Site)

Activity space	HBN size	Quantity	Area	Subtotals	Notes
Acute Emergency Care Unit (Acute & Planned Site): Option 4, 13 trolleys					
Entrance & Public Facilities					
Reception: 2 staff	5.5	2	11		
Waiting area (size based on number of places)	2.25	5	11.25		
WC: semi-ambulant	2.5	2	5		
WC & handwash: accessible, wheelchair	5.5	1	5.5		
	<i>Sub Total</i>			32.75	
Clinical Zone					
Trollyed Area	12	13	156		No HBN Equivalent
Staff Base: 3 place	16.5	2	33		5.5m2 per member of staff
	<i>Sub Total</i>			189	
Support facilities					
WC & handwash: accessible, wheelchair	5.5	2	11		
Parking bay: mobile X-ray unit	2.0	1	2		
Parking bay: ultrasound unit	1.0	1	1		
Clean Utility	16	1	16		
Dirty Utility	12	1	12		
Linen Store	6	1	6		
Disposal Hold: 1700 litres	8	1	8		
Cleaners' room	8	1	8		
	<i>Sub Total</i>			64	
Staff Spaces					
Staff support					
Office: 1 person	8	1	8		
Locker bay: 12 small lockers	1.5	1	1.5		
WC: ambulant	2	2	4		
Staff rest & mini-kitchen (size based on number of seats)	1.9	8	15.2		
Communal changing area (size based on number of lockers)	1.4	12	16.8		
	<i>Sub Total</i>			45.5	
Net internal area (NIA)				331.25	

Note: Circulation & Engineering Allowance to be added.

SaTH Sustainable Services: Indicative Space Standards

Exemplar 2 Theatre Suite

capacity is under review as part of the OBC as additional theatres are unlikely to be required

Activity space	HBN size	Quantity	Area	Subtotals	Notes
Entrance & reception					
Reception (size based on number of places)	5.5	2	11		
Waiting area (size based upon number of places)	1.7	8	13.6		
WC: semi-ambulant	2.5	2	5		
WC: independent wheelchair	4.5	1	4.5		
	<i>Sub Total</i>			<i>34.1</i>	
Clinical Spaces					
Operating Theatre Suite Facilities					
Anaesthetic Room	19	2	38		
Scrub-Up & Gowning Room	11	2	22		Option to use shared scrub facility at 16m2
Preparation Room	12	2	24		
Operating Theatre	55	2	110		
Exit parking bay: 1 bed / trolley	12	2	24		
Store: Theatre equipment	1	2	2		
Dirty Utility	12	2	24		
	<i>Sub Total</i>			<i>244</i>	
Recovery / PACU					
Recovery Bay - Post Anaesthetic: 1 place	13.5	8	108		4 per theatre*
Staff Base: 2 Staff	11	1	11		
Clean Utility with blood bank	17	1	17		
Dirty Utility: bedpan disposal & urine test	12	1	12		
WC: independent wheelchair	4.5	1	4.5		
Store: Linen	6	1	6		
Parking Bay: resuscitation trolley	1	1	1		
	<i>Sub Total</i>			<i>159.5</i>	
Net internal area (NIA)				437.6	

Note: Circulation & Engineering Allowance to be added.

Note: Assumes shared support & staff facilities

Note: Assumes access to shared discharge lounge

* Assumes 4 x Stage 1 recovery per theatre, with no dedicated Stage 2 Recovery - on assumption that inpatients will go back to their wards for Stage 2; daycases recover in DSU